

(NOT FOR DISTRIBUTION)

**EVALUATION OF USAID
HUMAN CAPACITY DEVELOPMENT
IN HEALTH**

**Carol D. Brancich
Andrew Kantner**

August 2003

**Submitted by
LTG Associates, Inc.
Global Health and Development Strategies
a division of Social & Scientific Systems, Inc.**

**Submitted to:
The United States Agency for International Development
Under USAID Assignment No. 2003-134**

ACRONYMS

CA	Cooperating Agency
CC	Country Coordinator
CDC	Centers for Disease Control
CIDA	Canadian International Development Agency
DIFD	Department for International Development, United Kingdom
GH	Bureau for Global Health
HCD	Human capacity development
HHS	(Department of) Health and Human Services
HIDN	(Office of) Health, Infectious Disease, Nutrition
HIV/AIDS	Human immunodeficiency virus/acquired deficiency syndrome
HPN	(Office of) Health, Population, Nutrition
HRM	Human resource management
IMF	International Monetary Fund
JSI	John Snow, Inc.
MAQ	Maximizing Access for Quality
NIH	National Institutes of Health
OHA	(Office of) HIV/AIDS
PI	Performance improvement
PRH	(Office of) Population and Reproductive Health
QA	Quality assurance
RCS	(Office of) Regional and Country Support
Reps	Representatives
TA	Technical Advisors
USAID	United States Agency for International Development
WHO	World Health Organization
WB	World Bank

ACKNOWLEDGMENTS

The Team would like to express its gratitude to the Global Health Bureau staff, to the staff of POPTECH, and to survey respondents and those individuals who participated in the interviews. The evaluation benefited greatly from the time and effort contributed by these individuals.

EXECUTIVE SUMMARY

The purpose of this evaluation is to provide an overview of Human Capacity Development HCD activities across the four main offices of the United States Agency for International Development's (USAID's) Bureau for Global Health (GH) and recommend options for addressing future HCD needs in health service provision. This evaluation report was undertaken for GH's Task Force on Human Capacity Development.

USAID has a long and relatively successful track record in various aspects of HCD for health service providers throughout the developing world. Unfortunately, previous USAID investments in HCD have been eroding (and in much of Sub-Saharan Africa quickly disappearing) in recent years. Recognition of this looming crisis has been slow to take hold within the donor community and will require aggressive "catch-up" action if health delivery systems are not to deteriorate further.

Much of the evidence compiled for this evaluation was derived from in-person and telephone interviews. The Team interviewed GH senior management staff, Country Coordinators (CCs), GH Cognizant Technical Officers (CTOs), USAID Population, Health, and Nutrition staffs residing in overseas missions, and CA Representatives. A short on-line survey of HCD was sent to the same individuals who participated in the qualitative interview sessions. The survey collected information on current HCD activities, future HCD needs, and actionable short and long-term HCD priorities that might be considered for incorporation by USAID in future activities.

Results from the survey indicate that there is broad agreement that USAID should give greater emphasis to HCD in the future and that current projects could be doing more to strengthen HCD for service providers. Most respondents agreed that the per-capita availability of health service providers had declined over the past decade. This view was especially marked among USAID Mission respondents in sub-Saharan Africa.

Most survey respondents were in agreement that future HCD needs in service provision will be concentrated in HIV/AIDS, maternal and child health, infectious disease and other reproductive health services (e.g., adolescent programs and post-abortion care). In the survey responses, family planning was not ranked highly as a future HCD priority area. In order to meet future demand for health care, it was noted that greater resources will need to be allocated for the training of nurse/midwives, paramedics (including various types of auxiliary workers), and community workers (including community-based fieldworkers and outreach workers). Lower priority was given to doctors, traditional nurse-midwives, and traditional healers.

The most important HCD needs typically identified by survey respondents were in-service training, staff deployment, employee incentives, conditions of service, and

pre-service training. Instituting better time/attendance reporting and the training of human resource specialists were ranked as the lowest priority areas.

When survey respondents were asked whether USAID could be effective in changing specific policies and practices in HCD (given host country political, regulatory and legal environments), there was considerable skepticism concerning the Agency's ability to significantly influence or assume responsibility for many HCD areas. For example, most respondents indicated that issues surrounding staff recruitment, staff retention, time/attendance reporting, civil service reform, and conditions of service were likely beyond USAID's ability to do much about. Respondents were more optimistic that USAID could play an important role in HCD activities that have been traditionally supported (e.g., pre and in-service training as well as the certification/accreditation of service providers), technical fields such as workload planning, and the training of human resource managers.

Findings, conclusions and recommendation based on interview information were organized according to four HCD classifications for action identified by the HCD Task Force - legal, policy and financial; human resource management (HRM); leadership; and, partnerships. Provision of service issues spans all four of these elements. Major findings under these headings are summarized below:

Legal, Policy, Financial

Bureau Structure

The vertical organizational and appropriations funding structures of GH are seen as presenting problems for focused, strategically directed cross-bureau HCD emphasis and/or initiatives. Lack of permeability between Office walls was cited by CA, Mission and Bureau respondents alike as being an obstacle in cross-office HCD areas. Because of the vertical nature of GH's structure, a variety of CAs and bilateral organizations under different programs currently work independently on HCD issues. They often do not collaborate. This current fragmented approach is viewed as costly in expended resources and time.

Recommendation 1: Advocacy by senior management levels of GH is required for undertaking HCD initiatives.

Recommendation 2: Establish the need for consensus on joint programming and funding for HCD initiatives in GH.

Salary Structures

In many country programs, limitations in host country salary structures and their companion civil service regulations were cited as almost insurmountable barriers to HCD. A number of respondents reported salary imbalances as root causes for current service provider supply and retention problems. Antiquated personnel

administration systems are reported to be in place in many countries, often deeply entrenched in the governmental culture. Performance appraisals are reported as largely nonexistent and certainly not linked to actual performance, neither in terms of quality nor in quantity.

Recommendation 3: Salary issues should be explored in selected countries to identify potential mechanisms for improving levels and/or imbalances in service provider remuneration, including partnering with other donors in this endeavor.

Essential Commodities

Problems in shortages of supplies, equipment, drugs and facilities shortcomings were reported as compounding the difficulties of service providers in quality of care provision. Lack of essential supplies was seen as greatly reducing providers' abilities to successfully fulfill standards of practice and also as a contributing factor to heightened worker frustration. Insufficient local financial resources were named as playing a large role in the shortages.

Recommendation 4: As procurement requirements in OHA continue to be delineated, GH should expand existing logistic management systems rather than creating new ones. Cross-bureau coordination must be strengthened using previous lessons learned (e.g., established purchasing, warehousing, and distribution systems).

Human Resource Management (HRM)

Country Strategic Plans

A number of Mission strategic plans include a Strategic Objective (SO), i.e. Egypt; Intermediate Objective (IR), e.g. Cambodia, Kenya; or sub-IR, e.g. South Africa, that would support HCD activities. Other Missions indicated that even though no specific IR for HCD exists in their strategic plans there would be no specific prohibition to conducting such activities. Emphasis on HCD and its system components have to date not been a priority in GH programming and funding. Findings indicate that all Missions contacted are facing HCD needs.

Recommendation 5: In collaboration with USAID field missions, consider undertaking HCD needs assessments in selected countries with success potential that will generate information on priority HCD needs in health.

Recommendation 6: Based upon the HCD needs identified through these assessments, propose mechanisms for incorporating HCD activities in USAID's country strategic plans.

Integrated Broad Scale HCD Programming

This evaluation noted that numerous and scattered HCD activities are being conducted throughout most CA projects and in bilateral agreements. However, broad scale integrated HCD efforts were not reported. Disjointed CA and bilateral HCD efforts are achieving output objectives, and although contributing to HCD practice improvement to varying degrees, they are not reported to be achieving long-term sustainability in HCD. Additionally, very little if any operations research or evaluation to assess HCD approaches has been conducted.

Recommendation 7: Integrated HCD should adopt a systems development approach in its programming.

Recommendation 8: Integrated HCD should include evaluation and operations research to determine the effectiveness of different HCD approaches and the potential for replicating successful models.

Realignment of Service Provider Categories/Cadres

Due to human resource crises in numerous countries, certain provider cadres are either being stretched far beyond polyvalence and/or being raided to staff crisis service areas. Others are leaving their employment. New service demands are being made of already overburdened staffs that are not necessarily the most appropriate cadre for performing the task. Respondents recognized the need for allocation of required skill sets to non-professional worker cadres.

Recommendation 9: Expand and realign the categories of service providers in the health workforce (e.g., community health workers, paramedics, auxiliary health workers, and pharmacists, and home care workers).

Recommendation 10: Redesign required skill sets for capacity development and supervision systems required to accommodate service provider realignment.

Training Practices

Over utilization of in-service training as an exclusive means of bolstering HCD gaps was reported quite frequently. Respondents support the notion that in-service needs will always exist especially in selected technical areas. However, they also acknowledge that invariably a policy of using in-service training in lieu of pre-service education is in practice.

Recommendation 11: In-service training should be carefully targeted to address performance gaps in newly identified tasks being added to job requirements or to personnel as new technologies and knowledge requirements emerge.

Pre-Service Education and Long-Term Training

In many of the countries canvassed, current professional leadership capacity is seen as weakening and not being readily replaced. Professional schools are under-

funded, lack needed technology and updated training approaches and are unable to meet current health care delivery demands. Clinical expertise in very complex HIV/AIDS prevention, treatment and care modalities is reported as lacking, as well as expert management skills to carefully balance other essential health services, e.g. child survival, immunization, population/reproductive, maternal-neonatal.

Loss of GH technical support for pre-service institutions, curriculum revision and long-term training is evident in the diminishing numbers of public health professionals and upper level managers. The concept of ‘twinning’ with US-based university programs for long-term training is also considered at a diminished level, thereby lessening the supply of cadres such as trained public health professionals.

Recommendation 12: Recommit to pre-service education and long-term training with emphasis on supporting regional and south-to-south educational and training institutions and US twinning mechanisms.

Recommendation 13: In order to effectively address HCD policy reforms and restructuring, USAID needs to be working not only with Ministries of Health, but also possibly with Ministries of Finance (for education funding), Ministries of Education (for nursing and medical education), and Ministries of Labor (for remuneration levels, incentive structures, and conditions of work).

Leadership

Finding: HCD Category/Cadre

A leadership layer of expert, well-practiced HCD leaders and managers does not appear to exist within any of the countries contacted, neither at central nor decentralized levels. No respondents reported broad scale training or mentoring of HCD managers and no one reported HCD in pre-service curriculum.

Recommendation 14: Pre-service education and in-service training in HCD management should be initiated to develop a critical mass of managers dealing with prevailing HCD issues.

Cooperating Agencies, PHN Field and GH Staff

HCD leadership qualities and technical expertise within CAs were described by field and GH respondents as ranging from non-existent to limited. CA activities in contacted countries were often seen to be repetitive in nature. The approaches were interpreted as being “off the shelf” (e.g., in-service training and supervision models) and not addressing the complexity of the country’s HCD problems. Sharing HCD experience and active collaboration among organizations is not currently being done. Bringing many of the GH technical expertise areas (e.g. quality assurance, performance improvement, curriculum design, training of trainers, management and supervision) together to collectively resolve service provider performance dilemmas

would begin to ensure strengthened HCD systems supportive to various program achievements.

Recommendation 15: Increase general awareness of HCD issues within GH and across CA organizations and establish consultative mechanisms for sharing project experiences and identifying best practices including those from Maximizing Access to Quality (MAQ), performance improvement (PI), and quality assurance (QA).

Recommendation 16: Clarity of language in CA annual work plans is highly desirable regarding the range and type of CA efforts in HCD. This would bolster awareness and confidence regarding HCD capacities within CA organizations and throughout the CA community.

Partnerships

Donor Coordination in HCD

Few respondents reported actual partnering with other donors in the HCD sphere (e.g., the World Bank, EU, DIFD or CIDA). The potential for donor partnering is reported to be within the HCD components of personnel administration (salaries paid) and integration of HR and health system objectives (civil service reform). US organizations were also identified as either having presence or the potential for in-country partnering, e.g. Centers for Disease Control (CDC), Health and Human Services (HHS), National Institutes of Health (NIH), and US foundations - Gates, Hewlett, Packard. Several respondents were concerned by the lack of consistent GH senior-level participation in discussions with these organizations to assure that USAID is seen and acknowledged for its technical assistance capacity.

Recommendation 17: Host country representatives and organizations should be considered full partners in developing and implementing any HCD initiatives.

Recommendation 18: Substantive liaison between USAID GH and potential partners such as the WB, WHO, and EU would greatly increase the potential for success in HCD.

Recommendation 19: Participation at senior management levels with other US organizations (e.g., CDC, NIH, and HHS) is required for administrative and programmatic partnering in health HCD efforts.

Based upon the findings and recommendations from this assessment, concrete next steps were identified for consideration by the GH Task Force on HCD. These are as follows:

1. Develop an HCD Strategy that articulates HCD needs and identifies the scope and depth of priority HCD initiatives GH may be prepared to support

(within each office and jointly). This strategy should be guided by USAID's programmatic experience, current technical capabilities, and careful assessments of the potential for success. This is an overarching recommendation for the evaluation.

2. Implement an Integrated HCD Country Initiative. This activity would address priority HCD needs in a selected number of countries where the potential for programmatic action appears promising. The objective of this initiative would be to field test various HCD initiatives in diverse country environments in order to identify successful models for action, best practices in HCD, and interventions that appear to have good potential for replicability.
3. Review the status of GH's internal and contractual mechanisms for supporting Long-Term Training in the United States.
4. Evaluate the potential of Professional Exchange Programs and Collaboratives in Health as effective HCD strategies.
5. Better position USAID to assume a more prominent Global Leadership Role in HCD for health.

I. INTRODUCTION

Purpose of the Evaluation

In recent years there has been a growing recognition of the need to better address human capacity development (HCD) needs in health service delivery in developing countries. This concern has been driven both by the ever-growing client base for health care and by the HIV/AIDS crisis that has decimated the ranks of service providers in countries that have been hit hard by the epidemic. There is currently considerable concern that the international donor community is not making the long-term investments in human resources and health system reform needed to ensure the provision of accessible and high quality care.

The purpose of this evaluation is to provide an overview of HCD activities across the four main offices of United States Agency for International Development (USAID) Bureau for Global Health (GH) and recommend options for addressing future HCD needs in health service provision. These GH offices are the Office of Population and Reproductive Health (PRH), the Office of HIV/AIDS (OHA), the Division of Health, Infectious Disease, and Nutrition (HIDN), and the Office of Regional and Country Support (RCS).

This evaluation report was undertaken for GH's Task Force on Human Capacity Development. This Task Force includes representatives from all four offices within GH. As stated in the original Scope of Work, the purpose of this evaluation is to "present a series of options for the HCD Task Force related to USAID's manageable interest regarding the type, extent, and level of involvement in HCD in the health sector as it relates to service delivery". Specific activities for this evaluation are as follows:

1. Finalize questions pertaining to HCD that will be asked of Missions, Cooperating Agencies (CAs), and GH staff in response to current HCD activities and facilitate an exercise that reviews and revises (where needed) the goals and objectives of the HCD Task Force.
2. Conduct a survey of global health and bilateral projects to determine what is being done in HCD
3. Make a series of recommendations (in the forms of options) to the Task Force as to how GH should support HCD in the future.

