Planning, Developing and Supporting the Health Workforce

Results and Lessons Learned from the Capacity Project, 2004–2009

USAID FROM THE AMERICAN PEOPLE

the Capacity Project

Table of Contents

1. Overview . . . 7
- Background . . . 7
- Project Description . . . 8
- Moving from Awareness to Action . . . 9
  - *National Advocacy* . . . 9
  - *International Advocacy* . . . 10
- Technical Leadership in Critical HRH Areas . . . 10
  - *Workforce Planning and Leadership* . . . 10
  - *Workforce Development* . . . 11
  - *Workforce Performance Support* . . . 11
- Strengthening National Capacity . . . 11
  - *Working with Stakeholders* . . . 11
  - *Developing Leadership* . . . 11
  - *Learning for Performance* . . . 11
- Increasing the Use of Knowledge in HRH Development . . . 12
- External Evaluation . . . 12

2. Results and Lessons Learned . . . 15

Workforce Planning and Leadership . . . 15
- Background and Strategy . . . 15
- Results . . . 15
  - *HRIS Strengthening* . . . 15
  - *Data-Driven Decision-Making* . . . 16
  - *HR Management and Leadership Strengthening* . . . 17
  - *Streamlining Recruitment and Deployment* . . . 18
  - *Task Shifting* . . . 19
- Lessons Learned . . . 21

Workforce Development . . . 23
- Background and Strategy . . . 23
- Results . . . 23
  - *Learning for Performance* . . . 23
  - *Strengthening Pre-Service Education* . . . 24
  - *Professional Associations* . . . 26
- Lessons Learned . . . 27

Workforce Performance Support Systems . . . 29
- Background and Strategy . . . 29
- Results . . . 29
  - *Productivity* . . . 29
  - *Retention* . . . 29
  - *Supporting Health Worker Performance with Effective Supervision* . . . 31
- Lessons Learned . . . 33

Knowledge Management . . . 35
- Background and Strategy . . . 35
- Results . . . 35
  - *HRH Global Resource Center* . . . 35
  - *National HRH Knowledge-Sharing System in Uganda* . . . 36
  - *Project Publications and Dissemination* . . . 36
- Lessons Learned . . . 37

Gender Equity and Equality . . . 39
Background and Strategy . . . 39
Results . . . 39
Increasing Staff Capacity to Implement Gender Work . . . 39
Workplace Violence Study in Rwanda . . . 39
Men as Providers of HIV/AIDS Care in Lesotho . . . 40
Lessons Learned . . . 41

Integrating FBOs . . . 43
Background and Strategy . . . 43
Results . . . 43
Christian Health Association Technical Working Group on HRH . . . 43
HRH Mapping in Tanzania . . . 43
FBO HRH Strengthening Model in Kenya . . . 44
Lessons Learned . . . 44

Global Partnerships . . . 46
Background and Strategy . . . 46
Results . . . 46
The HRH Action Framework (HAF) . . . 46
HRH Action Workshops . . . 47
Lessons Learned . . . 48

Support to the Global Fund to Fight AIDS, Tuberculosis and Malaria . . . 49
Background and Strategy . . . 49
Results . . . 49

Impact on Family Planning and Other Reproductive Health Programming . . . 51
Background and Strategy . . . 51
Results . . . 52
Kenya: National FP Training Plan . . . 52
Rwanda: Comprehensive FP Service Strengthening . . . 52
Rwanda: No-Scalpel Vasectomy Program . . . 53
Study on Bottlenecks to Implementing Updated FP/RH Guidelines . . . 53
Lessons Learned . . . 54

Impact on HIV/AIDS Programming . . . 55
Background and Strategy . . . 55
Results . . . 55
Kenya: EHP . . . 55
Central America: Performance Support . . . 55
Rwanda and Namibia: Clinical Service Delivery . . . 56
Building Systems for Orphans and Vulnerable Children . . . 56
Lessons Learned . . . 57

Management and Partnership . . . 59

Monitoring and Evaluation . . . 60

Looking Ahead . . . 64

Annex A: Funding Overview: Core and Field Support . . . 66

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Overview

Background

In many developing countries, health systems face daunting challenges to meet even basic health care needs. These challenges include:

- Inadequate numbers of qualified health workers
- Mismatches between needed health worker skills and available skills
- Inaccurate or incomplete data about the health workforce, which hampers workforce planning and decision-making
- Retention problems, including out-migration of trained providers and shifts between sectors
- Slow and ineffective recruitment, hiring and deployment processes
- Weak human resources management systems for the health workforce and a lack of supportive human resources policies
- Weak planning
- Poor use of available financial and material resources.

A comprehensive and coordinated response to these challenges is vital—without sustained attention, the increasing pressures on national health systems could lead to their contraction or collapse, particularly in sub-Saharan Africa, where HIV/AIDS has had the most severe effects on the health workforce.

Human resources for health (HRH) first attracted global attention when it became evident that the health workforce in the developing world was facing a crisis, and that this was affecting health service delivery and health outcomes. The Joint Learning Initiative on Human Resources for Health and Development (JLI), a consortium of more than 100 health leaders from around the world, undertook an exploration of the HRH landscape during 2002-2004 and identified three major aspects of an accelerating global HRH crisis:

- The devastation of HIV/AIDS
- An accelerated level of out-migration of health professionals from developing countries
- Chronic underinvestment in human resources.

The JLI concluded that "mobilization and strengthening of the health workforce is central to combating health crises in some of the world's poorest countries and for building sustainable health systems." Strengthened HRH capacity is essential to meeting almost every national and international health objective, as well as the objectives of the United States Agency for International Development (USAID) Global Health Bureau, the President's Emergency Plan for AIDS Relief (PEPFAR), the President's Malaria Initiative and the Millennium Development Goals. Improved and expanded HRH is vital to sustaining the gains made in past decades in areas such as family planning (FP) and child survival as well as more effectively addressing HIV/AIDS, tuberculosis and malaria.

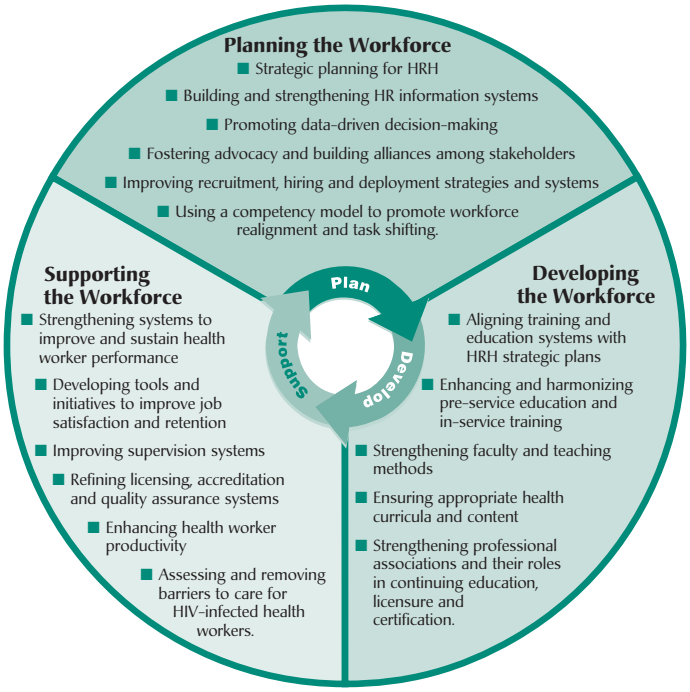
In September 2004, the USAID Bureau for Global Health/Office of Population and Reproductive Health/Service Delivery Improvement Division awarded to IntraHealth International the Human Capacity Development Program to address the HRH challenge, later renamed the Capacity Project. This five-year Leader with

Associates cooperative agreement began in October 2004. It was led by IntraHealth and enriched through the extensive experience of six other global organizations serving as partners (IMA World Health, Jhpiego, Liverpool Associates in Tropical Health, Management Sciences for Health, PATH, Training Resources Group) as well as collaboration with numerous global, regional and national organizations.

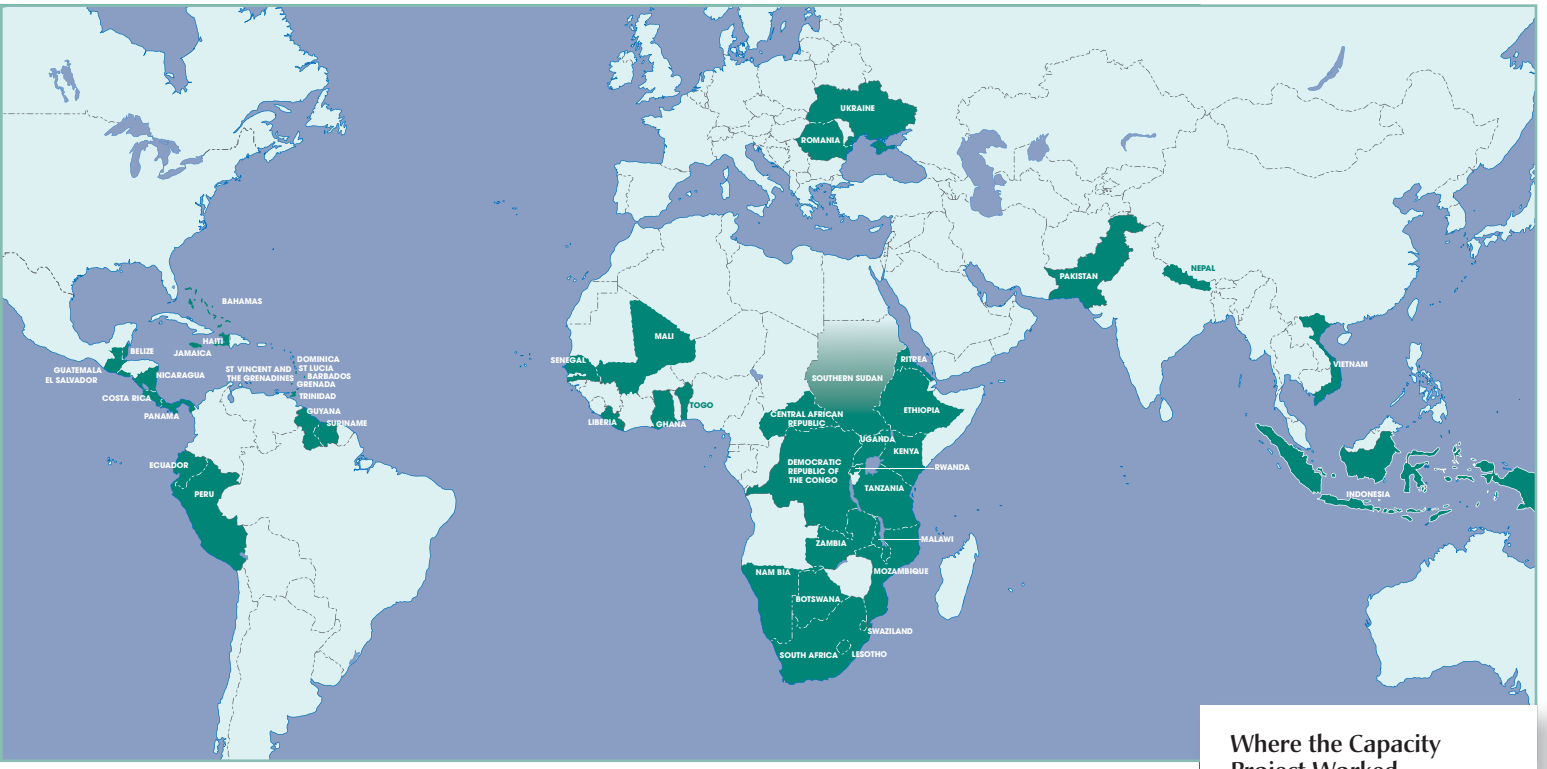
Project Description

The Capacity Project strengthened human resources to implement quality health programming in developing countries, focusing on:

1. **Improving workforce planning and leadership** to ensure that the right type and number of health workers are deployed to the right locations
2. **Developing better education and training programs** so that health workers have the knowledge and skills to meet the needs of their communities
3. **Strengthening systems to support workforce performance** and encourage workers to remain on the job.



The Project worked across sectors such as health, education, planning, public service commissions and local government entities to address the varied forces that affect the health workforce. The Project also worked in multiple priority health areas, including HIV/AIDS, FP and reproductive health (RH) and maternal and child health. Promoting gender equality in HRH, integrating faith-based and nongovernmental organizations (NGOs), enhancing HRH knowledge-sharing and fostering global partnerships represented key cross-cutting focus areas.



Where the Capacity Project Worked

Bahamas
Barbados
Belize
Botswana
Central African Republic
Costa Rica
Democratic Republic of the Congo
Dominica
Ecuador
El Salvador
Eritrea
Ethiopia*
Ghana
Grenada
Guatemala*
Guyana
Haiti
Indonesia
Jamaica
Kenya*
Lesotho
Liberia
Malawi
Mali*
Mozambique
Namibia*
Nepal
Nicaragua
Pakistan
Panama
Peru
Romania
Rwanda*
Senegal
South Africa*
Southern Sudan*
St. Lucia
St. Vincent and the Grenadines
Suriname
Swaziland
Tanzania/ Zanzibar*
Trinidad
Togo
Uganda*
Ukraine
Vietnam
Zambia

*Country office

Moving from Awareness to Action

Through the Capacity Project's leadership in HRH knowledge management, its relationships with partners and its field work, the Project consistently underscored the importance of HRH capacity-building in strengthening health systems and improving health outcomes. The Project emphasized the vital contribution of the health workforce to good practice and greater accessibility of FP/RH services and to the care and treatment of people living with HIV, as well as to other health care services.

National Advocacy

Obtaining political commitment at the highest levels of government for strengthening HRH proved essential in several important country-based activities. In Rwanda, for example, with the commitment of the president and Ministry of Health (MOH) support, the Project helped to develop a strong HRH strategic plan that includes projections to determine the best distribution of the workforce in alignment with the country's Health Sector Strategic Plan, which encourages FP initiatives. In Kenya, the Project negotiated at all levels of the government, despite strong opposition at times, to develop and implement an emergency hiring plan to increase access to a wide range of services, including HIV/AIDS and FP, particularly in underserved areas. The Kenyan government committed to continuing employment of these workers at the Project's end. In Uganda, the Project partnered with the MOH on a number of key HRH studies and initiatives; the complete package of HRH interventions is fully owned by the MOH, whose leaders are now using data for planning and decision-making.

"Recruitment to fill the staffing gaps has also been a critical area of support from Capacity Project…. This will contribute significantly towards meeting the targeted staffing level of 80% as per the current Health Sector Strategic Plan."

—Francis Ntalazi, assistant commissioner of HR management, Uganda MOH

International Advocacy

The Capacity Project engaged a broad array of high-level strategic partnerships, and quickly established and maintained a leadership position—for itself and for USAID—in HRH strengthening. The external evaluators of the Project were "impressed by the overwhelming consensus among respondents of appreciation for USAID for undertaking this bold initiative on HRH, described as 'timely, far-sighted, and generous.' USAID is now recognized as one of the global leaders in this field, and expectations are high that it will maintain this status." The Project's leadership position in this changing world scene was evidenced by its participation in key global discussions, its active partnerships in taking forward innovations and its growing reputation as a source of information on promising practices in HRH. For example, the Project engaged global health leaders such as the Global Health Workforce Alliance (GHWA), World Health Organization (WHO)/Regional Office for Africa, Pan American Health Organization (PAHO), WHO/Geneva, the World Bank, the East, Central and Southern Africa Health Community (ECSA) and the West African Health Organization as partners to organize and implement high-level, action-focused workshops to move the HRH agenda forward at the country level and provide fora for country-to-country and interagency knowledge-sharing.

The Project played a key role with WHO and GHWA in facilitating the development of the HRH Action Framework (HAF) and website, and in leading the process to apply the HAF at the country level. The Project had representation on the GHWA task forces on tools and guidelines and universal access, provided leadership to the task force on workforce development tools and contributed to many international meetings on HRH, including the first annual GHWA forum in 2008. From this position of leadership, the Project influenced partners to collaborate at the country level on the health workforce agenda.

Technical Leadership in Critical HRH Areas

The Capacity Project organized its technical leadership work around three Intermediate Results (IR) areas: workforce planning and leadership, workforce development and workforce performance support.

Workforce Planning and Leadership

The Project supported countries to conduct and sustain strategic HRH planning and to strengthen and professionalize HRH leadership. To do this, the Project convened stakeholders to develop, prioritize and address HRH issues, and supported the development and implementation of national HRH strategic plans and policies that are based on national data. Because essential data were not available in most countries, the Project developed a human resources information systems (HRIS) strengthening approach and software applications that align with countries' data needs to provide critical information to support regular HR planning and data-driven decision-making. The Project convened global experts in two HRIS meetings in 2007 to foster improved coordination of HRIS at the national level and to further advance simplification of those systems to ensure more effective analysis across programs. In addition, the Project conducted workshops and courses to strengthen using data for HRH decision-making.

Workforce Development

The Project worked to strengthen countries' education and training systems in alignment with national health priorities, developing the clinical skills and knowledge required to support quality service delivery. To achieve this, the Project developed the capacity of professional associations and strengthened pre-service education and in-service training systems using approaches that are efficient, competency- and performance-based and responsive to the countries' current needs.