Background

USAID has a long and relatively successful track record in the training of health service providers throughout the developing world. In recent decades these efforts have shifted from longer-term pre-service training (focusing on the production of new doctors) to in-service training of nurse/midwives and various types of auxiliary and community-based workers. The training of individual service providers has also tended to supplant USAID's earlier commitment to investing for the long-term in educational and training organizations in developing countries (institution building).

Unfortunately, previous USAID investments in HCD have been eroding (and in much of Sub-Saharan Africa quickly disappearing) in recent years. Recognition of this looming crisis has been slow to take hold within the donor community and will require aggressive "catch-up" action if health delivery systems are not to deteriorate further.

In many Sub-Saharan African countries, a growing shortage of new service providers (and skill sets) relative to projected health care needs (disease burdens) is occurring. Low salaries, poor working conditions, and the effect of economic decline combined with donor-driven structural readjustments of the public sector have all contributed to the rapidly growing human resources crisis within the health sectors of many sub-Saharan countries. Dwindling investments in regional and national medical and nursing schools (as donors shy away from pre-service training involvements) is also making it more difficult for many developing countries to produce the number and type of health workers they need.

Professional health sector cadres are also shrinking in many African countries owing to the morbidity/mortality impact of the HIV/AIDS crisis. Current evidence suggests that around 20 percent of the African health workforce will eventually be lost to the HIV/AIDS epidemic (Tawfik and Kinoti, 2001:3). In addition, HCD needs are being exacerbated by the emigration of health workers from poorer countries to settings with higher salaries and improved career prospects, and the early retirement of health workers owing to low salaries, poor working conditions, and the growing danger of treating sick patients with new infectious diseases.

In other regions of the developing world, HCD issues can take on a very different complexion. In countries such as Egypt and South Africa, HCD problems are often viewed more in terms of staff deployment, retention, and achieving an appropriate mix of skills among new service providers rather than a problem of undersupply per se (although both Egypt and South Africa presently have severe nursing shortages).

While HCD needs have reached crisis proportions in many developing countries, especially those significantly impacted by the HIV/AIDS epidemic, worries about how to best train, deploy, and retain service providers have bedeviled international

health experts for decades. Much donor-driven HCD activity has focused on the in-service training of individual practitioners with respect to specific program areas (e.g., in family planning and reproductive health, maternal and child health, and the diagnosis, treatment, and prevention of specific infectious diseases such as malaria, polio, and TB). While these efforts have no doubt made useful contributions, they are increasingly viewed as inadequate in terms of improving the overall functionality and performance of health systems and enhancing the delivery of health care in resource poor settings.

Owing to the growing awareness that much HCD technical assistance has failed to greatly enhance individual and institutional capacities or produce sustainable results, there is a growing recognition that HCD initiatives should go well beyond the never-ending need to provide training to individual service providers. Instead, it is increasingly recognized that HCD issues need to be articulated in relation to the health environments (disease burdens) of specific countries or regions and be engaged within the functional context of indigenous health systems. In other words, HCD interventions need to be highly sensitive to in-country managerial and resource realities, programmatic need, and political sensitivities in order to be successful.

While upgrading the knowledge and competencies of individual service providers will continue to be a central feature of any HCD strategy, other HCD needs come into sharper relief when considering how HCD inputs contribute to the outcomes generated by health systems. One respondent participating in this evaluation succinctly summed up matters as follows:

Donor projects tend to focus on the production of health workers, supervision training, and the quality of work done by providers (mainly in the public sector). The real issues in HCD are distribution of health manpower within a country, motivation of workers to perform primarily related to salary and benefits, and drug and supply logistics so that workers have the materials they need to actually perform the work the systems ask of them. We generally don't consider these areas as HCD issues, but they are (POPTECH Respondent, 2003).

For the purposes of this evaluation, HCD is defined as the process of developing the abilities, skills, and motivation of service providers to deliver high quality health services. Meeting HCD needs also entails strengthening human resource management in order to ensure the effective supply, deployment, and retention of health manpower within a health delivery system. Perhaps the term human resources management (HRM) would better describe the complex of components considered in this report. However, for the sake of clarity, the term HCD will be used in this report.

The GH Task Force has identified five major HCD components in considering current and future HCD needs in health service provision¹. Similar typologies have been adopted by other international and bilateral donor organizations (e.g., WHO, the World Bank, DFID, and CIDA) in their efforts to respond to HCD needs in health. These components are described in Table 1.

As is obviously apparent, the five HCD components listed in Table 1 constitute a broad, some might say unmanageable programmatic agenda. Not only are HCD agendas far ranging, but they often involve sensitive issues pertaining to program ownership, domestic legal and regulatory practices, cultural bureaucratic environments, and ultimately national sovereignty. However, if these crucial health input "issues" are not adequately dealt with in the future, it is unlikely that health systems will be capable of generating the hoped-for outputs (results) everyone would like to see. Picazo et al., (2003) succinctly summarize the dilemma of HCD in terms of the immediate health challenges facing Africa.

A key factor in the neglect of health workers' (HCD) issues is the view held by governments and donors that HR (human resources) is too big, too complex, and too intractable to be solved by one donor or by the government alone depending on its meager resources. A second factor is the tradition that donor projects can only provide resources for capital costs or for foreign exchange requirements (e.g., drug imports, international technical advisory services, or staff training abroad), but not for recurrent costs, and certainly not for salary support or enhancement. A third factor is the continuing fragmentation of African health systems largely balkanized by donor projects, each having its own overlapping set of HR sub-systems, incentive structures, training programs, and disease priorities. Clearly the HR problem is the elephant in the room that both donors and African governments have ignored and that is now throwing its weight around (Picazo et al., 2003:36).

Another challenge facing HCD is that short-term project cycle perspectives don't fit well with the long-term investment strategies that will be needed to make lasting headway. As one respondent in this evaluation noted, HCD requires a marathon rather than sprint mentality when developing interventions and programming resources. This longer-term perspective will entail adjustments in USAID's current predilection for project assistance tied to the achievement of short-term results.

Methodology

A two-person team experienced in human capacity development, manpower planning, and service provision in developing countries undertook this evaluation

¹ For further elaboration of the organizational scheme presented in Table 1 see Martinez and Martineau, (1998), "Rethinking human resources: an agenda for the millennium", *Health Policy and Planning*, 13(4).

Table 1: Major Components of Human Resources in Health

1. **Staff Supply: What people recruited for health programs and where do they work?**
 - a. **Deployment:** Defining and filling positions.
 - b. **Job Description:** Specifying the role of different categories of workers, including the mix of different skill sets.
 - c. **Recruitment:** Identifying candidates for staff positions relating to health system needs.
 - d. **Career Development:** Developing promotion criteria and policies for employees and providing career opportunities based on performance.
2. **Performance Management: Managers have some objective means for evaluating the performance of their staff and the authority to act on evaluations.**
 - a. **Performance Appraisal Systems:** Evaluating the performance of health staff using clear criteria and records.
 - b. **Time/Attendance Reporting:** Maintaining routine system records pertaining to who is working, where they are working, and for how long.
 - c. **Incentives:** Rewarding or sanctioning employees based on performance.
3. **Personnel Administration and Employee Relations: There are formal rules and procedures governing the management of personnel issues, other than individual performance.**
 - a. **Conditions of Service:** Instituting job requirements, fringe benefits, and rights of employees.
 - b. **Terms of Employment:** Establishing salary scales, requirements for full versus part time employment, flexibility in hours worked, contracting procedures and regulations.
 - c. **Labor Relations:** Union representation, collective bargaining, role of professional organizations.
 - d. **Staff Promotion:** Explicit criteria and policies are in place.
4. **Education and Training: Do professional and technical educational institutions and in-service training programs support an overall assessment of system needs?**
 - a. **Coordination of Pre-Service Education:** Adopting pre-service educational planning, coordinating health education needs and standards across ministries, and developing professional managed HR units.
 - b. **In-Service Training:** Usually the largest area of donor support, but to what degree does this fit into an overall plan? Instituting competency testing and the systematic maintenance of training records and undertaking research to improve cost-effectiveness.
 - c. **Certification:** Attaining formal recognition based on demonstrated skills or knowledge; applies to private sector providers.
 - d. **Accreditation:** Periodically evaluating training programs based on well-defined standards.
 - e. **Licensing:** Adhering to formal legal requirements for practicing a profession, which may involve competency testing or periodic re-testing, or continuing education requirements.
5. **Integration of Human Resources and Health System Objectives: Changes at the policy level may involve broader health sector reform, or go beyond the health sector.**
 - a. **Civil Service Reform:** Instituting changes in civil service regulations to increase performance; may require changes in law or high-level political decisions.
 - b. **Staffing Needs Assessment/Workload Planning:** Evaluating the actual amount of work different categories of staff are carrying out, followed by corresponding plans to get the most out of available workers.
 - c. **Formal, Transparent Management of Human Resources:** More effectively managing human resources on the basis of formal procedures that reflect the needs of a health care system as found in a human resources plan or evaluation
 - d. **Training and Other Support for Human Resource Specialists and Units:** Upgrading the professional qualifications and experience of HR practitioners (e.g., in general personnel administration) and deal with challenges to HR management posed by decentralization.

Heiby (2003).

for the GH Task Force on HCD. Much of the evidence compiled by the team was derived from in-person interviews and phone calls. The team interviewed GH Country Coordinators (CCs), GH Cognizant Technical Officers (CTOs), USAID Population, Health, and Nutrition staffs residing in overseas missions, and CA Representatives. A complete list of persons contacted as part of this evaluation is shown in Appendix VI.

A short online questionnaire (administered through surveymonkey.com) consisting of 25 questions was also deployed as part of this evaluation. The questionnaire was sent to the same individuals that were contacted for phone interviews. The survey collected information on current HCD activities, future HCD needs, and actionable short and long-term HCD priorities that might be considered for incorporation by USAID in future activities.

As part of this evaluation, a brief review of HCD activities being undertaken by other multilateral and bilateral donor organizations was undertaken. This information was compiled through phone interviews and by visiting web sites of relevant organizations (e.g., the World Bank and World Health Organization). The team also reviewed USAID project documents pertaining to HCD, including research studies, progress reports, management reviews, and training evaluations.

This assessment is not a detailed formal evaluation of all HCD activities in health currently being implemented by USAID (either through bilateral projects or centrally-funded organizations). It does provide a general overview of current HCD activities and policies within GH and proposes options for enhancing HCD strategies relevant to achieving future strategic objectives in health.

II. FINDINGS FROM THE EVALUATION SURVEY ON HUMAN CAPACITY DEVELOPMENT

A short survey of human capacity activities and future priorities was undertaken as part of this evaluation. The survey was administered to GH CCs, CTOs, Population, Health, and Nutrition Officers in USAID field missions, and representatives from USAID's CA community. The countries and CAs selected for inclusion in this survey are shown below. While the number of respondents for the survey was not large (and the level of response among GH CCs and CTOs somewhat disappointing), it is still possible to a degree to identify essential characteristics of current HCD activities and future need. Results from the survey are presented in Appendices II-V.

The range of potential HCD issues is extensive and varies considerably across regions and individual country settings. However, there is also broad agreement that USAID should give greater emphasis to HCD in the future and that current projects could be doing more to strengthen HCD for service providers.

Countries Contacted	Cooperating Agencies Contacted
Bangladesh	PHR+/Abt Associates
Cambodia	Basics II
Egypt	Catalyst
Indonesia	EngenderHealth
Kenya	JHPIEGO/TRH
Malawi	JSI/Deliver
Nigeria	MSH/M&L
Senegal	Pathfinder
South Africa	PRIME II
Uganda	URC/QAWD
Ukraine	
Zambia	

Respondents identified several HCD problems (or imbalances) that are seriously affecting the accessibility and quality of health services in many developing countries. For example, USAID Missions noted that too few new service providers are being trained and that too many existing providers are concentrated in urban areas (see Appendix V, Table 2). CA Representatives (Reps) also stated that the ratio of doctors to nurses is too high in many settings and that highly trained doctors with specialized skills tend to be over-represented in relation to general practitioners. Somewhat surprisingly, very few USAID Missions (only Zambia) reported that the emigration of health workers is a significant problem affecting the deployment and retention of health workers in their countries.

GH Country Coordinators and USAID Mission Staff	GH CTOs and Cooperating Agency Representatives
Ratio of Urban to Rural Providers Too High	Ratio of Urban to Rural Providers Too High
Ratio of Doctors to Nurses Too High	Ratio of Doctors to Nurses Too High
Few New Service Providers Entering Service	Few New Service Providers Entering Service

Most respondents agreed that the per-capita availability of health service providers had declined over the past decade. This view was especially marked among USAID Mission respondents in sub-Saharan Africa (e.g., Senegal, Malawi, Uganda, and Zambia), where availability was often described as having “greatly deteriorated”. In general, rural service availability appears to have declined more rapidly than in urban areas, which suggests that future HCD efforts will need to give greater weight to improving service delivery in more remote areas. Respondents also report that the per-capita availability of family planning service provision has declined relative to HIV/AIDS, maternal and child health, infectious disease, and other reproductive health services during this same time frame.

There is general agreement that the impact of HIV/AIDS has greatly increased the need to train more service providers and address HCD issues. This view is especially pronounced among USAID Missions in sub-Saharan Africa. The

growing appreciation for HCD issues in health service delivery may also be reflected by the large percentage of developing countries that have recently requested assistance in addressing HCD needs. For example, 89 percent of all USAID Missions and 88 percent of CA Reps say that they have received requests for technical assistance in HCD. Respondents also report that other donors are becoming more active in HCD work. However, donor coordination on HCD issues is generally weak, and appears to be highly country-specific.

In spite of this growing concern, many of the countries surveyed do not have specific HCD strategies in place that allocate resources for health service providers. Among countries with HCD strategies, priority appears to be given to HIV/AIDS service provision, with infectious disease and nutrition receiving the least attention (especially as reported by CA Reps). HCD components (listed in Table 1) that typify these strategies include personnel administration and the education/training of service providers. The supply system for health, performance management, and the integration of human resource competencies in health system planning tend to receive less attention.

Respondents provide a somewhat inconsistent depiction of the extent to which HCD issues have been incorporated in strategies for addressing future health service delivery needs. Eighty percent of GH/CCs say that USAID has adopted comprehensive HCD strategies at the country level, while only 50% of USAID Missions report having such strategies in place. However, all respondents report that USAID is actively engaged in the education and training of service providers, primarily of the in-service rather than pre-service variety. Other HCD components are relatively neglected at the present time.

GH Country Coordinators, USAID Missions, and CA Reps agree that USAID-funded training activities for health service providers have not been systematically evaluated. Only GH CTOs seem to be of the view that evaluation is not a current deficiency. Curiously, in situations where this training has been evaluated, GH and USAID Mission staffers are more skeptical about the effectiveness of these efforts. For example, only 25 percent of USAID Missions rated in-country training activities as “highly effective”, whereas 100% of CA Reps thought that USAID-funded training events warranted this rating.

Current training activities funded by USAID appear to be focusing primarily on doctors and nurse/midwives. Respondents report that low priority is now being given to training traditional nurse/midwives, paramedics, community workers, and traditional healers. All but one of the five CTOs responding to this survey said that nurse/midwives are currently being accorded low priority in USAID’s training activities, a depiction very much at odds with replies from Country Coordinators, USAID Missions, and CA Reps.

All respondents were in agreement that future HCD needs in service provision will be concentrated in HIV/AIDS, maternal and child health, infectious disease and

other reproductive health services (e.g., adolescent programs and post-abortion care). Family planning was not ranked highly as a future HCD priority area.