Workforce Performance Support

The Project helped to develop national capacity and systems to help the existing workforce provide the highest possible quality of services and encourage greater job satisfaction, motivation and retention. To do this, the Project strengthened HR management systems, developed and implemented approaches to increase worker productivity and retention and designed and implemented systems for performance support, including more effective supervision.

Strengthening National Capacity

Of all of its activities, the Capacity Project spent most of its efforts on technical collaborations at the country level to strengthen the health workforce in alignment with national priorities, to achieve better health outcomes. At the same time, the Project's significant time spent in developing and strengthening global partnerships made the country-level technical collaborations more fruitful—both in terms of HRH advocacy and leveraging funds and people.

Working with Stakeholders

Convening a national stakeholder group to oversee the development of the health workforce was a central principle and component of the Project's work in all countries. Often the stakeholder group initially formed around strengthening HRIS, to assess HRIS needs and existing data systems. With support, some groups took on a broader remit of workforce development overall, overseeing issues of regulation, continuing professional development programs, health worker production issues and much more.

Developing Leadership

The Capacity Project facilitated a number of leadership programs at the national level and through virtual learning, as well as face-to-face multicountry workshops. Leadership has proved to be a missing ingredient in the field of HRH. In many countries, managers of the workforce have had little or no management preparation, and do not understand how to run an HR unit, use data for strategic decision-making and be leaders of change. This proved to be a richly rewarding area of work for the Project, which facilitated leadership programs in Ethiopia, Kenya, Rwanda, South Africa, Southern Sudan, Tanzania and Uganda.

Learning for Performance

The Project's *Learning for Performance: A Guide and Toolkit for Health Worker Education and Training Programs* (LFP) offers guidelines and tools for focusing curricula on the priority desired performance outcomes. LFP is more than a learning program: it can be

The HRH Action Framework

Designed to help governments and health managers build an effective and sustainable health workforce, the HRH Action Framework (HAF) is a global effort to bring a shared approach and resources to complex HRH issues at the country level. The framework guides those tasked with addressing HRH issues through the components or action fields that need to be addressed in a comprehensive HRH strategy. The HAF website (www.capacityproject.org/framework) is available in English, French and Spanish. On the website, each HAF action field is associated with accompanying resources that provide "how to" tools and guidelines as well as links to additional information.

Quotes from the External Evaluation Field Visits

- *"In-country implementation of Capacity represents a happy marriage of PEPFAR indicators with the wider needs of HRH."*
- *"Capacity's emphasis on HRH looks at the issues of public health in a unique way."*
- *"Capacity's IT work represents good engineering practices, good documentation, consistency and high standards."*
- *"Capacity in Rwanda exemplifies what can be done to be proactive in response to national policy."*
- *"Work undertaken in Uganda exemplifies the focus of Capacity on setting the framework for HRH development."*

used as a basis for workforce development based on competencies needed to improve performance. In Mali and Rwanda, the Project used LFP to strengthen pre-service education as well as training approaches, and made a measurable impact on the competence of nursing graduates. LFP was used to strengthen the HIV/AIDS prevention and treatment and FP and gender components of Rwanda's three-year nursing and midwifery curricula. In Mali, the Project used LFP to finalize FP/RH and child health modules for the curriculum at a remote nursing school serving three under-served northern regions.

Increasing the Use of Knowledge in HRH Development

The Capacity Project's HRH Global Resource Center (GRC), a digital library of HRH resources, supports national-level HRH development, providing high-level support to individual users. The Project dramatically increased the number and quality of HRH resources available online. With approximately 30,000 visits to the site per month—from users in over 170 countries—and over 2,000 resources, the HRH GRC is the world's leading HRH resource knowledge base and the largest online HRH collection. Global leaders and HRH practitioners recognized the contribution this website makes to the dissemination of relevant information around the world.

External Evaluation

In 2008 the consulting firm GH TECH conducted an external evaluation of the Capacity Project. In its report, the evaluation team recommended that USAID balance the need for data on service delivery "with a clear understanding and appreciation that the driving force of health system performance is the health worker, and that strategies to alleviate the ongoing HRH crisis in the developing world will have a positive effect on all health indices."

Results and Lessons Learned

Workforce Planning and Leadership

Background and Strategy

To strengthen health care, countries need accurate data and professional leadership to support strategic planning of HRH. The Capacity Project aimed to achieve the following results within the area of workforce planning and leadership:

- Strengthened HRIS
- Improved workforce planning, allocation and utilization
- Strengthened workforce policies
- Effective multisectoral stakeholder workforce planning groups
- Strengthened human resources management (HRM)
- Increased numbers and types of health workers deployed.

The most significant results included developing and applying an HRIS strengthening process and transferring HRIS software technology to the field; supporting HR strategic policy and plan development and implementation; and building HRH leadership and management skills, both at the country level and by contributing to the growth of an HRH leadership cadre in sub-Saharan Africa.

Results

HRIS Strengthening

Without accurate, up-to-date, accessible information, HRH managers cannot efficiently plan or manage their health workforces. The Capacity Project's HRIS strengthening program led the growing recognition and redress of the critical gap in health workforce information.

A mature and complete HRIS equips decision-makers with the ability to answer key policy and management questions to ensure a steady supply of trained health professionals; deploy health workers with the right skills to the right positions and locations to meet health care needs; and retain health worker skills and experience. The Project provided technical assistance to strengthen HRIS in nine African countries. By working with stakeholders at the national level, the Project assessed field needs and developed a comprehensive HRIS strengthening process that involved stakeholders in all stages. Representatives from ministries, licensing and registration/certification bodies and private-sector organizations collaborated to plan and implement fully functional HRIS that fit their countries' specific needs.

The Project developed the iHRIS Suite of web-based Open Source software products, including iHRIS Manage (an HRM system), iHRIS Qualify (a training, licensing and certification tracking system) and iHRIS Plan (workforce planning and modeling software), along with a comprehensive and easy-to-use toolkit to guide HRIS development. The products integrate seamlessly with each other and are easily customizable. In 2009 the Project's iHRIS software suite was listed by Nursing Assistant Guides as one of 50 Open Source projects that are changing medicine. In addition, WHO's OpenHealth program and

Promising Practices for Monitoring and Evaluation (M&E) Human Resources Capacity-Building

Using the HAF as an organizing structure, the Project, together with the Office of the Global AIDS Coordinator's Strategic Information technical working group, identified over 25 interventions used in Africa, Asia, Eastern Europe and Latin America that show promising results in building HR capacity for M&E. A collection of two-page abstracts describing the context, process and results of each promising practice, along with associated tools and resources, will be distributed widely to provide models for those working to strengthen national-level monitoring systems.

Read *HRH Strategic Planning* (available at www.capacityproject.org).

"We developed the HRIS for the health sector. It includes the public service, the NGOs, missions and the private units—all the health workers. We have all their information. Also, we are able to trace all those people who have already left the Ministry. We found people who remained in the payroll for some time, as ghost workers, and we saved the money…. Now, with the information we have, we can tell who is working where. It is helping us a lot in planning for the sector."

—Thembisile Khumalo, chief nursing officer, Swaziland MOHSW

"Everybody felt they were able to contribute and were part of the process of developing a human resources database for Uganda that would be functional. That approach ensures that the program that's being designed fully meets the local requirements and promotes use of information from the human resources team for policy decisions and allocations. The three key words here are ownership, sustainability and capacity-building."

—Dr. Edward Mukooyo, assistant commissioner, Resource Center, Uganda MOH

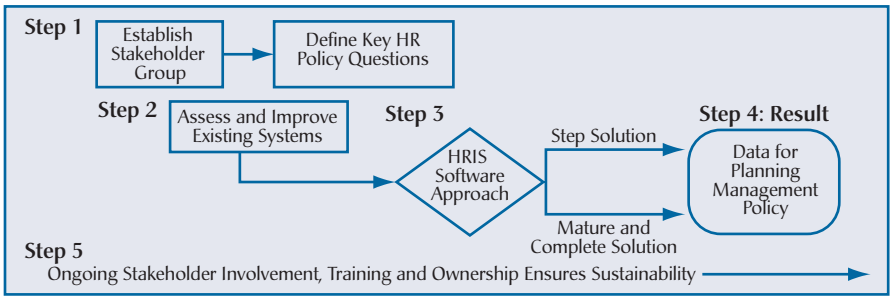
the Health Metrics Network have identified the iHRIS Suite as the reference application for health HRIS to be included in an Integrated Information Systems Toolkit intended as an all-in-one health information systems solution for developing countries.

The HRIS strengthening program earned the Project and USAID recognition as a global leader in increasing the quality and availability of information for HRH planning, development and support. The Project documented numerous health system impacts resulting from HRIS strengthening, including improved HR data accessibility and accuracy; more efficient HR systems; increased HR transparency; and greater cost-effectiveness. For example, in Swaziland the time required to identify "ghost workers"—those who are not currently in post but are on the payroll—and stop payment on their salaries was reduced from up to two years to one month; the time to verify the status of employees for promotion or appointment was reduced from four to six months to an almost instantaneous process; and the time to put a new health worker on payroll was reduced from three to six months to one month. Health workforce outcomes included improved leadership, policy and advocacy; increased strategic planning and research; and improved HRH management and personnel systems. For example, the Swaziland Ministry of Health and Social Welfare analyzed vacancies and staffing needs with the HRIS to create well-supported requests for new staff from central government. As a result, an unprecedented 200 posts were approved and added during the first year of the HRIS, and 300 posts the next year.

A strong HRIS is a phenomenal tool for integrating and analyzing data, as it allows managers and decision-makers to see how the whole becomes much more important than the parts, turning distant data into powerful information. The passionate support of the ministries of health, district and regional HRH managers and professional councils in the countries involved has been a clear indicator of the Project's success. Partnering with regional health organizations (such as ECSA) has been an essential factor in this success, raising awareness of the need for better health workforce information among national and regional health leaders and ensuring that HRIS are counted among regional health ministers' resolutions.

The Project's success has stimulated interest from other countries (such as India, Pakistan and South Africa) in using and adapting Project-developed approaches, software and tools to address their own health workforce challenges.

Flowchart of the HRIS Strengthening Process



Data-Driven Decision-Making

In working with ministries of health and health professional bodies to develop stronger HRIS, the Project emphasized simple, practical approaches to support HR planners and senior decision-makers to be effective leaders and managers of HR data. It is not enough simply to make data available. Health sector leaders need to have a process in place for analyzing the reports and information and getting it to the right decision-maker at the right time with the power and resources to act on the data. This process needs to be mainstreamed into the day-to-day operations and thinking of health sector leaders and managers.

Contextualizing HR data and information for more effective policy-making and practice remains a key challenge facing HRH practitioners and policy-makers. To address this challenge, the Project designed and delivered a three-day participatory workshop in Uganda on data-driven decision-making for mid-level policy planners and HR managers representing the MOH, Ministry of Education and faith-based subsector. The workshop generated practical next steps, including building capacity at the MOH Resource Center to act as the focal point for all HR data management and utilization efforts for the health sector, and tasking the MOH director of planning with spearheading the promotion of HR data for decision-making.

The Project offered a similar course to a group of health sector leaders in Swaziland, and worked with local counterparts and key HRIS stakeholders in Rwanda to facilitate a workshop on data-driven decision-making, focusing on using the country's HR data to accomplish the goals and objectives of the Health Sector Strategic Plan and HR Strategic Plan. These efforts assisted the countries in utilizing and contextualizing reports from their own HRH data systems and other relevant case studies, and informed the practice and development of decision-making skills and techniques in practical and meaningful ways.

In addition, the Project planned and supported a regional technical meeting for HRIS administrators, HR managers and senior HR planners in East, Central and Southern Africa to share and replicate lessons, tools and resources in order to promote and strengthen a culture of using HR data to enhance planning, decision-making and policy development. This effort targeted countries in the ECSA region (Kenya, Lesotho, Swaziland, Southern Sudan, Rwanda, Uganda, Namibia and Tanzania/Zanzibar) implementing new or improved HRIS as well as countries interested in learning more about the opportunities offered by HRIS strengthening.

HR Management and Leadership Strengthening

In many countries, managers responsible for HR had little or no preparation, had little professional HR background and did not understand how to run an HR unit, use data for strategic decision-making and be a leader of change. The Capacity Project facilitated a variety of leadership programs ranging from regional workshops and applications of Management Sciences for Health's Virtual Leadership Development Program to testing an intensive method of strengthening a national HRH cadre in Kenya.

Read *The Impact of HRIS Strengthening* and *Data Quality Considerations in HRIS Strengthening* (available at www.capacityproject.org).

"One of the key challenges that health-sector leaders usually have are issues of decision-making and the lack of accurate, quality data. [This process] is going to be very beneficial for the health sector and beyond the Ministry of Health."

–Zanele Dlamini, technical assistant on HIV/AIDS to the Principal Secretary's Office, Swaziland MOHSW

"I used to feel guilty when requested to talk about the total number of qualified nurses and midwives in the country because I knew that we did not have accurate data…. I can now speak boldly because of the more accurate data."

–Margaret Lutalo, senior nursing officer, Uganda Nurses and Midwives Council

Read *Building the Bridge from HR Data to Effective Decisions* and *An Overview of HRH Projection Models* (available at www.capacityproject.org).

"I commend Capacity Project for working closely with MOH to develop programs that are relevant to the unique needs of our country. In 2005, we faced enormous challenges—we did not know how many health workers were practicing in the country or the training output of pre-service institutions. HR systems and structures did not exist. With the support of Capacity Project and other partners, we have made a lot of progress. The contribution of Capacity Project has led to the recognition of the MOH HR unit and programs as the best among all government ministries in Southern Sudan."

—Dr. Monywiir Arop Kuol, undersecretary of health, Government of Southern Sudan

"Now I have both managerial skills and leadership skills—like focusing, aligning, inspiring. They are complementary."

—Aquilino Michael Oduma, director of health planning and training, Southern Sudan MOH

Read *Global Partnerships: Strengthening HRH Approaches Together* and *HRH: Tackling the HRM Piece of the Puzzle* (available at www.capacityproject.org).

The Project contributed to the growth of an HRH leadership cadre in sub-Saharan Africa through technical assistance that resulted in the implementation of country-level HRH action plans in Kenya, Namibia, Rwanda, Southern Sudan, Swaziland, Tanzania and Uganda. Country-level technical assistance continued to support and build this network in eight countries.

In Southern Sudan, the Project facilitated a leadership development program that included skills-development workshops, creating a learning environment and coaching. Each program was adapted to the needs of these managers in their contexts, and consisted of three days of face-to-face experience.

In Kenya, the Project delivered a blended learning program (three short workshops delivered over six months with face-to-face and virtual support and coaching) designed to develop and support a critical mass of HRH champions and knowledge brokers with the right skills and "clout" to articulate the issues and advocate for appropriate strategies and HRM systems. Participants overwhelmingly described the program as helpful in increasing HRH networks and circles of influence across relevant agencies. Participants valued most the strategies for collaborating on shared HRH bottlenecks and sharing among themselves a new language of frameworks, concepts and tools for HRH problem-solving. The most commonly mentioned and highly regarded tools were the HRH Action Framework (HAF), which many participants said broadened their perspective and linked often neglected HRH issues, and the HRH Scorecard, which many participants described having used, modified to the needs of their own institutions and shared with colleagues at their home institutions. Participants described significant progress on a wide range of activities as being a direct result of skills and resources gained from their experience in the program.

With the support of USAID/Africa Bureau, the Project prepared a technical brief, *Human Resources for Health: Tackling the Human Resource Management Piece of the Puzzle*, which describes the HRM problems that contribute to the health worker crisis, identifies specific strategic actions to address these HRM challenges and concludes with examples of innovations to stimulate programmatic funding opportunities for strengthening HRH. The brief was widely disseminated, along with the Project's related documentation of four HRM promising practices from Uganda, Malawi, Ghana and Namibia.