In order to meet future demand for health care, it was generally agreed that greater resources need to be allocated for the training of nurse/midwives, paramedics (including various types of auxiliary workers), and community workers (including community-based fieldworkers and outreach workers). Lower priority was given to doctors, traditional nurse-midwives (a cadre that has received considerable attention from USAID in countries such as Bangladesh and Indonesia in the past), and traditional healers.

Table 4: Program Areas in which Future Demands on Service Provider HCD will be Most Critical	
GH Country Coordinators and USAID Mission Staff	GH CTOs and Cooperating Agency Representatives
HIV/AIDS	HIV/AIDS
Maternal and Child Health	Infectious Disease
Other Reproductive Health Services	Maternal and Child Health

Table 5: Type of Health Worker that should receive Priority Attention in Meeting Future HCD Needs	
GH Country Coordinators and USAID Mission Staff	GH CTOs and Cooperating Agency Representatives
Nurse/Midwives	Nurse/Midwives
Community Workers	Community Workers
Paramedics	Paramedics

As noted in Table 1, HCD includes a broad array of issues and potential interventions. Respondents were asked to rank these HCD elements in terms of their level of importance in individual countries or across the project activities of Cooperating Agencies participating in this evaluation. While there was some variation in findings when comparing the four respondent categories employed by this survey, informants typically identified in-service training, staff deployment, employee incentives, conditions of service, and pre-service training as the most important needs in HCD. Instituting better time/attendance reporting and the training of human resource specialists were ranked as the lowest priority HCD issues. According to information supplied by USAID missions, these results generally applied across the countries surveyed for this evaluation (see Table 4 in Appendix V).

Table 6: Current Priority HCD Needs as Reported by Survey Respondents	
GH Country Coordinators and USAID Mission Staff	GH CTOs and Cooperating Agency Representatives
In-Service Training	Staff Deployment
Employee Incentives	Employee Incentives
Conditions of Service	Pre-Service Training

Unfortunately, the HCD priorities identified in this survey do not always correlate well with USAID's perceived programmatic and technical competencies in HCD. When respondents were asked whether USAID could be effective in changing specific policies and practices in HCD (given host country political, regulatory and legal environments), there was considerable skepticism concerning the Agency's ability to significantly influence and assume responsibility for many HCD areas.

For example, most respondents indicated that issues surrounding staff recruitment, staff retention, time/attendance reporting, civil service reform, and conditions of service were likely beyond USAID's ability to do much about. Respondents were more optimistic that USAID could play an important role in HCD activities that have been traditionally supported (e.g., pre and in-service training as well as the certification/accreditation of service providers), technical fields such as workload planning, and the training of human resource managers.

Table 7a: HCD Components that USAID Resources and Technical Assistance could Likely Impact	
GH Country Coordinators and USAID Mission Staff	GH CTOs and Cooperating Agency Representatives
Pre-Service Training	In-Service Training
Certification/Accreditation	Pre-Service Training
In-Service Training	Certification/Accreditation
Table 7b: HCD Components in which USAID Resources and Technical Assistance would Likely Have Little or No Impact	
GH Country Coordinators and USAID Mission Staff	GH CTOs and Cooperating Agency Representatives
Staff Retention	Staff Recruitment
Time/Attendance Reporting	Time/Attendance Reporting
Civil Service Reform	Conditions of Service

III. INTERVIEW FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

In-person and telephone interviews were also conducted as part of this evaluation using the five HCD Component areas specified in Table 1 as the basis for discussions. As noted in the Methodology section, the same respondents that were sent the survey questionnaire were contacted for interviews.

The findings, conclusions and recommendation based on interview information have been organized according to four HCD classifications for action identified by the HCD Task Force - legal, policy and financial; human resource management (HRM); leadership; and, partnerships. Provision of service issues spans all four of these elements.

Legal, Policy, Financial

Finding: Bureau Structure

The vertical organizational and appropriations funding structures of GH are seen as presenting problems for focused, strategically directed cross-bureau HCD emphasis and/or initiatives. Lack of permeability between Office walls was cited by CA, Mission and Bureau respondents alike as being an obstacle in cross-office HCD areas such as, but not limited to, standardization in delivery system supervision, personnel deployment, frontline worker task and skill requirements (job descriptions), and training management, logistical and supply management systems. One respondent described the need as “lacking a corporate consensus regarding HCD.”

HCD leadership within GH was not apparent to those interviewed. That a Bureau wide Task Force has been commissioned to assess HCD needs and activities, was welcome new information for respondents. Of special importance to Mission respondents was the possibility that monies could be mixed to effect broader changes in HCD in meeting overlapping service demands and the needs of an integrated (polyvalent) workforce. Co-mingling of funds across Bureau offices in a balanced way was described as being desirable. Several of the Mission officers reported recent shifts in program priorities as causing imbalances in previously emphasized service areas; e.g. ID, child survival, family planning.

Because of the vertical nature of GH’s structure, a variety of CAs and bilateral organizations under different programs currently work independently on HCD issues in a number of countries. They occasionally collaborate yet often do not. This current fragmented approach is viewed as costly in expended resources and time. Although a variety of outputs are reported being produced, scattered approaches under this vertical construct appear to be producing very few sustainable, stable changes in the five HCD Components.

Field officers, by and large, understand the need for HCD although vary in their assessments as to which of the five HCD Components apply in their situation. Several respondents noted that the creation of a GH task force charged with exploring HCD issues was in itself a sign for GH’s leadership that these issues are priorities and that cross-office programming is needed.

Conclusion

Collaborative, joint venture HCD programming and funding are needed within GH. Systemic issues confront program and project implementation across the Bureau’s offices. In health delivery systems dependent upon polyvalent workers and/or service providers performing multiple tasks, HCD is at the heart of quality assurance and service delivery efficiency. HCD constraints of staff supply, performance management, personnel administration, education and training and integration of HCD and health system objectives are critical programming issues across all GH offices.

Cross-office strategic planning is fundamental to HCD technical expertise being well coordinated and strategically directed. Minimizing redundancy in efforts, maximizing resource investments, and programming strategically directed interventions would produce a greater degree of stability and sustainability in health service infrastructure components than is currently being achieved. Vertical programming for HCD is not dealing with the broad systemic issues satisfactorily. The question of HCD as a means (input) leading to strategic outcomes and not an outcome in itself seemed to have value for several respondents.

Recommendations

Recommendation 1: Advocacy by senior management levels of GH is required for undertaking HCD initiatives.

Recommendation 2: Establish the need for consensus on joint programming and funding for HCD initiatives in GH.

Finding: Salary Structures

In many country programs, limitations in host country salary structures and their companion civil service regulations were cited as almost insurmountable barriers to HCD. A number of respondents reported salary imbalances as root causes for current service provider supply and retention problems. Antiquated personnel administration systems are reported to be in place in many countries, often deeply entrenched in the governmental culture.

Additionally, in lieu of salary supplements or salary structure change, training stipends for in-service participants were frequently cited as being used as an incentive factor by USAID. Although effective to a point, training participant stipends were described as ultimately unsatisfactory especially when competing with other donors' provision of long term salary supplements that result in frequent employee transfers to donor salary supplemented projects.

Performance appraisals are reported as largely nonexistent and certainly not linked to actual performance, neither in terms of quality nor in quantity. Subsequently, performance appraisal linked to performance remuneration, incentives, or salary adjustments are not readily encountered.

Conclusion

Delays in or avoidance of civil service reforms continues the problems of salary inequities, employee retention, deployment imbalance and poor job performance. It is acknowledged that HCD policy restructuring is not always within the exclusive control of the Ministry of Health (MOH). Other ministries are frequently involved like those of Finance and Labor. Therefore, whole-scale MOH transformation is

undoubtedly not possible in most countries; rather, incremental changes could be effected in selected countries.

In a few select countries, where the potential for broader infrastructure interventions is highest, partnering with other donors to address root cause factors would be of most benefit. GH need not assume full responsibility, but rather it could provide the technical expertise for which USAID is best positioned and partner with those donors able to provide funding, e.g. Department for International Development-United Kingdom (DIFD), World Bank (WB).

Recommendation

Recommendation 3: Salary issues should be explored in selected countries to identify potential mechanisms for improving levels and/or imbalances in service provider remuneration, including partnering with other donors in this endeavor.

Finding: Essential Commodities

Problems in shortages of supplies, equipment, drugs and facilities shortcomings were reported as compounding the difficulties of service providers in quality of care provision. Lack of essential supplies was seen as greatly reducing providers' abilities to successfully fulfill standards of practice and also as a contributing factor to heightened worker frustration. Insufficient local financial resources were named as playing a large role in the shortages. Inefficient logistic management procedures also play a role. Frontline service delivery is dependent on availability of proper and sufficient commodities to perform well. Burdening frontline workers with logistical management tasks was reported as needing restructuring, especially where specific management criteria are essential to safety in pharmaceutical logistics, e.g. cold chain for immunizations, shelf-life for ARVs.

Conclusion

Developing and maintaining well functioning supply and equipment systems is seen as being critical to the quality performance factor for providers. Within GH, large numbers of lessons learned in this area already exist, especially in the Offices of HIDN and PRH. As the requirements in OHA continue to be delineated, expanding existing logistic management systems could be more quickly and efficiently achieved than creating new ones.

Recommendation

Recommendation 4: As procurement requirements in OHA continue to be delineated, GH should expand existing logistic management systems rather than creating new ones. Cross-bureau coordination must be strengthened using previous lessons learned (e.g., established purchasing, warehousing, and distribution systems).

Human Resource Management (HRM)

Finding: Country Strategic Plans

A number of Mission strategic plans include a Strategic Objective (SO), i.e. Egypt; Intermediate Objective (IR), e.g. Cambodia, Kenya; or sub-IR, e.g. South Africa, that would support HCD activities. Other Missions indicated that even though no specific IR for HCD exists in their strategic plans there would be no specific prohibition to conducting such activities, e.g. Uganda. One country, Senegal, did report severe office staff shortages as a barrier to currently adding HCD to their workload. Several Missions contacted have the potential for HCD system interventions within the five HCD Components. Two Missions, Cambodia and South Africa, show promise and interest in programming for a number of the five HCD Components, and in Cambodia in perhaps in all five components. Other Missions show promise in programming in a few selected components - Kenya, Malawi, Uganda, and Ukraine. Egypt has already embarked on a major pre-service curricula reform and expects to complete it within two years. It is understood that Egypt has other potential HCD programming areas.

Conclusion

Emphasis on HCD and its system components have to date not been a priority in GH programming and funding. The findings indicate that all Missions contacted are facing HCD needs. It seems logical that HCD planning should be a priority in those country strategic plans and in their GH programming. A 'corporate HCD consensus' spanning GH and field offices vis-à-vis health programs is in order. Careful (1) identification of the root cause issues of HCD problems, (2) selection of feasible interventions and (3) developing HCD activities to address priority problems is warranted. Those country field programs noted above require further exploration/assessment.

Recommendations

Recommendation 5: In collaboration with USAID field missions, consider undertaking HCD needs assessments in selected countries with success potential that will generate information on priority HCD needs in health.

Recommendation 6: Based upon the HCD needs identified through these assessments, propose mechanisms for incorporating HCD activities in USAID's country strategic plans.

Finding: Integrated HCD Programming

In response to whether activities were in progress or recently completed in any of the five HCD Components, numerous and scattered HCD activities were reported as being conducted throughout most CA projects and in bilateral agreements. These

activities included large numbers of in-service training activities; some activities in supervision strengthening (Malawi, Zambia); one bilateral funded pre-service curriculum reform initiative (Egypt); and a few CA activities in decentralized HCD strengthening (Zambia). Of special note are those CAs whose objectives already include HCD components. An illustrative list includes INTRAH/PRIME II, URC/QAWD, JHPIEGO/TRH, Abt/PHR +, and PI/Catalyst. Additionally, other CAs without HCD objectives also report involvement in some aspect of the five Components, e.g. BASICS II, EngenderHealth. Yet, broad scale integrated HCD efforts were not reported.

In addition to numerous small-scale interventions taking place some Missions and CCs reported two or more CAs working independently in countries. Linkages and cohesiveness between interventions are not occurring. At least two countries reported that current CAs are not systems-oriented and so continue to function within comfort-level zones of skills training-both technical and managerial. Only two CAs were described as oriented to systems development, yet the impression is that other CAs could and should redirect their efforts.

Disjointed CA and bilateral HCD efforts are achieving output objectives, and although contributing to HCD practice improvement to varying degrees, they are not reported to be achieving long-term sustainability in HCD. Delivery infrastructures are reported as crumbling and are not able to sustain new service demands being placed upon many of them. Additionally, very little if any operations research or evaluation to assess HCD approaches has been conducted.

Conclusion

Over the years, USAID in-service and pre-service investments have been well received and recognized as being beneficial, yet training/education alone does not guarantee quality of service practice nor better health outcomes. A range of events in many countries has led to deterioration in health service infrastructures and consequently, erosion of USAID prior investments. Close attention is needed to assure that CA interventions are responding to strategic HCD needs.

Approaches in the five HCD Components, added to continuing the time honored activities of the component for in-service and pre-service education, are required to attend to weakened ineffective HCD systems within fragile health delivery infrastructures. Review of the input from interview and survey respondents indicate that without concentrated, well-directed inputs into HCD systems, host country health delivery infrastructures will further erode and even further lessen the achievement potential of GH programmatic outputs/outcomes. And, without operations research and evaluation, HCD approaches and practices may or may not produce lasting and replicable HCD advances.

Recommendations

Recommendation 7: Integrated HCD should adopt a systems development approach in its programming.

Recommendation 8: Integrated HCD should include evaluation and operations research to determine the effectiveness of different HCD approaches and the potential for replicating successful models.

Finding: Realignment of Service Provider Categories/Cadres

Due to human resource crises in numerous countries, certain provider cadres are either being stretched far beyond polyvalence and/or being raided to staff crisis service areas. Others are leaving their employment. Factors cited for departure by health workers include emigration, retirement, stress, economic hardship due to salary inequities and/or non-payment, HIV/AIDS morbidity/mortality and fear of acquiring infection, and health system reorganization with position redundancy or redeployment. Service areas are reported to be unattended, staffed with unskilled providers, or with overburdened and disheartened providers. A disproportionate distribution of personnel, e.g. urban to rural, continues to be a problem in many country programs and compounds the issue of staff deployment.

New service demands are being made of already overburdened staff that are not necessarily the most appropriate cadre for performing the task. Respondents recognized the need for allocation of required skill sets to non-professional worker cadres. However it must be acknowledged that this call for realignment of frontline provider tasks requires skill capacity development and supervision and management adjustments to accommodate the realignment up and down the service provider line.

Conclusion

Traditional professional cadres, e.g. physicians, nurses, nurse-midwives, can no longer be considered as the frontline workers through which the bulk of services can be provided. Numbers are dwindling, replacement numbers are not keeping up with attrition, new skills and tasks are being required, cost effectiveness in workforce expenditures is paramount, and management capacity is vitally needed. Reducing barriers to professional practice would allow for job task realignment.

Expanding or realigning the service provider workforce pool presents new challenges in HCD. Inclusion of such personnel categories as community workers, pharmacists and outreach and home care workers, to name a few, is required. Additionally, performance improvement principles would need to be applied and quality of care standards established.

Recommendations

Recommendation 9: Expand and realign the categories of service providers in the health workforce (e.g., community health workers, paramedics, auxiliary health workers, and pharmacists, and home care workers).