Streamlining Recruitment and Deployment

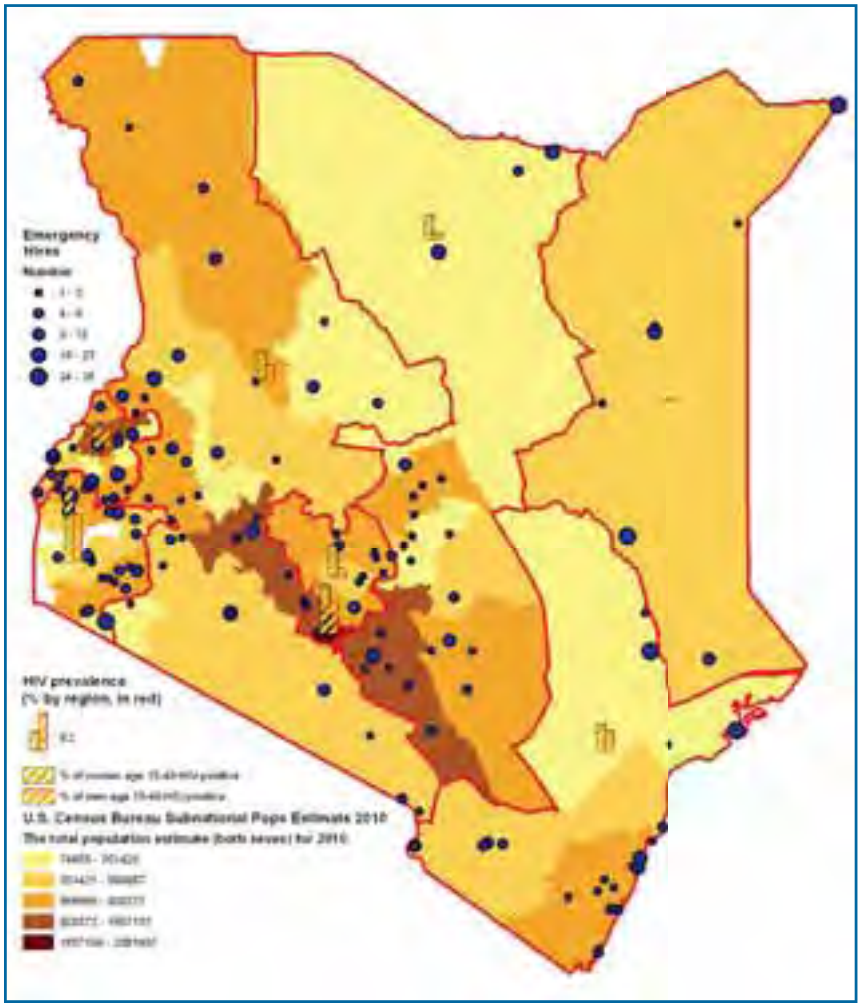
To ease the critical shortage of health workers in Kenya, the Capacity Project designed an Emergency Hiring Plan (EHP) to quickly hire and train large numbers of qualified health workers and deploy them where they are most needed. The EHP consisted of open recruiting, fair interviewing, candidate short-listing and transparent hiring. Hired workers received orientation and a two-week HIV-skills training and were subsequently deployed to districts with identified severe workforce gaps, where they received the same salaries as those hired by the government.

The EHP reduced the time for recruitment from approximately one year (and sometimes as much as 18 months) to less than three months. In approximately six months, the EHP recruited, hired, trained and deployed 830 new workers. The Project filled 100% of the total

830 high-priority posts over three hiring phases, placing workers in 193 facilities in 63 districts in all seven provinces, and hiring replacements to fill vacated posts. The new hires had an immediate impact. Lopiding Sub-District Hospital in remote Turkana District, for example, was able to remain open because of 14 new hires posted there. Facilities retained health workers at a high rate; 94% of the new hires were still employed in October 2008.

Most importantly, the EHP improved access to HIV and other services in the hard-to-reach areas and high volume facilities where previous studies had identified service gaps. Compared to baseline, more patients received prevention of mother-to-child transmission (PMTCT), voluntary counseling and testing (VCT) and antiretroviral therapy (ART) services, and facility hours increased for PMTCT, VCT, FP, child health and prenatal care.

The program's ultimate success persuaded the MOH to adopt the approach more broadly. For example, after postelection violence in 2008 the government used the EHP to quickly deploy health workers to displaced persons camps. The government included funding for EHP salaries in its budget and committed to transfer EHP hires to the public service as full-time employees.



"The [EHP] recruitment, hiring and posting process was very fair, indeed the regional balancing was good. Such a fair and open process earns the government credibility and improves its image."

–Christine Rotich, senior HR officer, Kenya MOH

"When I came here there was only one [family planning] method given to the clients, and I found very few are taking the methods–five in a month, ten in a month…I have gone up to 100, sometimes 170 a month."

–Nurse Susan Kajuju, EHP hire, North East Province

Read *Task Shifting for a Strategic Skill Mix* (available at www.capacityproject.org).

"With AMTSL our work has been made easier, and I can say that it has allowed us to save many women's lives."

– Berthé Aissata Touré, *matrone*, Mali

Task Shifting

Global interest in task shifting—the rational redistribution of tasks among health workers—to improve productivity increased midway through the Capacity Project. Invited Project leadership participated in a meeting of the Joint WHO/UNAIDS/PEPFAR Collaboration on Task Shifting (Geneva, December 2007) and shared the Project's experiences. This assisted WHO to finalize its recommendations and guidelines for the implementation of task shifting in countries facing a crisis in HRH as well as high HIV prevalence. The resulting document was launched at the WHO's first International Conference on Task Shifting in January 2008, where Project leadership facilitated a session on training needs to meet the HIV crisis, presenting the Project's LFP approach linked to workforce competency assessment. LFP addresses task shifting at the country level by tying learning to specific, identified job responsibilities and competencies. The Project also advocated for attention to relevant policy issues.

In Mali, the Project put task shifting concepts into action. Due to a severe shortage of skilled birth attendants, most vaginal births—especially those in rural areas—are attended by *matrones* (auxiliary midwives), who were not authorized to provide active management of the third stage of labor (AMTSL). The WHO recommends using AMTSL to prevent postpartum hemorrhage, the leading cause of maternal mortality. Addressing this issue, the Project partnered with the MOH, the Prevention of Postpartum Hemorrhage Initiative and USAID-funded bilateral projects on a pilot intervention to study and demonstrate the efficiency and safety of *matrones* using AMTSL. The study compared *matrones'* use of AMTSL with skilled birth attendants who were authorized to perform the practice, and assessed factors that could affect *matrones'* ability to perform AMTSL.

According to the Project's final assessment, *matrones* were just as adept as skilled birth attendants in AMTSL methods. After training, *matrones* scored 96% on an assessment of skills and techniques involved in AMTSL—essentially the same as the skilled birth attendants' score of 97%. *Matrones'* scores in recognizing and handling delivery complications were virtually identical to those of skilled birth attendants. Data from the final assessment showed that almost all vaginal deliveries in the study's health facilities had occurred using AMTSL. *Matrones* attended an important number of these births, and the postpartum hemorrhage rate decreased from 1.9% (93 cases) in the baseline survey to 0.13% (11 cases) during the final assessment. Presented with the study's promising results, the minister of health promptly authorized *matrones* to practice AMTSL and requested a commission to develop an action plan for training all *matrones* throughout the country.

Lessons Learned

- Developing foundational systems such as HRIS helped to move HRH leadership to more strategic and data-driven decision-making. The link to using the data is not automatic, however, and workshops focusing on data-driven decision-making can be a very important tool in helping to get senior HRH leaders to use the more accurate data that becomes available through improved HRIS.
- HRM systems in the health sector are typically very weak, and these weak systems threaten to impede progress on all significant HRH interventions. Work to raise awareness about the need to strengthen HRM systems is ongoing, and the Project played an important role in raising this issue, but it needs significant future attention.
- A six-month blended learning program as piloted in Kenya holds much promise for building a critical mass of HR professionals at the country level, and creating an HRM reference group in the process.
- Fundamental changes in basic HR processes like recruitment and posting are very important to undertake and can have far-reaching results that go beyond the process itself. In Kenya, for example, the process modeled a more transparent and fair location-based recruiting and placement system that the government may adopt in the long run. These types of fundamental changes take time, however, as they frequently involve entities outside the health sector, raise difficult issues and are often highly political.
- Task shifting is more likely to be successful when closely linked to policy change.

HRH Performance Appraisal for TB/HIV

The Project completed an HRH performance appraisal for TB/HIV collaboration in Kenya and developed draft HRH performance standards for TB/HIV collaboration services. Findings of the HRH performance appraisal were presented to TB/HIV stakeholders. The Project worked to ensure that the TB stakeholders formed a technical working group to work alongside government agencies in responding to HR needs specific to TB.

Workforce Development

Background and Strategy

Quality health care services rely on education and training systems that develop health workers' clinical skills and knowledge in alignment with national health priorities. The Capacity Project aimed to achieve the following results within the area of workforce development:

- Prepare more providers to meet priority national health needs with a particular emphasis on FP/RH
- Strengthen pre-service education institutions, tutors and systems
- Strengthen professional associations to support national workforce development and service delivery
- Improve linkages among national plans and policies, education/training systems and strong professional associations.

Results

Learning for Performance

Too often, health worker training is conducted without regard to an environment that enables good practice, nor to the transition from learning to practice. The Capacity Project's *Learning for Performance* (LFP) approach offers a step-by step, customizable instructional design process and practical tools that focus training and education on:

- *Relevance* (to the specific job responsibilities and work environment of employees)
- *Efficiency* (by removing unnecessary content and retaining only essential content, thus shortening the time required for training)
- Preparing learners for *job performance* (by using experiential, competency-based training methods that increase opportunities for skills practice and by addressing the performance factors that determine whether new knowledge and skills can be applied).

Throughout LFP learning interventions of any scale, the support and involvement of stakeholders (e.g., ministries, nursing schools, health education professionals) is critical. To facilitate this engagement, the LFP approach is highly participatory from the beginning of the development of a learning intervention through its implementation.

LFP plays an important role in key strategies to address HRH issues, including task shifting, developing new cadres, accelerating training and deployment of emergency hires and aligning training with national goals. For example in Rwanda, the Project used LFP to identify on-the-job training (OJT) as an appropriate approach for accelerating the training of FP providers in 11 Project-supported districts without disrupting services. Project staff and stakeholders then used LFP tools and processes to adapt the national two-week classroom-based FP curriculum to an eight-week structured OJT approach, removing unnecessary content and integrating missing content on Healthy Timing and Spacing of Pregnancies and HIV/AIDS that the FP providers needed to offer integrated FP/HIV services. Project staff used LFP tools to establish a learning support system for OJT, including training trainers and supervisors to use the materials and training methods, establishing small FP libraries in the OJT sites, providing anatomical teaching models and clinical equipment and organizing a supervision system to support the clinic managers, trainers and trainees for the duration of the program. The LFP-developed structured approach trained more than twice as many

"The [*Learning for Performance*] approach is focused on the essence of what health workers need in order to do their work in a hospital, a health clinic or a community health center."

–Dr. Mohamed Salia Maiga, director of studies, Gao Nursing School, Mali

Read: *Applying the Learning for Performance Approach* (available at www.capacityproject.org).

"The new competency-based curriculum will help the community, because the students are learning knowledge and skills in the lectures and clinical practica. They go out to the community to get to know the people."

–Immaculae Muhawenimana, midwifery assistant and member of Nursing and Midwifery Task Force, Rwanda MOH

"Every health worker coming to practice in Southern Sudan or completing health training knows that we now have registration criteria which they must satisfy. Before the development of these guidelines, there were no clear criteria to guide registration and many people practiced without being registered. The new regulation has also enabled us to maintain a database of health practitioners in Southern Sudan which is extremely useful in planning."

– James Maluit Ruach, director of HR development, Southern Sudan MOH

FP providers to competency (457) over the same duration of time (about eight months) at half the cost per participant, and served twice as many clients during training compared to the two-week workshop approach (193 providers). Plans are underway to scale up the FP OJT approach throughout Rwanda, and to use LFP to convert the Rwanda Basic Emergency Obstetrical and Neonatal Care (EmONC) training for health center staff to an OJT approach.

Strengthening Pre-Service Education

Based on recommendations from a Project-supported needs assessment, the Project provided comprehensive support to Mali's Gao Nursing School in order to address the lack of skilled HRH in three under-served northern regions. The Project used LFP to lead faculty and managers to develop and implement FP/RH and child health modules for the nursing and midwifery curriculum. The participatory LFP process linked faculty with clinic managers to identify the specific job-related skills needed by graduates to serve the diverse population of this remote area. The Project assisted the school with its technology needs, including supplying computers and multimedia equipment and teaching software, and installing a networked learning system. The Project updated faculty in FP/RH/child health and performance-based teaching methods, and faculty then taught the new modules to third-year students.

As a result, instructors reported using a much broader range of participatory and technology-based instructional methods. Students achieved much higher skills and knowledge scores than those from two other schools using a more traditional learning approach, and students, teachers, supervisors and managers all expressed satisfaction with the LFP approach. Central government representatives participated in the process with an eye toward using LFP for national curriculum revision. The school's leadership expanded use of the new FP/RH and child health modules beyond the third year of training, incorporating the modules into the first-year curriculum. The Project also assisted in the development of a five-year strategic plan (2007-2012) and reorganization of the school's board of directors to include political and administrative representatives from the region of Gao as well as teachers and administrators. All of these interventions have strengthened the Gao Nursing School as a Center of Excellence in community-supported, technology- and performance-based training.

Read *Strengthening Professional Associations for Health Workers* (available at www.capacityproject.org).

Rwanda's 2005 HIV/AIDS nursing school performance needs assessment, carried out in collaboration with the Project, revealed that graduates were performing at different levels depending on the institution from which they graduated, and that the performance and skills of A2-level nurses were generally inadequate. As a result, the MOH decided to eliminate the A2 cadre and focus on A1 instruction. Little or no attention had been given to HIV/AIDS pre-service education, and the existing nursing curriculum lacked HIV-related materials and training. Several of the schools were in poor condition and lacked IT infrastructure, libraries and Internet connectivity.

The Project worked with the Rwanda MOH to use the LFP approach to develop competency-based HIV/AIDS prevention and treatment, FP, EmONC and gender components and integrate them into the new three-year A1 nursing and midwifery curricula. The competency-based nursing and midwifery school curricula were used with the first A1 class starting in 2007, and are now used in all five nursing schools across the country

to train approximately 300 graduates per year. The Project also provided operational support through subcontracts to five nursing and midwifery schools and helped with their launch of the Registered Nursing and Nurse Midwifery A1 Programs, including financial support for the renovation of classrooms, dormitories and the purchase of office equipment. For each of the five schools, the Project provided computers, Internet connections, training equipment and technical reference materials; organized library management training; updated faculty and clinical preceptors in HIV/AIDS, FP, EmONC and gender; and supported the development of five-year strategic plans for 2009–2013.

The Project's support made a significant impact on both the students' education and the schools' ability to administer professional nursing and midwifery programs. Approximately 650 students now perform their practica at the community level, in addition to hospital and health center practica. As decentralization supports government interest in greater delivery of services in the community, this effort helps to better prepare nursing students for their future careers. The FP curriculum revision provided for training of nurses in the insertion of IUDs and implants and the administering of DMPA injections. Also, nurses can now counsel and assure follow-up of patients on ART.

The Project also led successful pre-service education strengthening activities in Lesotho and Belize, and, with ECSA, led a regional workshop for midwifery tutors on Contemporary Issues in Family Planning, which is being replicated in Malawi for nursing and midwifery tutors under USAID's Southern Africa Human Capacity Development Coalition Project. The Project established an online community of practice, the Global Alliance for Pre-Service Education (GAPS), aimed at strengthening pre-service education in FP/RH. The Project supported GAPS in collaboration with WHO and the Implementing Best Practices (IBP) Consortium. Moderated by a Project team, the GAPS website served as a forum for guided discussions on basic principles related to competencies and competency-based education; specific FP competencies; and challenges and best practices in educating students using competency-based educational principles. The site remained active after the planned fora were completed. For example, 70 participants from Ethiopia created a subforum and used GAPS to address national pre-service strengthening initiatives.

Professional Associations

Stronger health professional associations can help address two critical HRH issues: attracting more people into the health professions; and supporting, sustaining and retaining those health workers who are already employed within the health sector. To address HRH issues related to out-migration and the lack of an adequate supply of well-trained professionals to deliver key services, the Project worked to strengthen professional associations in Kenya, Uganda and Ukraine. With the Project's assistance, the associations promoted standards of practice, advocated for the needs of both consumers and providers, formed networks with other professional associations, and liaised with legislative and regulatory bodies. Responding to identified needs, the Project assisted in a variety of professional association strengthening activities, including completing continuing professional development guidelines; improving leadership, management, communications and advocacy skills; and creating health professional awards.

Partnering Initiatives through the USAID/ Latin America and Caribbean (LAC) Bureau

Beginning in 2006, the Project worked to improve the capacity of the health workforce by introducing the HAF to several countries in the LAC region, including Peru, Ecuador, Colombia, Chile, Bolivia and Belize. The Project assisted the Caribbean HIV/AIDS Regional Training Network (CHART) to develop and implement a rapid training needs assessment (RNA) tool for use in regional training centers located throughout the Caribbean. The Project also provided technical assistance for Caribbean countries to more effectively manage their Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) grants. These GFATM grants are performance-based and require management systems that many Caribbean organizations are still developing. Selected activities from these initiatives included:

- *Creating and implementing a health economics course, focusing on HRH, for the top 36 leaders and managers in the Peru MOH*
- *Providing technical assistance to the Caribbean Regional Network of People Living with HIV/AIDS to manage its regional GFATM grant*
- *Strengthening the monitoring and evaluation (M&E) capacities of line ministries and civil society organizations to enable them to report into their national M&E system more effectively*
- *Providing technical assistance to the CHART Regional Coordinating Unit to enable its staff to conduct RNAs.*

"The materials I got from the workshop helped me a lot. The updates have spiced my lectures. Some of the content that I was able to add includes healthy timing and spacing of pregnancy, medical eligibility criteria, Standard Days Method/ cycle beads and postpartum family planning. I am also going to take the students through family planning in the context of HIV/AIDS."