Recommendation 10: Redesign required skill sets for capacity development and supervision systems required to accommodate service provider realignment.

Finding: Training Practices

Over utilization of in-service training as an exclusive means of bolstering HCD gaps was reported quite frequently. Respondents support the notion that in-service needs will always exist especially in selected technical areas. However, they also acknowledge that invariably a policy of using in-service training in lieu of pre-service education is in practice. In-service training has been substituted to fill the gaps in pre-service curricula and education that over years continue to exist and have not yet been revised to meet emerging care practice and competency needs.

Conclusion

Over reliance on in-service training as the producer of such yields as quality of care, improved supervision and others may reflect misinterpretation of the root causes for gaps in these areas. It may also reflect selecting the most familiar, more easily programmed intervention with assurance of output numbers. In-service training when appropriately used can successfully assist with adding new knowledge and skills to existing personnel cadres. However, its application should be carefully targeted to address performance gaps in newly identified tasks being added to job requirements or in the updating of personnel as new technology/knowledge requirements emerge. The use of in-service training as a singular intervention tool to deal with systemic service delivery issues has not necessarily been proven to be effective.

Recommendation

Recommendation 11: In-service training should be carefully targeted to address performance gaps in newly identified tasks being added to job requirements or to personnel as new technologies and knowledge requirements emerge.

Finding: Pre-Service Education and Long-Term Training

Respondents frequently cited regret regarding the erosion that has occurred over recent years due to the policy shift in GH financial support reduction for the pre-service education and US-based long-term investments made by USAID in previous years. As leadership ranks dwindle, the need to attend to the supply side of HCD cannot be left unaddressed.

In many of the countries canvassed, current professional leadership capacity is seen as weakening and not being readily replaced. Professional schools are underfunded, lack needed technology and updated training approaches and are unable to meet current health care delivery demands. Clinical expertise in very complex HIV/AIDS prevention, treatment and care modalities is reported as lacking, as well as expert management skills to carefully balance other essential health services, e.g. child survival, immunization, population/reproductive, maternal-neonatal.

Loss of GH technical support for pre-service institutions, curriculum revision and long-term training is evident in the diminishing numbers of public health professionals and upper level managers. The concept of ‘twinning’ with US-based university programs for long-term training is also considered at a diminished level, thereby lessening the supply of cadres such as trained public health professionals.

Conclusion

Strategic planning and management of complex health delivery systems need knowledgeable, skilled leaders and technically competent experts. Policies directing GH investments in these areas require reexamination. Supply mechanisms for assuring quality performance within professional and leadership ranks need attention.

Highly technical/clinical information could be accessed through a reestablishment of twinning with US universities. Support for twinning US universities with selected regional university centers of excellence for long-term training would expand this resource base in more cost-efficient and practical ways.

Pre-service curriculum revision involves a longer-term commitment than is found in in-service interventions. Its value however is in the long term rewards it produces when revisions attend to the tasks and technical requirements of health care challenges of today that also can accommodate those of the future. Appropriate introduction of newer education approaches, e.g. computer-based programs, distance learning, would also strengthen reform endeavors. Changes in health professional pre-service curricula and education methodologies will understandingly require approval from Ministries of Education.

GH partnership and collaboration with country-based training and educational institutions have diminished over the years. Additionally, US-based universities have seen their presence diminish within countries and GH education stipends for health professionals, e.g. public health, at US universities has all but disappeared. South-to-South institutional partnering has often been discussed as ideal yet actual agreements between identified centers of excellence seem to be few if any. Field office respondents reported that the following institutions could be potential “centers of excellence” sites:

French: Benin Institute for PH, Diop Medical School in Senegal

English: Makerere University in Uganda, Nairobi University, Kenya (nursing) Universities in Eastern Cape, South Africa (clinical management, nursing).

Recommendation

Recommendation 12: Recommit to pre-service education and long-term training with emphasis on supporting regional and south-to-south educational and training institutions and US twinning mechanisms.

Recommendation 13: In order to effectively address HCD policy reforms and restructuring, USAID needs to be working not only with Ministries of Health, but also possibly with Ministries of Finance (for education funding), Ministries of Education (for nursing and medical education), and Ministries of Labor (for remuneration levels, incentive structures, and conditions of work).

Leadership

Finding: HCD Category/Cadre

A leadership layer of expert, well-practiced HCD leaders and managers does not appear to exist within any of the countries contacted, neither at central nor decentralized levels. Decentralization was described by several of the field and GH staff as providing opportunities for developing and strengthening HCD systems and the development of HCD managers at multiple local sites. It must be noted however, that the jury is not yet in as to the full ramifications affected through decentralization. HCD activities were reported in such illustrative areas as logistics management (Ghana), team supervision problem solving (Malawi, Egypt, Nicaragua), work-load planning (Zambia, Armenia). However, no respondents reported broad scale training or mentoring of HCD managers and no one reported HCD in pre-service curriculum. One respondent felt that pharmaceutical logistics management should be introduced into pharmacy schools curricula. In South Africa, one of the universities has an established certificate program for health professionals in management, a potential South-to-South resource for HCD professional development.

Conclusion

HCD knowledge and skills are not currently being fostered to develop a critical mass of experts in host countries sufficient to deal with prevailing HCD issues. GH through its CA structure and country field experiences has collected a body of HCD knowledge and practices that could be shared across office lines in an effort to initiate progress in this area.

However, sustainable HCD changes cannot be achieved nor maintained without good leadership and management. In its leadership capacity, the primary role of GH regarding HCD involves advocating for (championing) HCD in Mission

programming and also in CA agreements. GH advocacy for HCD to be effective needs placement at the senior level.

In appropriate settings, pre-service educational changes and curricula revisions directed toward inclusion of HCD seem warranted, albeit with longer-term investments. Country and regional settings for these interventions would assure greater investment returns than would investment in US-based training (e.g., in terms of personnel retention, return of students, cheaper and closer accessibility to institutions, and more relevant learning experiences).

Recommendation

Recommendation 14: Pre-service education and in-service training in HCD management should be initiated to develop a critical mass of managers dealing with prevailing HCD issues.

Finding: Cooperating Agencies, PHN Field and GH Staff

HCD leadership qualities and technical expertise within CAs were described by field and GH respondents as ranging from non-existent to limited. As previously noted, often CAs were described as not always responsive to Mission strategic objectives. CA activities in contacted countries were often seen to be repetitive in nature. The approaches were interpreted as being “off the shelf” (e.g., in-service training and supervision models) and not addressing the complexity of the country’s HCD problems.

On the other hand, (1) GH staff generally described Mission staff as wanting in vision in and ability to judge HCD needs while (2) field staff was unsure as to GH scope of technical assistance capacity in HCD. The interviewers found a number of field staff that once made aware of this evaluation’s scope of work and the HCD typology being applied, did indeed recognize their HCD needs and current status of activities. However, they often felt that their options for sourcing appropriate technical input were limited.

Sharing HCD experience and active collaboration among organizations is not currently being done. Bringing many of the GH technical expertise areas (e.g. quality assurance, performance improvement, curriculum design, training of trainers, management and supervision) together to collectively resolve service provider performance dilemmas would begin to ensure strengthened HCD systems supportive to various program achievements.

Another leadership layer that is wanting is GH internal and CA technical assistance capacity in HCD. Several respondents stated that GH CAs do not have a systems perspective, e.g. training skills but not skills in development of training management systems. Additionally, some GH staff are not well versed in technical aspects of HCD approaches, e.g. performance improvement, workforce planning, as

well as sensitive to the matching of a given approach to a prevailing situation. These technical assistance shortcomings seem to be contributing to the lack of progress in HCD and the development of leaders and managers in the field.

Conclusion

Increasing the general awareness level of HCD in the staffs of CA organizations, PHN field and GH is warranted. Mutual confidence in HCD knowledge and technical capacity needs to be bolstered. And the dilemma of differing perceptions of CA functions in field operations needs to be clarified to the satisfaction first of field offices, and then the CAs and their CTOs and Technical Advisors (TA).

Recommendations

Recommendation 15: Increase general awareness of HCD issues within GH and across CA organizations and establish consultative mechanisms for sharing project experiences and identifying best practices including those from Maximizing Access to Quality (MAQ), performance improvement (PI), and quality assurance (QA).

Recommendation 16: Clarity of language in CA annual work plans is highly desirable regarding the range and type of CA efforts in HCD. This would bolster awareness and confidence regarding HCD capacities within CA organizations and throughout the CA community.

Partnerships

Finding: Donor Coordination in HCD

Few respondents reported actual partnering with other donors in the HCD sphere (e.g., the World Bank, EU, DIFD or CIDA). Most reported that other donors are present in countries, but that their degree of activity is mostly at the interest level and not necessarily at the action level. The potential for donor partnering is reported to be within the HCD components of personnel administration (salaries paid) and integration of HR and health system objectives (civil service reform).

US organizations were also identified as either having presence or the potential for in-country partnering, e.g. Centers for Disease Control (CDC), Health and Human Services (HHS), National Institutes of Health (NIH), western US foundations- Gates, Hewlett, Packard. Several respondents were concerned by the lack of consistent GH senior-level participation in discussions with these organizations to assure that USAID is seen and acknowledged for its technical assistance capacity.

Conclusion

Donors such as the World Bank (WB) and the European Union (EU) have mechanisms for direct financial assistance and could provide complimentary technical assistance in these component areas. Substantive liaisons between USAID/GH and potential partners would greatly increase the success factor for substantial sustainable HCD changes. It goes without saying that any HCD initiatives must be developed and implemented in full consultation with host country representatives and organizations.

Active involvement related to HCD with crucial US based organizations is warranted at a time of rapidly changing Agency priorities and mandates. Participation may well need to be at a senior management level to assure that both the administrative and programmatic interests of GH are well represented.

Recommendations

Recommendation 17: Host country representatives and organizations should be considered full partners in developing and implementing any HCD initiatives.

Recommendation 18: Substantive liaison between USAID GH and potential partners such as the WB, WHO, and EU would greatly increase the potential for success in HCD.

Recommendation 19: Participation at senior management levels with other US organizations (e.g., CDC, NIH, and HHS) is required for administrative and programmatic partnering in health HCD efforts.

Overarching Recommendation

GH should develop an HCD Strategy that articulates HCD needs and identifies the scope and depth of priority HCD initiatives GH may be prepared to support (within each office and jointly). This strategy should be guided by USAID's programmatic experience, current technical capabilities, and careful assessments of the potential for success. The strategy should discuss mechanisms for strengthening USAID's leadership role in HCD, both through bilateral project assistance and through collaboration with relevant multilateral organizations.

IV. THE WAY FORWARD: OPTIONS FOR FUTURE GH INITIATIVE IN HCD

Initial Steps for Consideration by the GH Task Force on HCD

Based upon the conclusions and recommendations of this evaluation, the GH Task Force on HCD may want to consider the following options as potential next steps. It should be noted at the outset that the proposed initiatives outlined below must be predicated on the formulation of an HCD strategy. Once this strategy has been

adopted, future GH action in HCD will require that GH address the following three issues:

1. The identification of a person (or persons) who will be seen as well qualified in HCD issues and readily identified as the ‘champion’ of GH HCD efforts. Concerted advocacy for HCD changes within existing and future programs is critical to future success.
2. The need to secure staff support for GH’s HCD strategy and future programmatic agendas.
3. Liaise and/or partner with domestic organizations (e.g., CDC, HHS, and US foundations) and international donors (e.g., WB, EU, DFID, and CIDA) on HCD issues. (As noted in Recommendation 20, liaison representation in HCD should be undertaken at senior management levels.)

Integrated HCD Country Initiative

In addition to developing an HCD Strategy, an important next step for the GH Task Force would be the implementation of an Integrated HCD Country Initiative. This activity would address priority HCD needs in a selected number of countries where the potential for programmatic action appears promising. The objective of this initiative would be to field test various HCD initiatives in diverse country environments in order to identify successful models for action, best practices in HCD, and interventions that appear to have good potential for replicability.

Initial work required:

1. In order to better identify current HCD technical capacities that can be readily accessed by USAID (and as input for the GH HCD Strategic Plan), request CAs to prepare short statements of their technical capabilities that speak directly to the five HCD Components presented in Table 1.
2. Consult with USAID field offices to identify HCD priorities and promising opportunities for HCD programming. Several Population, Health, Nutrition (PHN) officers interviewed in this evaluation have indicated preliminary interest in programming for HCD, i.e. Cambodia, South Africa, Uganda, Kenya, and Malawi. Although not interviewed, Zambia appears to have interest and potential.
3. In countries identified as providing promising opportunities for HCD work, undertake systematic assessments of HCD conditions covering the five HCD components in Table 1. These assessments should be undertaken in collaboration with USAID field missions and should be informed by

discussions with relevant host country counterparts/organizations and other donors actively working in HCD.

4. Based upon the HCD information gathered, identify country-specific HCD priorities with USAID Missions in order to prepare concrete actionable plans for addressing these needs.

In order to undertake this Integrated HCD Country Initiative, GH will need to access new resources and technical competencies. There are several options that the GH Task Force should consider in deciding how this might be accomplished.

Pre-Requisites for an Integrated Initiative:

1. Form an internal GH HCD Working Group or Unit for the Integrated HCD Country Initiative. This body would contain several staff assigned to the Working Group full-time plus input from additional staff from the Offices of PRH, OHA, HIDN, and RCS. The Working Group would assume a coordinating role in interacting with field missions and would expedite communication between the field and the organization(s) designated to implement this activity.

Or Alternatively:

2. Outsource the functions of the HCD Working Group to an external agency that would liaise with GH (specifically the GH Task Force and GH Country Coordinators for countries participating in the Initiative) and arrange for appropriate technical assistance through sub-contracts.

An implementing body for this activity could be selected through a new competitive procurement. This might entail one of the following three options:

1. Identify a single CA with experience in HCD process areas to implement the Integrated HCD Country Initiative. This CA would collaborate with existing CA organizations for specific HCD content when required, (e.g. training and education, performance improvement, quality assurance, management, and commodity procurement) or by drawing upon current mandates and ongoing activities/contracts already resident in the CA community. The drawing on current mandates would likely offer fast mobilization of a broad range of HCD technical expertise in the CA community, but it could also entail recasting existing contractual arrangements and commitments that might be time consuming and administratively difficult to enact.)
2. Identify a small consortium of CAs to act as partners in implementing the Integrated HCD Country Initiative. This partnership would be responsible

for both HCD process and content areas. This option as well as the option above assumes that the full range of HCD technical competencies required to address widely varied country needs can be accessed exclusively from the CA community.

3. Identify an implementation mechanism for the Initiative that would tap into both CA and university-based communities for technical support. This option would draw upon the technical strengths of selected CAs and also provide access to specialized expertise and longer-term training opportunities primarily available through university-based educational facilities in the United States.

Additional Thoughts for Consideration by the GH Task Force on HCD

Review the Status of GH’s Internal and Contractual Mechanisms for Supporting Long-Term Training in the United States

It is not clear to the Evaluation Team what mechanisms currently exist within GH for supporting long-term degree training in the population and health sciences. We did learn that at least one mission (Malawi) was sending several people to the United States for long-term degree training in health, but the mechanism for doing this wasn’t clear. Given that GH may want to provide more long-term training opportunities in the future, it would be useful to commission a short internal review of current administrative mechanisms (both internal to GH and through outside agencies supported by USAID) that could provide greater clarity regarding the steps GH would need to consider if it chooses to become more active in supporting long-term training. In particular, it would be useful to review the current status of the Office of Professional and Career Development within GH and the Professional Leadership Program (PLP) as potential mechanisms for collaborating more extensively with Missions in supporting long-term training and coordinating future “twinning” efforts with US-based educational institutions.

Evaluate the Potential of Professional Exchange Programs and Collaboratives in Health

USAID is currently supporting several professional exchange programs in health that deserve further scrutiny as potential models for implementing HCD in the future. One potential model is the American International Health Alliance (AIHA) that partners American and foreign medical facilities and staff to collaborate on upgrading specific skill sets. AIHA’s valuable work in Russia on neonatal resuscitation comes to mind. This mechanism has proven to be highly effective in promoting good collegial exchange, although its cost may inhibit widespread replicability in the developing world. We also heard much talk about the concept of “collaboratives” in which health professionals in the United States and developing countries exchange knowledge and information on best practices through long-distance learning technologies. This model has not been widely assessed as yet, and

might currently be frustrated in many developing country settings with poor Internet connectivity. However, as technology advances, collaboratives could well become central features of any HCD strategy.

Position USAID to Assume a More Prominent Global Leadership Role in HCD for Health

During this evaluation, our attention was drawn to initiatives of the WB and WHO in HCD. The Bank's HCD efforts tend to be country-based and integrated with their support for health sector reform and SWAP mechanisms. The WHO has an active interest in human resource development and workforce planning (e.g., through WHO's Global Health Workforce Strategy Group). However, WHO's involvement in HCD tends to be more at the theoretical and conceptual level, with recommended actions often under-resourced and inadequately implemented.

The GH Task Force on HCD should consider ways to become more pro-active in multilateral organizations (particularly WHO and UNICEF) both in terms of the provision of financial resources and technical assistance. USAID could be playing a far greater multilateral leadership role in HCD than is the case at present. Given the broad sweep of HCD issues and the potentially invasive nature of some HCD reforms that potentially impinge on national sovereignty sensitivities (e.g., efforts in civil service reform), it may well be the case that a strong multilateral effort in HCD could offer the most effective way forward.

APPENDIX I

Scope of Work for HCD Task Force Consultant

7/1/03

Background

Need

Human Capacity Development and human resource issues have been a problem in less developed countries for a long time. Health personnel to population ratios in Africa have been high and have always lagged behind the rest of the world. In the 1980s, the ratio was 1 doctor to 10, 800 people in comparison to 1:1,400 in other developing countries and 1/300 in industrial countries. During the same period the nurse to population ratio was 1:2,100 in Africa; 1:1,700 in all developing countries and 1:170 in industrial countries. Through the 1990's and into 2000, there is evidence to suggest that this has not been resolved, but in fact gotten worse. There are approximately ten countries in Africa that have doctor population ratio of 1:30,000.²

² The Health Sector Human Resource Crisis in Africa: An Issues Paper, USAID February 2003, pg.

In addition to an inadequate number of trained health workers, there are other factors that contribute to the human capacity dilemma. The number of new workers entering the health system is insufficient to meet the need of the population; this is especially true in Sub-Saharan Africa. In places like Malawi³, secondary schools are unable to graduate enough candidates for medical, nursing or midwifery school. Furthermore, the underfunding of medical and nursing education has had a negative effect on the quality of the training graduates receive. When you consider these phenomena in the context of the number of health workers who retire, get retrenched, take advantage of voluntary retirement packages, go abroad for better employment opportunities or get sick from AIDS and eventually die, the numbers issue is overwhelming.

Apart from the number of health workers, the quality of their training and length of service, there are concerns about the workers who are functioning within the health system. Many public sector employees are under paid. Except in relatively wealthier countries like South Africa and Botswana, most African governments have salary levels that are generally low.⁴ Not only are salaries low, in some cases they are not given on time. In addition to worker compensation, there are concerns around other motivational factors such as promotion and advancement opportunities, worker deployment, as well as environmental conditions like lack of equipment, drugs and supplies.

USAID has a long history in successfully dealing with many of these human capacity development issues. There have been extensive investments in training, both pre and in-service, as well as supplying equipment and other essential supplies. However, the advent of the HIV/AIDS epidemic has had a dramatic effect on human capacity, forcing people to look closer at some of these critical issues that effect all health sectors. One of many examples would be the fact that in many high-prevalence countries the responsibilities of many FP/RH providers has shifted away from FP service delivery and more towards the provision of HIV-related services.

HCD Task Force

Recognizing the pressing problems of human capacity the senior management team of the global bureau asked staff within the bureau to form a task force to examine key human capacity development issues and determine possible interventions for the global bureau. This task force is chaired by a representative from the Office of HIV/AIDS (OHA), and has representatives from the Office of Population and Reproductive Health (OPRH), Health, Infectious Diseases and Nutrition (HIDN), and the Office of Regional and Country Support (RCS).

What is Human Capacity Development?

³ IBID, pg. 6

⁴ IBID, pg. 12

There are many definitions of the term human capacity development (HCD). For the purposes of the HCD task force and this assignment the HCD is defined as:

“Developing the will, skills, abilities and Human Resource Management (HRM) systems to enable people to effectively provide health services.”

The HCD task force identifies four critical components of action for HCD activities: they are: legal, policy and financial requirements; human resource management (HRM); leadership and partnerships. The three spheres of action are the:

- individual, family & community
- provision of services (the focus of this SOW)
- allocation of resources and policy

Purpose of this consultancy

The purpose of this consultancy is to present a series of options to the HCD task force related to USAID’s manageable interest regarding, type, extent and level of involvement in HCD in the health sector as it relates to service delivery. The task force will then take this information and make recommendations to the senior management team.

Two POPTECH consultants with prior experiences in human capacity development projects will be needed to carry out the assignment.

A Population Leadership Program fellow will act as the facilitator during the Human Capacity Development Task Force Meeting on July 11, 2003.

Specific Activities for this assignment:

1. Organize and facilitate a retreat for HCD tasks force members. The purpose of this retreat will be to finalize the questions that will be asked of missions, CAs and GH staff in response to their current HCD activities. A list of both GH project countries and missions needs to be determined as well. Some illustrative questions could be:
 - What is currently being done in HCD now?
 - What is the impact of the HIV/AIDS crisis on other health sectors?
 - Are there any success stories? What are they? Why have they been successful?
 - Is HCD an issue for the mission? If so, what are the most pressing needs to missions re: HCD?
 - What can the global bureau do to solve these problems?

The second part of the purpose is to facilitate an exercise that reviews, revises where needed the goals and objectives of the HCD task force.

- Using the HCD framework, conduct a survey of global health and bilateral projects to determine what is being done in HCD. Below is an illustrative list of potential global bureau projects for the consultant to contact:

Deliver	Policy II	Advance Africa
Catalyst	JHPIEGO/TRH	Engender Health
Intrah	Youthnet	Call to Action – EGPAF
Synergy	PHR+	QAWD
IMPACT	HIV/AIDS Alliance	BASICS
JHPIEGO/MNH		

For the global projects this could be done by contacting the various CTOs/STAs as well as the CAs themselves. For the bilateral projects, the first point of contact should be the country coordinators, bureau staff and then the missions. Key bilateral countries are Ethiopia, South Africa, Tanzania, and Uganda. Also, the HCD task force began to look at the HCD activities in 7 countries: Malawi, Zambia, Rwanda, Kenya, Egypt, Cambodia and Honduras.

- Make a series of recommendations (in the forms of options) to the task force as to how the global bureaus should support HCD in the future.

Timeline:

- Background reading and planning: 4-5 days
- Task force retreat: 1 day
- Information gathering: 10-15 days
- Report writing presentation preparation: 5-10 days

Please see Human Capacity Development assignment calendar.

Total level of effort: POPTECH consultants 23-28 days

Deliverables:

- Facilitate and document a 1 day retreat for the HCD task force.
- Two 60 minute presentations discussing the findings of this assignment. One presentation will be to the HCD working group and the second to a broader audience determined at a later date.
- A written report – to be tentatively POPTECH edited.

Background Reading/background material:

- The Health Sector Human Resource Crisis in Africa: An Issues Paper
- Country-specific work done by HCD Task force members

3. MSH/M&L HCD Presentation

APPENDIX II

Persons Interviewed

USAID/Washington, Global Health Bureau

Margaret Neuse, Director-Office of Population & Reproductive Health

Gary Newton, Director-Office of Regional & Country Support

Constance Carrino, Director-Office of HIV/AIDS

Willa Pressman, Africa Team Leader, Office of Regional & Country Support

Global Health Bureau, Cognizant Technical Officers/Technical Advisors

Tony Boni, MSH/RPM

Dennis Carroll, Infectious Disease Specialist, Office of Health, Infectious
Disease and Nutrition

Elizabeth Fox, BASICS II

Jim Griffin, JHPIEGO/TRH

Jim Heiby, URC/QAWF

Karen Kavanaugh, PRH+/Abt

Debbie Kosko, PRIME II

Maureen Norton, CATALYST

Jessica Pollak, EngenderHealth

Marne Sommers, MSH/RPM

Susan Wright, MSH/M&L

Global Health Bureau, Country Coordinators

Celeste Carr, South Africa

Frances Davidson, Senegal

Robert Emrey, Chief-Division of Health Systems & Country Coordinator; Egypt

Joyce Holfeld, Nigeria

Gerry Jennings, Uganda

Pam Mandel, Ukraine

Nancy McCharen, Senegal

Mark Rilling, Indonesia

Liz Schoenecker, Cambodia

Barbara Seligman, Bangladesh

Patricia Stephenson, Zambia

Wyman Stone, Malawi

Dana Vogel, Chief-Division of Service Delivery Improvement and
Country Coordinator; Kenya

Cooperating Agency Representatives

Lynn Bakamjian, EngenderHealth

Mona Byrkit, PRIME II

Joseph Dwyer, MSH/M&L

Barbara Felling, JSI/Deliver

Kama Garrison, JHPIEGO/TRH

Dan Kraushaar, BASICS II

Ron McCarick, JHPIEGO/TRH

Edgar Necocchea, JHPIEGO/TRH

David Nicholas, URC/QAWF

Mary O'Neil, MSH/M&L

Nancy Pielemeier, PRH+/Abt

Cathy Solter, Catalyst/Pathfinder Intl.

USAID/Missions

Ali Abdelmegeid, Egypt

Felix Awantang, Senegal

John Crowley, South Africa

Robert Cunnane, Uganda

Jeannie Friedmann, Bangladesh

Nancy Godfrey, Ukraine

Cheryl Kamin, Malawi

Monica Kerrigan, Indonesia

Mike Strong, Kenya

Mark White, Cambodia

APPENDIX III

HCD Survey Results USAID Country Coordinator and Mission Responses

Table 1: How would you characterize trends in per-capita availability of health service providers in your host country by geographic area over the past decade?						
	Greatly Deteriorated	Declined Somewhat	Remained Same	Improved	Greatly Improved	Response Total
Country Coordinator						
Urban	0%	33%	17%	33%	17%	6
Rural	17%	33%	33%	17%	0%	6
National	0%	50%	33%	0%	17%	6
USAID Mission						
Urban	22%	22%	11%	33%	11%	9
Rural	44%	22%	0%	33%	0%	9
National	33%	33%	0%	33%	0%	9

Table 2: How would you characterize trends in per-capita availability of health service providers in your host country by program element over the past decade?						
	Greatly Deteriorated	Declined Somewhat	Remained Same	Improved	Greatly Improved	Response Total
Country						

Coordinator						
FP	0%	40%	40%	20%	0%	5
Other RH	0%	20%	40%	40%	0%	5
HIV/AIDS	0%	20%	0%	80%	0%	5
MCH	20%	20%	20%	40%	0%	5
ID	0%	40%	0%	60%	0%	5
Nutrition	20%	20%	20%	40%	0%	5
USAID Mission						
FP	22%	22%	44%	11%	0%	9
Other RH	11%	22%	33%	33%	0%	9
HIV/AIDS	22%	11%	33%	33%	0%	9
MCH	22%	44%	0%	22%	11%	9
ID	22%	44%	0%	33%	0%	9
Nutrition	33%	22%	11%	33%	0%	9

Table 3: Has the impact of HIV/AIDS increased the need to train more service providers in your country?

	Greatly Increased Need	Increased Need Somewhat	No Effect	Response Total
Country Coordinator	17%	67%	17%	6
USAID Mission	67%	22%	11%	9

Table 4: Has your country asked for assistance in addressing future HCD needs in health service delivery?

	Yes	No	Response Total
Country Coordinator	40%	60%	5
USAID Mission	89%	11%	9

Table 5: In your country, are there HCD strategies in place that allocate resources for health service providers?

	Yes	No	Response Total
Country Coordinator	60%	40%	5
USAID Mission	56%	44%	9

Table 5a: If yes, do specific strategies exist for meeting future needs in the following health program areas?

	Yes	No	Don't Know	Response Total
Country Coordinator				
FP	100%	0%	0%	3
Other RH	67%	33%	0%	3
HIV/AIDS	100%	0%	0%	3
MCH	100%	0%	0%	3
ID	100%	0%	0%	3
Nutrition	67%	33%	0%	3
USAID Mission				
FP	80%	20%	0%	5
Other RH	60%	40%	0%	5
HIV/AIDS	80%	20%	0%	5
MCH	80%	20%	0%	5
ID	60%	40%	0%	5
Nutrition	80%	0%	20%	5

Table 5b: If no, has there been interest in developing HCD strategies for service delivery?

	Yes	No	Response Total
Country Coordinator	100%	0%	2
USAID Mission	75%	25%	4

Table 6: Does your country have specific policies and programs that address the following HCD components?

	Yes	No	Don't Know	Response Total
Country Coordinator				
Supply System for Health	80%	20%	0%	5
Performance Management	40%	0%	60%	5
Personnel Administration	60%	20%	20%	5
Education/Training of Service Providers	80%	20%	0%	5
Integration of HR and Health System	40%	20%	40%	5
USAID Mission				
Supply System for Health	38%	38%	25%	9
Performance Management	38%	50%	12%	9
Personnel Administration	86%	14%	0%	9
Education/Training of Service Providers	75%	25%	0%	9
Integration of HR and Health System	38%	12%	50%	9

Table 7: Does the USAID mission in your country currently have a strategy for addressing future health service delivery HCD needs?

	Yes	No	Response Total
Country Coordinator	80%	20%	5
USAID Mission	50%	50%	8

Table 8: Does the USAID mission in your country currently have a strategy for addressing future health service delivery HCD needs?

	Yes	No	Response Total
Country Coordinator			
Bilateral	100%	0%	5
Central	60%	40%	5
USAID Mission			
Bilateral	89%	11%	9
Central	67%	33%	9

Table 9: Which HCD components are being addressed in your projects at the present time?

	Yes	No	Don't Know	Response Total
Country Coordinator				
Supply System for Health	40%	40%	20%	5
Performance Management	0%	50%	50%	4
Personnel Administration	0%	60%	40%	5
Education/Training of Service Providers	100%	0%	0%	5
Integration of HR and Health System	20%	40%	40%	5
USAID Mission				
Supply System for Health	50%	38%	12%	8
Performance Management	67%	33%	0%	9
Personnel Administration	50%	50%	0%	8
Education/Training of Service Providers	100%	0%	0%	9
Integration of HR and Health System	44%	44%	11%	9

Table 10: Could your projects be doing more to strengthen service delivery HCD at this time?