–Training participant, Kenya Medical Training College

With support from the Society of Obstetricians and Gynecologists (SOGC) of Canada, the Project assisted the Ukrainian Association of Obstetricians and Gynecologists to expand membership by more than 50%, add a WHO-based FP training module to its training curriculum, create a website to disseminate professional information and build a core team of instructors to sustain training of future members in emergency obstetric care and FP. Collaboration between doctors and nurses improved, and the association opened its doors to midwives and general practitioners, demonstrating increased understanding between ob/gyn specialists and midwife-practitioners.

The Project's efforts in Kenya and Uganda strengthened communications and networks within and, in the case of Kenya, among associations. Project-supported communications training was especially impactful. An evaluation found that communication with policy-makers had improved. Association leaders appreciated the activities to improve association management and communications, and members—particularly in Kenya—noted improvements. In Uganda, there was widespread agreement that communication with the media had improved and that nurses are not being as harshly criticized in the media. The nurses also felt that because they had learned how to communicate more effectively, clients were complaining less about nurses. The efforts in Ukraine and Uganda to carry out continuing medical education and establish appropriate guidelines support high standards of practice.

In Southern Sudan, the Project worked with senior MOH managers, WHO and NGOs/faith-based organizations (FBOs) to create a legally constituted, fully functional and autonomous Health Personnel Council, responsible for registering medical personnel and regulating medical practice among all cadres of health workers. Previously, the council had no organizational structure or dedicated staff and lacked a regulatory framework to guide action; thus, many practicing health workers were not registered. The Project conducted an assessment of regulatory institutions and developed guidelines to support governance of the council and to guide its operations through the development of an appropriate regulatory framework. The guidelines developed with the support of the Project have been finalized, and the government is now registering health workers using the new guidelines.

HRH eLearning Course

To support ongoing HRH learning within the broader global health community, the Project developed a self-paced HRH eLearning course focusing on the basics of HRH and systems strengthening. Hosted at USAID's Global Health eLearning Center (www.globalhealthlearning.org) to provide broad access, the course gives learners a 90-minute interactive self-learning module through which to learn basic information and promising practices related to HRH issues. The course includes an overview of HRH worldwide, and provides links to documents, organizations and other resources that address HRH issues. Learners receive a certificate of achievement upon successful completion of the course. CD and hard copy versions will reach audiences that lack reliable Internet access. While the primary audience is USAID officers and staff, the course will also provide country-level missions, ministries and others with easy access to information demonstrating the importance of HRH.

The HRH eLearning course supports USAID's commitment to health systems strengthening. Strong systems are vital to ensure widespread use of effective health measures and, ultimately, to improve health. Health systems strengthening is a continuous process of implementing changes in policies and management arrangements within the health sector. Guided by governments, NGOs and donor agencies, the process of strengthening health systems is taking place in many countries in response to their populations' needs. (Source: USAID website, overview of USAID support in health systems strengthening: http://www.usaid.gov/our_work/global_health/hs/)

Lessons Learned

- The LFP approach represents a useful instructional design tool and can play an important role in key strategies to address HRH issues, including task shifting, developing new cadres, accelerating training and deployment of emergency hires and aligning pre-service education and in-service training with national goals.
- The highly participatory nature of LFP contributes to the approach's success. Applying LFP fosters teamwork and improves collaboration and communication among managers, teachers, trainers, preceptors and supervisors, which in turn improves student/trainee learning and performance. The benefits of involving stakeholders must take into consideration the time that participatory activities require.
- A comprehensive approach to pre-service education strengthening can be accomplished in just three to four years.
- Because many donors and countries alike continue to view pre-service education as expensive, long-term and difficult to evaluate, there is a need to generate more compelling evidence that this is a fruitful area for investment.
- Professional associations are an important entry point for developing and strengthening health worker leadership skills, especially among cadres that are primarily female.
- Access to smart phones and other information technologies is rapidly changing the options for expanding and strengthening curriculum development.
- Establishing education programs closer to rural areas can improve deployment of health cadres to those areas (e.g., Gao Nursing School in Mali).

"Both midwives said that it is much better now; the doctors have become more accepting and believe that midwives are able to teach…. At work, these two midwives [also] say that they felt that doctors are more respectful in the hallways and behind closed doors."

–Moya Crangle, SOGC midwife who audited a midwife training program in Ukraine

At a Glance: Training

The Capacity Project trained 9,250 health workers: nurses, doctors, HR administrators, community health workers, ministry officials and peer counselors. In Ethiopia, the Project trained over 2,000 workers in HIV-related skills, including PMTCT, home-based care and peer counseling for people living with HIV and facility-referral for health extension workers. In Rwanda, the Project trained 1,655 people, the majority in the area of FP clinical skills, an area of special focus for the MOH. These trainings were part of a broader strategy of repositioning Rwanda's pre-service and in-service education curricula. In Kenya, the Project trained 1,507 health workers, 950 of whom were trained in HIV clinical skills as part of the EHP deployment.

"The depth of the ten-day on-the-job training made us capable of launching PMTCT services in our health center. The training gave us the capacity to counsel, test for HIV, determine the infection stage, provide treatment, follow up for the mother and the child—and a lot more…. I am [now] capable of counseling for HIV testing and keeping the mother in medical follow-up toward institutional delivery, which most women in our area are not willing to do. This way I can make a difference in one's family life."

–Sister Abiyot Bedane, maternal and child health nurse, Alem Tenna Health Center, Ethiopia

Workforce Performance Support Systems

Background and Strategy

The Capacity Project aimed to achieve the following results for performance support over the life of the Project:

- Health worker job satisfaction and retention increased in intervention settings; lessons learned and approaches suggested for wider use
- Provider productivity improved; approaches documented and disseminated
- Supervision systems strengthened
- Plan implementation skills of HR managers and practitioners enhanced.

The Project carried out a range of activities to increase knowledge about key factors affecting health worker productivity and retention, and assisted countries to design and test interventions to influence policies and improve service delivery. These ranged from identifying current best practices in retention to implementing work climate improvement and supportive supervision initiatives to conducting studies assessing health worker job satisfaction and reasons for leaving posts.

Results

Productivity

The most significant result of the Project's work in productivity and retention was the design and implementation of useful, operational studies that can be replicated in other areas of a country or other countries. These included studies of health worker satisfaction in Uganda and health worker productivity in Tanzania that generated data that can be used to design and implement country-appropriate strategies and policies to attract, recruit, retain and improve the performance of workers in high-need regions.

The Project worked with the Zanzibar MOHSW to improve health care service delivery, efficiency and system performance. Following a Project-led health worker time utilization study, which found that less than half of health workers' time was spent on direct patient care, and nearly a quarter was spent waiting for clients, in-country partners decided to focus on improving productivity at the primary health care level. The Project worked with key stakeholders on the agreed set of productivity improvement interventions, which included simple facility-driven interventions such as improved signage, posting of facility hours, completing daily work plans, instituting weekly meetings and completing community outreach forms to monitor the balance of health worker activities. Additional interventions were designed to strengthen the technical working groups at the MOHSW and facilitate ownership for the interventions implemented at the facility and district levels within the Zanzibar health system. An evaluation of the intervention's effectiveness found that although the actual time spent in direct patient care did not change, time spent waiting dropped to 11% and the ratio of overall patient care to wait time changed from 2.1:1 to 3.9:1.

Retention

Retention continues to be a serious challenge in the HRH crisis. There is increasingly widespread commitment to initiatives to attract and retain skilled workers, especially in rural areas. However, the factors influencing health workers' decisions to move

"Capacity Project has helped to fund a number of studies. Case in point is the retention study, leavers study [on health workers who left their employment], assessments in staffing gaps and needs in districts, the study on services for reproductive health and HIV/AIDS—to mention but a few. This will help the Ministry to develop appropriate plans of action in scaling up proper service delivery."

—Francis Ntalazi, assistant commissioner of HR management, Uganda MOH

"There is an aspect of involving everyone responsible in an activity, so that people feel it is our thing. Sometimes we seem to slow down but the Capacity Project keeps pushing us to continue. We very much appreciate that."

—Khamis Khamis, head of the HR Division, Zanzibar MOHSW

"There were tall grasses which even snakes could hide in. The workers were not comfortable. When patients came here, they were not interested [in entering] because this hospital is like they have come to the bush. [Now] we have so many flowers; they say the compound is neat."

–Morris Kai, nurse, St. Luke's Mission Hospital, Kilifi, Kenya

from impoverished rural areas to richer and better equipped urban settings and from low-income countries to those offering higher salaries are complex. Available evidence consistently shows that health workers are ready to leave their posts because of low compensation, lack of practical and educational opportunities, poor working and living environments and inadequate social amenities.