	Yes	No	Response Total

Country Coordinator	100%	0%	5
USAID Mission	100%	0%	9

Table 11: Should USAID give greater emphasis to service provider HCD in the future?			
	Yes	No	Response Total
Country Coordinator	100%	0%	5
USAID Mission	100%	0%	9

Table 12: In which sector has your support for service provider HCD been most concentrated over the past five years?				
	Public Sector	Private Sector	NGOs	Response Total
Country Coordinator	100%	0%	0%	5
USAID Mission	56%	0%	44%	9

Table 13: What priority has been given to each type of service provider in your country's training efforts?				
	High Priority	Medium Priority	Low Priority	Response Total
Country Coordinator				
Doctors	0%	100%	0%	5
Nurse/Midwives	80%	0%	20%	5
Trad Nurse/Midwives	25%	50%	25%	4
Paramedics	0%	50%	50%	4
Community Workers	0%	75%	0%	4
Traditional Healers	0%	25%	75%	4
USAID Mission				
Doctors	62%	25%	12%	8
Nurse/Midwives	33%	67%	0%	9
Trad Nurse/Midwives	25%	0%	75%	8
Paramedics	33%	33%	33%	9
Community Workers	12%	62%	25%	8
Traditional Healers	0%	25%	75%	8

Table 14: Has the effectiveness of this training been systematically evaluated?			
	Yes	No	Response Total
Country Coordinator	40%	60%	5
USAID Mission	33%	67%	9

Table 14a: If yes, how would you rate the effectiveness of this training in strengthening the capacity to deliver services in your country?					
	Highly Effective	Moderately Effective	Not Very Effective	Cannot Be Determined	Response Total
Country Coordinator	0%	100%	0%	0%	2
USAID Mission	25%	50%	0%	25%	4

Table 15: Are other donors in your country making contributions to HCD for service providers?				
	Yes	No	Don't Know	Response Total
Country Coordinator	60%	0%	40%	5
USAID Mission	100%	0%	0%	9

Table 16: Is there donor coordination on HCD issues in your country?				
	Yes	No	Don't Know	Response Total
Country Coordinator	20%	40%	40%	5
USAID Mission	56%	22%	22%	9

Table 17: In your country, how would you rank each health program element in terms of future demands on service delivery HCD?					
	High Demand	Moderate Demand	Low Demand	No Demand	Response Total
Country Coordinator					
FP	40%	20%	40%	0%	5
Other RH	60%	20%	20%	0%	5
HIV/AIDS	60%	40%	0%	0%	5
MCH	100%	0%	0%	0%	5
ID	100%	0%	0%	0%	5
Nutrition	60%	20%	0%	20%	5
USAID Mission					
FP	56%	33%	11%	0%	9
Other RH	67%	33%	0%	0%	9
HIV/AIDS	78%	22%	0%	0%	9
MCH	67%	33%	0%	0%	9
ID	44%	56%	0%	0%	9
Nutrition	44%	33%	22%	0%	0

Table 18: What type of health worker should receive priority attention in future service delivery HCD efforts in your country?				
	High Priority	Medium Priority	Low Priority	Response Total
Country Coordinator				
Doctors	17%	67%	17%	6

Nurse/Midwives	83%	17%	0%	6
Trad Nurse/Midwives	50%	50%	0%	4
Paramedics	40%	20%	40%	5
Community Workers	60%	40%	0%	5
Traditional Healers	25%	50%	25%	4
USAID Mission				
Doctors	56%	44%	0%	9
Nurse/Midwives	100%	0%	0%	9
Trad Nurse/Midwives	33%	33%	33%	9
Paramedics	44%	44%	11%	9
Community Workers	67%	22%	11%	9
Traditional Healers	12%	38%	50%	8

Table 19: How would you rank the importance of the following common HCD service provider imbalances in your country?

	Greatly Important	Moderately Important	Low Importance	Not Important	Response Total
Country Coordinator					
Ratio of New Entrants to Total Provider Stock Too Low	0%	33%	33%	33%	3
Ratio of Specialists to Generalists Too High	33%	33%	33%	0%	3
Ratio of Doctors to Nurses Too High	33%	33%	33%	0%	3
Ratio of Nurses to Auxiliary Nurse/Midwives Too High	0%	33%	67%	0%	3
Ratio of Urban to Rural Providers Too High	25%	25%	50%	0%	4
Ratio Emigrant to Retained Providers Too High	0%	33%	33%	33%	3
USAID Mission					

Ratio of New Entrants to Total Provider Stock Too Low	38%	25%	25%	12%	8
Ratio of Specialists to Generalists Too High	12%	12%	62%	12%	8
Ratio of Doctors to Nurses Too High	25%	38%	25%	12%	8
Ratio of Nurses to Auxiliary Nurse/Midwives Too High	25%	38%	25%	12%	8
Ratio of Urban to Rural Providers Too High	62%	25%	12%	0%	8
Ratio Emigrant to Retained Providers Too High	12%	0%	25%	62%	8

Table 20: How would you rank the importance of the following service delivery HCD issues in your country?

	High Priority	Medium Priority	Low Priority	Response Total
Country Coordinator				
Staff Recruitment	0%	80%	20%	5
Staff Deployment	50%	25%	25%	4
Career Development	60%	40%	0%	5
Staff Retention	40%	40%	20%	5
Staff Appraisal	0%	100%	0%	4
Time/Attend Reporting	0%	50%	50%	4
Employee Incentives	80%	20%	0%	5
Service Conditions	50%	50%	0%	4
Terms of Employment	75%	25%	0%	4
Pre-Service Training	25%	75%	0%	4
In-Service Training	60%	40%	0%	5
Certification/Accreditation	40%	60%	0%	5
Civil Service Reform	100%	0%	0%	4
Workload Planning	50%	50%	0%	4
Training HR Specialists	50%	50%	0%	4
USAID Mission				
Staff Recruitment	33%	44%	22%	9
Staff Deployment	44%	33%	11%	9
Career Development	44%	56%	0%	9
Staff Retention	67%	11%	22%	9
Staff Appraisal	56%	44%	0%	9
Time/Attend Reporting	50%	12%	38%	8
Employee Incentives	62%	38%	0%	8
Conditions of Service	88%	12%	0%	8
Terms of Employment	75%	25%	0%	8
Pre-Service Training	78%	22%	0%	9
In-Service Training	78%	22%	0%	9

Certification/Accreditation	78%	11%	11%	9
Civil Service Reform	44%	44%	11%	9
Workload Planning	50%	38%	12%	8
Training HR Specialists	38%	38%	25%	8

Table 21: In your opinion, what is the likelihood (probability) that USAID resources and technical assistance could be effective in changing policies and practices in the following HCD areas given your host country political, regulatory, and legal environments?

	High Probability	Moderate Probability	Low Probability	Response Total
Country Coordinator				
Staff Recruitment	0%	60%	40%	5
Staff Deployment	0%	20%	80%	5
Career Development	0%	40%	60%	5
Staff Retention	0%	20%	80%	5
Staff Appraisal	0%	40%	60%	5
Time/Attend Reporting	0%	20%	80%	5
Employee Incentives	0%	100%	0%	5
Service Conditions	20%	20%	60%	5
Terms of Employment	0%	20%	80%	5
Pre-Service Training	33%	50%	17%	6
In-Service Training	33%	67%	0%	6
Certification/Accreditation	50%	33%	17%	6
Civil Service Reform	20%	0%	80%	5
Workload Planning	17%	17%	67%	6
Training HR Specialists	20%	60%	20%	5
USAID Mission				
Staff Recruitment	11%	22%	67%	9
Staff Deployment	33%	11%	56%	9
Career Development	33%	44%	22%	9
Staff Retention	0%	22%	78%	9
Staff Appraisal	11%	44%	44%	9
Time/Attend Reporting	0%	22%	78%	9
Employee Incentives	0%	33%	67%	9
Conditions of Service	11%	44%	44%	9
Terms of Employment	0%	33%	67%	9
Pre-Service Training	67%	22%	11%	9

In-Service Training	78%	22%	0%	9
Certification/Accreditation	44%	56%	0%	9
Civil Service Reform	0%	33%	67%	9
Workload Planning	11%	56%	33%	9
Training HR Specialists	44%	11%	44%	9

APPENDIX IV

HCD Survey Results USAID CTO and CA Representative Responses

Table 1: How would you characterize trends in per-capita availability of health service providers in your countries by geographic area over the past decade?						
	Greatly Deteriorated	Declined Somewhat	Remained Same	Improved	Greatly Improved	Response Total
USAID CTO						
Urban	25%	50%	25%	0%	0%	4
Rural	50%	25%	0%	25%	0%	4
National	25%	50%	0%	25%	0%	4
CA Rep						
Urban	22%	22%	11%	44%	0%	9
Rural	33%	22%	33%	11%	0%	9
National	22%	22%	22%	33%	0%	9

Table 2: How would you characterize trends in per-capita availability of health service providers by program element in the countries where your organization (CA) has been working over the past decade?						
	Greatly Deteriorated	Declined Somewhat	Remained Same	Improved	Greatly Improved	Response Total
USAID CTO						
FP	50%	0%	50%	0%	0%	4
Other RH	50%	25%	25%	0%	0%	4

HIV/AIDS	25%	25%	0%	50%	0%	4
MCH	25%	25%	25%	25%	0%	4
ID	25%	25%	25%	25%	0%	4
Nutrition	33%	67%	0%	0%	0%	3
CA Rep						
FP	0%	62%	25%	12%	0%	8
Other RH	0%	50%	12%	38%	0%	8
HIV/AIDS	12%	12%	12%	62%	0%	8
MCH	11%	22%	44%	22%	0%	9
ID	11%	22%	22%	44%	0%	9
Nutrition	11%	44%	33%	11%	0%	9

Table 3: Has the impact of HIV/AIDS increased the need to train more service providers in your countries?

	Greatly Increased Need	Increased Need Somewhat	No Effect	Response Total
USAID CTO	60%	40%	0%	5
CA Rep	89%	11%	0%	9

Table 4: Have your countries asked for assistance in addressing future HCD needs in health service delivery?

	Yes	No	Response Total
USAID CTO	100%	0%	5
CA Rep	88%	13%	8

Table 5: In your host countries, are there HCD strategies in place that allocate resources for health service providers?

	Yes	No	Response Total
USAID CTO	50%	50%	4
CA Rep	33%	67%	9

Table 5a: If yes, do specific strategies exist for meeting future needs in the following health program areas?

	Yes	No	Don't Know	Response Total
USAID CTO				
FP	100%	0%	0%	2
Other RH	50%	0%	50%	2
HIV/AIDS	50%	0%	50%	2
MCH	50%	0%	50%	2
ID	0%	0%	100%	2
Nutrition	0%	0%	100%	2
CA Rep				
FP	33%	33%	33%	3

Other RH	33%	0%	67%	3
HIV/AIDS	100%	0%	0%	3
MCH	67%	0%	33%	3
ID	33%	0%	67%	3
Nutrition	0%	0%	100%	3

	Yes	No	Response Total
USAID CTO	100%	0%	2
CA Rep	67%	33%	6

	Yes	No	Don't Know	Response Total
USAID CTO				
Supply System for Health	40%	20%	40%	5
Performance Management	20%	80%	0%	5
Personnel Administration	40%	20%	40%	5
Education/Training of Service Providers	60%	40%	0%	5
Integration of HR and Health System	20%	60%	20%	5
CA Rep				
Supply System for Health	33%	44%	22%	9
Performance Management	22%	56%	22%	9
Personnel Administration	44%	44%	11%	9
Education/Training of Service Providers	56%	44%	0%	9
Integration of HR and Health System	0%	67%	33%	9

	Yes	No	Response Total
USAID			

CTO	60%	40%	5
CA Rep	67%	33%	9

Table 8: Are your CA projects currently incorporating HCD for service providers as part of their overall objectives?

	Yes	No	Response Total
USAID CTO	100%	0%	5
CA Rep	78%	22%	9

Table 9: Which HCD components are being addressed in your projects at the present time?

	Yes	No	Don't Know	Response Total
USAID CTO				
Supply System for Health	40%	60%	0%	5
Performance Management	100%	0%	0%	5
Personnel Administration	60%	40%	0%	5
Education/Training of Service Providers	100%	0%	0%	5
Integration of HR and Health System	60%	40%	0%	5
CA Rep				
Supply System for Health	57%	29%	14%	7
Performance Management	57%	43%	0%	7
Personnel Administration	29%	57%	14%	7
Education/Training of Service Providers	86%	14%	0%	7
Integration of HR and Health System	29%	57%	14%	7

Table 10: Could your projects be doing more to strengthen service delivery HCD at this time?

	Yes	No	Response Total
USAID CTO	100%	0%	4
CA			

Rep	89%	11%	9
------------	-----	-----	---

Table 11: Should USAID give greater emphasis to service provider HCD in the future?			
	Yes	No	Response Total
USAID CTO	80%	20%	5
CA Rep	89%	11%	9

Table 12: In which sector has your organization's (CA's) support for service provider HCD been most concentrated over the past five years?				
	Public Sector	Private Sector	NGOs	Response Total
USAID CTO	100%	0%	0%	5
CA Rep	88.9	0%	11%	9

Table 13: What priority has been given to each type of service provider in your organization's (CAs) training efforts?				
	High Priority	Medium Priority	Low Priority	Response Total
USAID CTO				
Doctors	20%	20%	60%	5
Nurse/Midwives	0%	20%	80%	5
Trad Nurse/Midwives	80%	20%	0%	5
Paramedics	60%	20%	20%	5
Community Workers	100%	0%	0%	5
Traditional Healers	100%	0%	0%	5
CA Rep				
Doctors	33%	44%	22%	9
Nurse/Midwives	78%	11%	11%	9
Trad Nurse/Midwives	22%	22%	56%	9
Paramedics	11%	44%	44%	9
Community Workers	33%	33%	33%	9
Traditional Healers	0%	11%	89%	9

Table 14: Has the effectiveness of this training been systematically evaluated?			
	Yes	No	Response Total
USAID CTO	80%	20%	5
CA Rep	33%	67%	9

Table 14a: If yes, how would you rate the effectiveness of this training in strengthening the capacity to deliver services in your countries?					
	Highly Effective	Moderately Effective	Not Very Effective	Cannot Be Determined	Response Total

USAID CTO	25%	75%	0%	0%	4
CA Rep	100%	0%	0%	0%	9

Table 15: Are other donors in your countries making contributions to HCD for service providers?

	Yes	No	Don't Know	Response Total
USAID CTO	40%	0%	60%	5
CA Rep	67%	11%	22%	9

Table 16: Is there donor coordination on HCD issues in your countries?

	Yes	No	Don't Know	Response Total
USAID CTO	40%	0%	60%	5
CA Rep	33%	44%	22%	9

Table 17: In your countries, how would you rank each health program element in terms of future demands on service delivery HCD?

	High Demand	Moderate Demand	Low Demand	No Demand	Response Total
USAID CTO					
FP	25%	50%	25%	0%	4
Other RH	0%	75%	25%	0%	4
HIV/AIDS	100%	0%	0%	0%	4
MCH	25%	75%	0%	0%	4
ID	50%	50%	0%	0%	4
Nutrition	0%	50%	50%	0%	4
CA Rep					
FP	38%	50%	12%	0%	8
Other RH	62%	12%	25%	0%	8
HIV/AIDS	88%	12%	0%	0%	8
MCH	50%	38%	12%	0%	8
ID	62%	25%	12%	0%	8
Nutrition	38%	38%	25%	0%	8

Table 18: What type of health worker should receive priority attention in future service delivery HCD efforts in your countries?

	High Priority	Medium Priority	Low Priority	Response Total
USAID CTO				
Doctors	40%	40%	20%	5
Nurse/Midwives	100%	0%	0%	5
Trad Nurse/Midwives	20%	60%	20%	5

Paramedics	60%	40%	0%	5
Community Workers	60%	40%	0%	5
Traditional Healers	0%	20%	80%	5
CA Rep				
Doctors	33%	56%	11%	9
Nurse/Midwives	100%	0%	0%	9
Trad Nurse/Midwives	56%	33%	11%	9
Paramedics	56%	44%	0%	9
Community Workers	89%	11%	0%	9
Traditional Healers	22%	56%	22%	9

Table 19: How would you rank the importance of the following common HCD service provider imbalances in your countries?

	Greatly Important	Moderately Important	Low Importance	Not Important	Response Total
USAID CTO					
Ratio of New Entrants to Total Provider Stock Too Low	20%	80%	0%	0%	5
Ratio of Specialists to Generalists Too High	0%	60%	40%	0%	5
Ratio of Doctors to Nurses Too High	20%	40%	0%	40%	5
Ratio of Nurses to Auxiliary Nurse/Midwives Too High	0%	50%	25%	25%	5
Ratio of Urban to Rural Providers Too High	80%	20%	0%	0%	5
Ratio Emigrant to Retained Providers Too High	25%	0%	75%	0%	4
CA Rep					
Ratio of New Entrants to Total					

Provider Stock Too Low	43%	29%	29%	0%	7
Ratio of Specialists to Generalists Too High	25%	50%	25%	0%	8
Ratio of Doctors to Nurses Too High	50%	25%	25%	0%	8
Ratio of Nurses to Auxiliary Nurse/Midwives Too High	14%	43%	43%	0%	7
Ratio of Urban to Rural Providers Too High	62%	38%	0%	0%	8
Ratio Emigrant to Retained Providers Too High	14%	43%	14%	0%	7

Table 20: How would you rank the importance of the following service delivery HCD issues in your countries?

	High Priority	Medium Priority	Low Priority	Response Total
USAID CTO				
Staff Recruitment	0%	50%	50%	4
Staff Deployment	100%	0%	0%	4
Career Development	25%	75%	0%	4
Staff Retention	50%	25%	25%	4
Staff Appraisal	75%	0%	25%	4
Time/Attend Reporting	0%	50%	50%	4
Employee Incentives	75%	25%	0%	4
Service Conditions	0%	75%	25%	4
Terms of Employment	25%	50%	25%	4
Pre-Service Training	50%	50%	0%	4
In-Service Training	50%	50%	0%	4
Certification/Accreditation	25%	75%	0%	4
Civil Service Reform	25%	50%	25%	4
Workload Planning	50%	25%	25%	4
Training HR Specialists	25%	25%	50%	4
CA Rep				
Staff Recruitment	44%	33%	22%	9
Staff Deployment	78%	22%	0%	9
Career Development	78%	22%	0%	9
Staff Retention	78%	22%	0%	9
Staff Appraisal	56%	33%	11%	9
Time/Attend Reporting	33%	44%	22%	9
Employee Incentives	89%	11%	0%	9
Conditions of Service	56%	33%	11%	9
Terms of Employment	56%	44%	0%	9
Pre-Service Training	89%	11%	0%	9

In-Service Training	78%	22%	0%	9
Certification/Accreditation	65%	33%	11%	9
Civil Service Reform	56%	33%	11%	9
Workload Planning	78%	11%	11%	9
Training HR Specialists	44%	44%	11%	9

Table 21: In your opinion, what is the likelihood (probability) that USAID resources and technical assistance could be effective in changing policies and practices in the following HCD areas given your host country political, regulatory, and legal environments?

	High Probability	Moderate Probability	Low Probability	Response Total
USAID CTO				
Staff Recruitment	0%	0%	100%	5
Staff Deployment	0%	60%	40%	5
Career Development	0%	100%	0%	5
Staff Retention	0%	40%	60%	5
Staff Appraisal	40%	60%	0%	5
Time/Attend Reporting	20%	20%	60%	5
Employee Incentives	20%	40%	40%	5
Service Conditions	0%	80%	20%	5
Terms of Employment	0%	40%	60%	5
Pre-Service Training	80%	20%	0%	5
In-Service Training	60%	40%	0%	5
Certification/Accreditation	60%	40%	0%	5
Civil Service Reform	0%	20%	80%	5
Workload Planning	40%	40%	20%	5
Training HR Specialists	40%	40%	20%	5
CA Rep				
Staff Recruitment	22%	44%	33%	9
Staff Deployment	33%	22%	44%	9
Career Development	11%	67%	22%	9
Staff Retention	0%	89%	11%	9
Staff Appraisal	33%	56%	11%	9
Time/Attend Reporting	11%	56%	33%	9
Employee Incentives	11%	56%	33%	9

Conditions of Service	0%	44%	56%	9
Terms of Employment	0%	56%	44%	9
Pre-Service Training	56%	33%	11%	9
In-Service Training	56%	33%	11%	9
Certification/Accreditation	67%	11%	22%	9
Civil Service Reform	0%	56%	33%	9
Workload Planning	33%	56%	11%	9
Training HR Specialists	50%	38%	12%	9

APPENDIX V

Open-Ended Responses to Survey Question 18a: What Are Important HCD Initiatives to Consider Implementing

What would be important HCD initiatives to consider implementing in your country?	
Country Coordinator	
Indonesia	- Owing to the country's push to decentralize the delivery of health services, strengthen technical and system capabilities at the regency (kabupaten) level.
Kenya	- Address issues pertaining to the quality of care and encourage more effective administration/management of the service delivery system - Promote incentives for RH service providers, better supervision, and efficient workload planning (Kenya has lots of staff who don't always have a lot to do).
South Africa	- Recruit and train more nurses. Also consider introducing financial incentives for community health workers.
USAID Mission	
Bangladesh	- More pre and in-service training for skill development. Also place greater emphasis on performance management for community-based service providers.
Cambodia	- Institute salary incentives based on performance (government rather than donor driven) and identify and reward achievements among health providers.
	- Cost recovery initiatives are needed to better fund health services and generate higher staff salaries and working conditions

Egypt	- Update medical and nursing school curriculums to be more competency-based and oriented toward evidence-based clinical practice.
	- Strengthen the teaching and training capabilities of university faculties and MOHP trainers.
	- Develop and update IT applications used by students and professionals in medical and nursing schools.
Malawai	- Support local institutions to increase capacity (e.g., by supporting lecturer/tutor training).
	- Undertake studies of HR needs (e.g., through situation analysis) and develop specific HR policies and interventions.
Senegal	- Provide more training in health program planning and system analysis, training in monitoring/evaluation and specific technical skills.
Uganda	- Focus initially on improving in-service and pre-service training – we will need to use inefficient vertical training programs until the training system improves.
	- Incentives and performance monitoring are critical but cannot be addressed effectively through a health sector program. This is a civil service policy issue.
Ukraine	- Civil service reform is most critical, along with reducing the number of physicians trained, increasing the number nurses and support staff.
	- Greater emphasis needs to be given to primary health care rather than specialized curative services.
	- The health system needs to be rationalized, patients need to pay for services, and health providers need to be paid.
	- Health facilities need to be appropriate to need (with some hospitals closed), and pharmaceuticals need to be procured and paid for.
Zambia	- Greater support to pre-service training and established training institutions instead of the current focus on disease specific in-service training.
	- Technical support to human resources management including recruitment and retention.
	-Participating with national governments in establishing incentive schemes for health workers like home ownership and transportation/loan schemes.
What would be important HCD initiatives to consider implementing in the countries where your organization (CA) is working	
USAID CTO	
	- Work with decentralized health regions to improve HCD for all facility-based clinical health care.
	- Go beyond pre/in service training and incorporate more management, supervision, and deployment issues in TA work
CA Rep	
	- Better staff recruitment and deployment systems are needed. Encourage motivation and incentive strategies that enhance performance and staff retention.
	- More work in health manpower planning and the identification of future skill sets is needed.
	- Better protect human capital in the health sector, especially in settings with elevated HIV/AIDS prevalence and high-risk occupations.
	- Promote quality assurance by giving greater attention to accreditation, certification, and licensing of service providers.
	- Improve pre-service curricula so that in-service training is eventually needed less.
	- Give greater attention to the in-country distribution of staff (in many cases distribution is the problem, not absolute numbers of staff trained).

	- Improve service outreach (again, numbers may not be the greatest HR problem) by increasing staff abilities to do outreach.
	- USAID's commitment to in-service training needs to be continued while providing more HR management training for supervisors.
	- Try out performance appraisal and remuneration systems for improved performance (e.g., performance contracting).
	- Much more work is needed on evaluation and operations research to determine the effectiveness of different HCD approaches.
	- Greater utilization of on-the-job training and distance learning methods should be promoted in future HCD work.
	- Much HCD work is done outside Ministries of Health. We should be working more with Ministries of Finance (for education funding), Ministries of Education (for nursing and medical education) and Ministries of Labor (for remuneration, incentive structures, deployment, and production policies).
	- We need to work with various ministries and the private sector in dealing with licensing, tax incentives, drug dispensing, importation regulations, and so on.
	- USAID projects do HCD work all the time, but there is no place where this experience is captured and reviewed to see what we know and assess new ideas. As a result we are spending millions of dollars on training, supervision courses, etc. without knowing what others are doing and without rigorous analysis of whether it is working. HCD is a critical priority but we don't do it well, we don't coordinate our work, we don't systematically evaluate it, and we don't share experiences (e.g., best and worst practices).
	- Donor projects tend to focus on the production of health workers, supervision training, and the quality of work done by providers (mainly in the public sector). The real issues in HCD are distribution of health manpower within a country, motivation of workers to perform primarily related to salary and benefits, and drug and supply logistics so that workers have the materials they need to actually perform the work the systems ask of them. We generally don't consider these areas as HCD issues, but they are.
	- We are all looking for quick fixes/successes. HCD is a long-term but critical thing and it affects everything we do. It's high time we do something, but the probability of doing anything that will have an impact on the short term is low. We should do something, but don't expect quick changes.

APPENDIX VI

Human Capacity Development Needs and Actionable Priorities Reported by USAID Field Missions

Table 1: How would you characterize trends in per-capita availability of health service providers in your host country by geographic area over the past decade?						
	Greatly Deteriorated	Declined Somewhat	Remained Same	Improved	Greatly Improved	Response Total
USAID Mission						
Urban	Malawi Zambia	Kenya Senegal	Uganda	Bangladesh Cambodia Ukraine	Egypt	9
Rural	Malawi Senegal Uganda Zambia	Kenya Ukraine		Bangladesh Cambodia Egypt		9
National	Malawi Uganda Zambia	Kenya Senegal Ukraine		Bangladesh Cambodia Egypt		9

Table 2: How would you rank the importance of the following common HCD service provider imbalances in your country?					
	Greatly Important	Moderately Important	Low Importance	Not Important	Response Total
USAID Mission					
Ratio of New Entrants to Total Provider Stock Too Low	Malawi Senegal Zambia	Bangladesh Cambodia	Uganda Ukraine	Egypt	8
Ratio of Specialists to Generalists Too High	Ukraine	Senegal	Bangladesh Cambodia Egypt	Malawi Uganda Zambia	8
Ratio of Doctors to	Egypt Zambia	Bangladesh Senegal	Cambodia	Malawi Uganda	

Nurses Too High		Ukraine			8
Ratio of Nurses to Auxiliary Nurse/Midwives Too High	Bangladesh Zambia	Cambodia Senegal Uganda	Ukraine	Egypt Malawi	8
Ratio of Urban to Rural Providers Too High	Bangladesh Egypt Senegal Uganda Zambia	Malawi Ukraine	Cambodia		8
Ratio Emigrant to Retained Providers Too High	Zambia		Uganda Ukraine	Bangladesh Cambodia Egypt Malawi Senegal	8

Table 3: Which HCD components are being addressed in your projects at the present time?				
	Yes	No	Don't Know	Response Total
USAID Mission				
Supply System for Health	Bangladesh Cambodia Egypt Malawi	Kenya Senegal Uganda Zambia	Ukraine	9
Performance Management	Bangladesh Cambodia Egypt Senegal Ukraine Zambia	Kenya Uganda Malawi		9
Personnel Administration	Egypt Senegal Malawi Ukraine	Bangladesh Cambodia Kenya Uganda Zambia		9
Education/Training of Service Providers	Bangladesh Cambodia Egypt Kenya Malawi Senegal Uganda Ukraine Zambia			9
Integration of HR and Health System	Bangladesh Egypt Malawi Zambia	Cambodia Kenya Uganda Ukraine	Senegal	9

Table 4: How would you rank the importance of the following service delivery HCD issues in your country?				
	High Priority	Medium Priority	Low Priority	Response Total
Staff Recruitment	Bangladesh Malawi Senegal Zambia	Cambodia Egypt Kenya	Uganda Ukraine	9
Staff Deployment	Cambodia Egypt Kenya Senegal Zambia	Bangladesh Malawi Uganda	Ukraine	9
Career Development	Bangladesh Cambodia Malawi Senegal Zambia	Egypt Kenya Uganda Ukraine		9
Staff Retention	Bangladesh Cambodia Egypt Malawi Senegal Zambia	Kenya	Uganda Ukraine	9
Staff Appraisal	Bangladesh Egypt Malawi Senegal Uganda Zambia	Cambodia Kenya Ukraine		9
Time/Attend Reporting	Bangladesh Cambodia Egypt Senegal Zambia	Malawi	Uganda Ukraine	8
Employee Incentives	Cambodia Malawi Senegal Uganda Zambia	Bangladesh Egypt Ukraine		8
Service Conditions	Cambodia Egypt	Bangladesh		8

	Malawi Senegal Uganda Ukraine Zambia			
Terms of Employment	Cambodia Malawi Senegal Uganda Ukraine Zambia	Bangladesh Egypt		8

Pre-Service Training	Bangladesh Cambodia Egypt Malawi Senegal Uganda Ukraine Zambia	Kenya		9
In-Service Training	Bangladesh Cambodia Egypt Malawi Uganda Ukraine Zambia	Kenya Senegal		9
Certification/Accreditation	Bangladesh Cambodia Egypt Kenya Senegal Uganda Ukraine	Malawi Zambia		9
Civil Service Reform	Cambodia Kenya Uganda Zambia	Bangladesh Malawi Senegal Ukraine	Egypt	9
Workload Planning	Bangladesh Cambodia Malawi Zambia	Egypt Senegal Ukraine	Uganda	8
Training HR Specialists	Bangladesh Cambodia Zambia	Egypt Malawi Uganda	Senegal Ukraine	8

Table 5: What is the likelihood (probability) that USAID resources and technical assistance could be effective in changing policies and practices in the following HCD areas given your host country political, regulatory, and legal environments?

	High Probability	Moderate Probability	Low Probability	Response Total
Staff Recruitment	Malawi	Cambodia Zambia	Bangladesh Egypt Kenya Senegal Uganda Ukraine	9
Staff Deployment	Cambodia Malawi Zambia	Egypt	Bangladesh Kenya Senegal Uganda Ukraine	9
Career Development	Bangladesh Cambodia Malawi	Egypt Senegal Ukraine Zambia	Kenya Uganda	9
Staff Retention	Zambia	Cambodia Malawi	Bangladesh Egypt Kenya Senegal Uganda Ukraine	9
Staff Appraisal		Bangladesh Egypt Malawi Ukraine	Cambodia Kenya Senegal Uganda	9
Time/Attend Reporting		Bangladesh Cambodia	Egypt Kenya Malawi Senegal Uganda Ukraine Zambia	9
Employee Incentives		Cambodia Senegal Ukraine	Bangladesh Egypt Kenya Malawi Uganda Zambia	9
Service Conditions	Malawi	Bangladesh Cambodia Egypt Ukraine	Kenya Senegal Uganda Zambia	9
Terms of Employment		Bangladesh Malawi Ukraine	Cambodia Egypt Kenya Senegal Uganda Zambia	9
Pre-Service Training	Cambodia Egypt Malawi Uganda Ukraine Zambia	Bangladesh Kenya	Senegal	9

In-Service Training	Cambodia Egypt Malawi Uganda Ukraine Zambia	Bangladesh Kenya Senegal		9
Certification/Accreditation	Bangladesh Cambodia Ukraine Zambia	Egypt Kenya Malawi Senegal Uganda		9
Civil Service Reform		Bangladesh Malawi Ukraine	Cambodia Egypt Kenya Senegal Uganda Zambia	9
Workload Planning	Bangladesh	Cambodia Egypt Malawi Uganda Zambia	Kenya Senegal Ukraine	9
Training HR Specialists	Bangladesh Cambodia Uganda Zambia	Egypt	Kenya Malawi Senegal Ukraine	9

APPENDIX VII

Human Capacity Development Needs and Actionable Priorities Reported by Cooperating Agencies

Table 1: How would you characterize trends in per-capita availability of health service providers in the countries where your organization works over the past decade?						
	Greatly Deteriorated	Declined Somewhat	Remained Same	Improved	Greatly Improved	Response Total
CA Representatives						
Urban	MSH	Pathfinder URC	Basics II	John Snow JHPIEGO PHR+ Prime II		8
Rural	MSH Pathfinder	John Snow URC	Basics II JHPIEGO Prime II	PHR+		8
National	MSH	Pathfinder URC	Basics II John Snow	JHPIEGO PHR+ Prime II		8

Table 2: How would you rank the importance of the following common HCD service provider imbalances in the countries where your organization is working?					
	Greatly Important	Moderately Important	Low Importance	Not Important	Response Total
CA Representatives					
Ratio of New Entrants to Total Provider Stock Too Low	Basics II MSH URC	Pathfinder JHPIEGO	Prime II		6
Ratio of Specialists to Generalists Too High	Basics II JHPIEGO	Pathfinder MSH Prime II	PHR+ URC		7
Ratio of Doctors to Nurses Too High	Basics II JHPIEGO Pathfinder	MSH PHR+	Prime II URC		7
Ratio of Nurses to Auxiliary Nurse/Midwives Too High	JHPIEGO	MSH URC	Basics II Pathfinder Prime II		6
Ratio of Urban to Rural Providers Too High	Basics II JHPIEGO MSH Pathfinder	PHR+ Prime II URC			7
Ratio Emigrant to Retained Providers Too High	JHPIEGO	Pathfinder Prime II	MSH	Basics II URC	6

Table 3: Which HCD components are being addressed in your projects at the present time?				
	Yes	No	Don't Know	Response Total
CA Representatives				
Supply System for Health	JHPIEGO PHR+ URC	Basics II MSH Prime II	John Snow	7
Performance Management	JHPIEGO John Snow Prime II URC	Basics II MSH PHR+		7
Personnel Administration	Prime II URC	Basics II JHPIEGO MSH PHR+	John Snow	7
Education/Training of Service Providers	JHPIEGO John Snow MSH PHR+ Prime II URC	Basics II		7
Integration of HR and Health System	JHPIEGO URC	Basics II MSH PHR+ Prime II	John Snow	7

Table 4: How would you rank the importance of the following service delivery HCD issues in the countries where your country works?

	High Priority	Medium Priority	Low Priority	Response Total
Staff Recruitment	JHPIEGO John Snow MSH	Basics II Pathfinder Prime II	PHR+ URC	8
Staff Deployment	Basics II JHPIEGO MSH Pathfinder Prime II URC	John Snow PHR+		8
Career Development	Basics II JHPIEGO MSH PHR+ Prime II URC	John Snow Pathfinder		8
Staff Retention	JHPIEGO John Snow MSH Pathfinder Prime II URC	PHR+ Basics II		8
Staff Appraisal	John Snow MSH PHR+ Prime II URC	Basics II JHPIEGO	Pathfinder	8
Time/Attend Reporting	MSH PHR+ URC	JHPIEGO John Snow Prime II	Basics II Pathfinder	8
Employee Incentives	Basics II JHPIEGO John Snow MSH PHR+ Prime II URC	Pathfinder		8
Service Conditions	Basics II JHPIEGO MSH URC	John Snow PHR+ Prime II	Pathfinder	8
Terms of Employment	Basics II JHPIEGO MSH URC	John Snow Pathfinder PHR+ Prime II		8
Pre-Service Training	Basics II JHPIEGO John Snow MSH Pathfinder PHR+ URC	Prime II		8

In-Service Training	Basics II JHPIEGO John Snow MSH Pathfinder PHR+ URC	Prime II		8
Certification/Accreditation	JHPIEGO John Snow PHR+	MSH Prime II URC	Basics II	8
Civil Service Reform	JHPIEGO MSH Pathfinder PHR+ URC	John Snow Prime II	Basics II	8
Workload Planning	JHPIEGO MSH Pathfinder PHR+ Prime II URC	John Snow	Basics II	8
Training HR Specialists	John Snow MSH PHR+ URC	JHPIEGO Pathfinder Prime II	Basics II	8

Table 5: What is the likelihood (probability) that USAID resources and technical assistance could be effective in changing policies and practices in the following HCD areas given indigenous political, regulatory, and legal environments?

	High Probability	Moderate Probability	Low Probability	Response Total
Staff Recruitment	Prime II	JHPIEGO John Snow MSH URC	Basics II Pathfinder PHR+	8
Staff Deployment	JHPIEGO Prime II	MSH URC	Basics II John Snow Pathfinder PHR+	8
Career Development	Prime II	JHPIEGO John Snow MSH Pathfinder PHR+ Prime II URC	Basics II MSH	8
Staff Retention		JHPIEGO John Snow MSH Pathfinder PHR+ Prime II URC	Basics II	8
Staff Appraisal	Pathfinder Prime II URC	JHPIEGO MSH PHR+ John Snow	Basics II	8
Time/Attend Reporting	URC	JHPIEGO MSH PHR+ Prime II	Basics II John Snow Pathfinder	8
Employee Incentives	JHPIEGO	John Snow PHR+ Prime II URC	Basics II MSH Pathfinder	8
Service Conditions		JHPIEGO PHR+ Prime II	Basics II John Snow MSH Pathfinder URC	8
Terms of Employment		JHPIEGO John Snow Prime II URC	Basics II MSH Pathfinder PHR+	8
Pre-Service Training	JHPIEGO John Snow MSH Pathfinder	PHR+ Prime II URC	Basics II	8
In-Service Training	JHPIEGO MSH John Snow URC	Pathfinder PHR+ Prime II	Basics II	8
Certification/Accreditation	JHPIEGO John Snow Pathfinder PHR+ URC		Basics II MSH	8

Civil Service Reform		JHPIEGO John Snow Prime II URC	Basics II MSH Pathfinder PHR+	8
Workload Planning	Prime II JHPIEGO John Snow	MSH Pathfinder PHR+ URC	Basics II	8
Training HR Specialists	JHPIEGO John Snow MSH URC	Pathfinder PHR+ Prime II	Basics II	8

APPENDIX VIII

Documents Consulted

Adams, Orville et al. 2002. "Human, physical, and intellectual resource generation: proposals for monitoring". In Christopher Murray and David Evans, *Health Systems Performance Assessment: Debates, Methods, and Empiricism*. (Geneva: World Health Organization).

Berman, Peter. 2003. "Health sector reform in developing countries: now more than ever". (Washington, DC: World Bank Web Site, www.worldbank.org/hnp/hsd/).

Biscoe, G. 2000. "Human resources: the political and policy context". *Human Resources for Health Development Journal* 4(3).

Bolger, Joe. 2000. *Capacity Development: Why, What and How*. (Ottawa: Policy Branch, CIDA).

Buchan, James and Mario R. Dal Poz. 2002. "Skill mix in the health care workforce: reviewing the evidence." *Bulletin of the World Health Organization*, 80(7).

Centers for Disease Control. 2003. *Public Health Systems Development*. CDC Division of International Health. (Atlanta: CDC Web Site www.cdc.gov/epo/dih/systems).

Family Health International. 2002. *Human Capacity Development for an Effective Response to HIV/AIDS – The Community Response: Addis Ababa, Ethiopia*. (Addis Ababa, Ethiopia: Addis Ababa AIDS Council Secretariat).

Family Health International. 2003. *Capacity Development in HIV Programming*. (Durham, North Carolina: FHI Web Site, www.fhi.org/en/HIVAIDS/FactSheets).

Green, Andrew. 1999. *Planning Human Resources: An Introduction to Health Planning in Developing Countries, Second Edition*. (Oxford, England: Oxford University Press).

Health Workforce Development Project: Highlights – Detailed Activity Description. No Date. (PowerPoint Presentation).

Heiby, James. 2003. "Human resources in health: talking points." USAID Internal Memorandum.

Kolehmainen-Aitken, R. 1998. "Decentralization and human resources: implications and impacts". *Human Resources Development Journal*, 2(1).

Lauro, Don. 1998. *Leadership Development and the Packard Population Program: A Report to the David and Lucile Packard Foundation*. (Los Altos: Packard Foundation).

Management Sciences for Health. 2003. "Human capacity development inquiry". Developed by Management Sciences and Leadership Development Program (M&L), (Draft memorandum).

Management Sciences for Health. 2003(b). *Report: Human Capacity Development Workshop for an Effective Response to HIV/AIDS in Malawi, March 27-28, 2003*. (Boston: Management Sciences for Health).

Martineau, Tim and J. Martinez. 1997. *Human Resources in the Health Sector: Guidelines for Appraisal and Strategic Development*. (Brussels: European Commission).

Martinez, Javier and T. Martineau. 1998. "Rethinking human resources: an agenda for the millennium." *Health Policy and Planning*, 13(4).

Measure Evaluation. 2000. *Measuring Capacity Building in health and Population Programs: Summary of Meeting held by Measure Evaluation, November 16-17, 1999, Arlington, Virginia*. (Chapel Hill, North Carolina: Carolina Population Center and the University of North Carolina at Chapel Hill).

Milen, Anneli. 2001. *What do we know about Capacity Building? An Overview of Existing Knowledge and Good Practice*. (Geneva: World Health Organization).

Morgan, Peter. 1998. *Capacity and Capacity Development: Some Strategies: Note Prepared for the Political and Social Policies Division, Policy Branch, CIDA*. (Ottawa: Policy Branch, CIDA).

Necochea, Edgar, Kama Garrison, and Wendy Voet. 2003. *Human Resources in Healthcare: A JHPIEGO Strategy Paper*. Draft Report. (Baltimore: JHPIEGO).

Pan American Health Organization. 1998. *Human Resources: A Critical factor in Health Sector Reform: Report of a Meeting in San Jose, Costa Rica, 3-5 December, 1997*. (Washington, DC: PAHO).

Picazo, Oscar, J. Huddart, and S. Duale. 2003. *The Health Sector Human Resource Crisis in Africa: An Issues Paper*. (Washington, DC: USAID, Bureau for Africa, Office of Sustainable Development, AED, and the SARA Project).

Prime II. 2003. *Strategy for Family Planning Program Recovery in Nigeria*. (Chapel Hill, N.C.: Prime II Web Site, www.prime2.org).

Rohde, Jon and J. Wyon. 2003. *Community-Based Health Care: Lessons from Bangladesh to Boston*. (Boston, Massachusetts: MSH).

Ross, John and John Stover. 2003. *Trends and Issues Affecting Service delivery over the Next Decade*. Prepared for the Service Delivery Improvement Division, Office of Population and Reproductive Health, USAID. (Washington, DC: The Policy Project).

Schofeld, Kenneth G. 2002. *An Assessment of Alternative Procurement Mechanisms*. Prepared for the Services Delivery Improvement Division, Office of Population and Reproductive Health, Bureau for Global Health. (Washington, DC: Poptech Project).

Standing, Hilary. 2001. "Gender – a missing dimension in human resource policy and planning for health reforms". *Human Resources Development Journal*. 4(1).

Tawfik, L. and S. Kinota. 2001. *The Impact of HIV/AIDS on the Health Sector in Sub-Saharan Africa: The Issue of Human Resources*. (Washington, DC: USAID/SARA Project, Academy for Educational Development).

Thollaug, Susan and Maria Mamlouk. 2002. "Use of bilateral mechanism for PHN Programming in the Field: How Much and Why". (USAID Draft Report).

USAID. 2001. "Note on USAID initiative to strengthen human capacity to lead, manage and implement HIV/AIDS and infectious disease (ID) programs." (Internal memorandum).

USAID. 2001. "Human capacity development initiative – draft global workplan." (Internal memorandum).

USAID. 2002. *The Impact of HIV/AIDS on Health Systems in Sub-Saharan Africa with Special Reference to the Issue of Human Resources*. (Washington, DC: Bureau for Africa, Office of Sustainable Development).

USAID. 2003(a). IWG Working Group Session: human capacity development (HCD). (USAID Internal Memorandum).

USAID. 2003(b). "HCD Task Force Meeting, June 16, 2003: summary of major points from the meeting." (USAID Internal Memorandum).

USAID/Egypt. 2003. "Health workforce development (HWD)." (Internal memorandum).

USAID, UNAIDS, and World Bank Institute. 2003. *Human Capacity Development for an Effective Response to HIV/AIDS: Adapted by Management Sciences for Health*, Powerpoint Presentation.

- UNAIDS. 2003(a). *Best Practices Collection*. (Geneva: UNAIDS Web Site).
- UNAIDS. 2003(b). *Implementation of the Declaration of Commitment on HIV/AIDS: Core Indicators*. (Geneva, Switzerland: UNAIDS Web Site).
- United States Department of Health and Human Services. 2003. Law and Policy: Capacity Development – HIV/AIDS Bureau. (Washington, DC: HHS Web Site, www.hab.hrsa.gov/law/dssletter8.htm).
- University Research Corporation. 2003. *Zambia AIDS Workforce Study: Draft Report of Findings*. (Washington, DC: QAP/Initiatives Inc., PowerPoint Presentation).
- Waters, Hugh. 1995. *Regional Initiatives for Capacity Building in the Health Sector*. (Washington, DC: Academy for Educational Development).
- World Health Organization. 2001. *World Health Report 2000. Chapter 4: What Resources are Needed*. (Geneva: WHO).
- World Health Organization. 2001(b). *Workshop on Global Health Workforce Strategy, Annecy, France, 9-12 December, 2000*. (Geneva: WHO).
- World Health Organization. 2002a. *Human Resources for Health: Developing Policy Options for Change – Discussion Paper*. (Geneva: WHO).
- World Health Organization. 2002b. *Technical Consultation on Imbalance in the Health Workforce*. (Geneva: Department of Health Services Provision).
- World Health Organization. 2003. *WHO Estimates of Health Personnel: Physicians, Nurses, Midwives, Dentists, and Pharmacists (around 1998)*. (Geneva: WHO Web Site).