The Project created an ambitious health worker retention initiative that identified and documented promising practices in retention (Ghana, Malawi), supported the collection and use of workforce data to understand trends in worker turnover and movement (Uganda, Liberia), identified and developed a set of innovative retention practices and implemented and tested those practices. In addition, the Project served as a contributing member of the WHO global expert group on retention.

The Project designed a retention study in Uganda to determine health worker job satisfaction and reasons for leaving health posts, and supported HRIS development to strengthen national-level retention planning. Data from the retention study were then analyzed to guide intervention development. Findings revealed that fewer than half of the 641 respondents reported being satisfied with their jobs. Satisfaction with salary was particularly low, and doctors were the least satisfied group. Working and living conditions were very poor, and workload was judged to be unmanageable. Working conditions were better in the private (nonprofit) sector than in the public sector, but compensation and job security were viewed as superior in the public sector. Although health workers had been in their jobs a long time (81% said they were still in their first jobs; average time with their employers was 13 years), about one in four would leave their jobs soon if they could, and more than half of doctors (57%) said they would like to leave their jobs. Most workers were employed where they were born or trained, suggesting implications for recruitment and retention. The important correlates of intent to stay or job satisfaction include the importance of salary (but not the satisfaction with salary, which is uniformly low), a good match between the job and the worker, active involvement in the facility, a manageable workload, supportive supervision, flexibility to manage the demands of work and home, job security and a job perceived as stimulating or fun.

Read *Worker Retention in HRH: Catalyzing and Tracking Change* and *Retention of Health Care Workers in Low-Resource Settings* (available at www.capacityproject.org).

Based on study findings, the Project assisted health ministry leaders in Uganda and Tanzania to pilot-test retention interventions to influence policies governing health worker retention. In Tanzania, the Project assisted the MOHSW to develop and begin implementation of an HRM briefing program for 19 districts participating in an emergency hiring initiative.

Tanzania's Ulanga District, facing shortages of health workers at every service delivery level, implemented a workplace climate improvement initiative (WCI) with support from the Project, to improve morale and performance. The aspects targeted for improvement included management practices for facility managers and the work environment for health workers in frontline facilities. The year-long WCI, which began in April 2008, was implemented in 14 public sector facilities. Health workers confirmed that functioning of facilities improved in the 12 months of WCI implementation. There were increases in the proportion of health workers reporting availability of work plans (51% to 80%), constructive feedback (77% to 92%) and the provision of expanded scope of outreach services (55% to 96%). There was a dramatic

increase in client load, especially for PMTCT and ART services, following the intervention; the mean number of PMTCT clients increased threefold (50 to 150). Facilities revived community health boards to strengthen facility-community linkages. On average four meetings were held with the community board in the 12-month intervention period compared to one meeting in the year before the intervention. The proportion of clients reporting dissatisfaction with services received on the day of the baseline and endline visits dropped from 40% to 11%.

The Project also worked with the Kenya MOH to select and pilot simple, low-cost WCI interventions in ten rural facilities over 18 months. The initiative focused on four key areas: the patient/health worker relationship, the health worker/supervisor relationship, workplace environment and worker wellness. Facility-based teams assessed their own work climates and generated activity plans to test low-cost approaches for improvement. The initial survey found very low morale, and a vast majority of respondents were unhappy about the work climate. Facility-based teams assessed their own work climates and generated activity plans to test low-cost approaches. Interventions included improved signage, job descriptions, organizational vision and mission statements, departmental work plans, more equitable shifts, managed inventories, safe waste disposal, cleaner yards and facilities, more organized patient flow, infection prevention protocols, staff lounges with free tea, new resource centers, painting and refurbishment of facilities, new equipment and more frequent team meetings and sharing of information. In addition, the Project provided leadership training to members of WCI facility teams to support the initiative. In a follow-up survey, nearly all staff in the ten sites expressed high satisfaction with their environments and had no intention of leaving. All sites reported increases in service use. Examples of improvements cited by Project supervisory teams include better staff morale, improved patient-provider relations, safe waste disposal procedures followed, improved signage, organized patient flow procedures and cleaner facilities for staff and patients.

"This is the first time in my career that I knew very clearly what the staff in the visited health center needed; it has been the first time that I was able to support them. The performance assessment tool allowed me to see beyond the appearance. Performance support is the key for making supervision supportive."

–District health officer, Uganda

Supporting Health Worker Performance with Effective Supervision

Access to quality health services depends on the performance of skilled personnel. Consequently, improving the effectiveness and efficiency of health services requires continuous support for health workers to allow those in the frontline of service delivery to perform as expected. Supervision, therefore, is one of the most relevant tasks in health systems management. However, health managers commonly neglect supervision, and many supervisors lack the knowledge, skills and tools for effective supervision. To address these shortcomings, the Capacity Project worked with governments and partners in Uganda and Central America to test a performance support (PS) approach that implements performance improvement and supportive supervision in a complementary way.

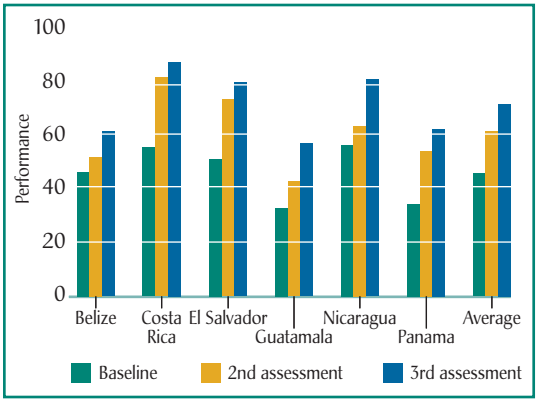
In Belize, Costa Rica, El Salvador, Guatemala, Nicaragua and Panama, national health authorities decided to increase the number of hospitals providing HIV services to address barriers to access given the centralization of services, persistence of stigma and discrimination and lack of nutritional management. The Project applied the PS approach in 36 hospitals across the six countries. The approach includes five steps: 1) foster agreements and commitments among stakeholders, 2) determine the expected performance of local health teams, 3) assist local health teams to carry out performance improvement, 4) manage change and 5) celebrate progress.

"Multidisciplinary teams at HIV clinics are being empowered and are implementing a series of unprecedented change and improvement efforts. The teams are now able to identify specific needs that should be addressed by the central level. This is a very significant change, because it has helped us identify that [the] technical accompaniment of operational services by central-level programs has been weak. The performance support approach is allowing us to address this topic in a more systematic, sustainable and friendly manner."

—Dr. Gloria Terwes, national officer of the HIV Prevention and Control Unit, Costa Rican Social Security

The implementation of this approach allowed local teams to identify performance standards, study current performance and bridge identified performance gaps, including improving logistics systems, acquiring basic equipment, addressing stigma and discriminatory practices and improving infection prevention practices. National authorities also addressed systemic cross-cutting issues, such as improving nutritional care guidelines, strengthening infrastructure deficiencies and addressing HRH shortages.

The national and regional management teams adjusted their usual supervision approach, aligning their plans to respond to the actual hospital needs. In Guatemala, the MOH's Hospital Management Unit incorporated PS into its plans and agendas. In Nicaragua, the general secretary of health led the PS implementation, adopting the performance standards for HIV treatment and care, including PMTCT, and expanding the use of PS beyond HIV services. Regional teams built partnerships with NGOs to implement PS in their private clinics. In Panama, the national HIV program incorporated PS into its supervision plan. Costa Rican Social Security used PS as the key intervention to facilitate the decentralization of HIV services, incorporating it into its management plans. El Salvador's national HIV program incorporated PS as one of its management responsibilities and created a budget line item to support these activities; hospitals created PS teams to continue its implementation beyond the Project's intervention. Follow-up assessments revealed an average improvement in HIV service standards performance of 26 percentage points from baseline (46%) to the third assessment (72%) across the six countries and strengthened supervision activities.



Average Compliance with HIV Service Performance Standards, Central America

Lessons Learned

- Stronger HRM systems and better HR management will lead to improved work climate and more effective supervision, and this in turn can enhance health workers' performance by encouraging motivation, productivity and retention.
- Based on local conditions, countries should consider an appropriate mix of incentives that will be sustainable in the long term. Encouraging HR managers to use simple survey methods and tools to solicit health worker input will help to determine the best incentive mix for a particular context.
- Building a strong team and systems at all levels of health care delivery to lead HRH planning and management is one untapped practice that may yield good returns for addressing shortages and imbalances, including high turnover.
- A workplace climate initiative that accounts for a skills update in management practices combined with action planning, supportive supervision and infrastructure improvement has a good chance for success, up to the service delivery level.
- Health workers are not necessarily looking for costly incentives; they see value in taking smaller actions to improve their workplace or their living conditions (especially if placed in a rural, remote area).
- Districts that take the initiative to include HRH interventions will more likely take actions to improve recruitment, productivity and the climate in the workplace.
- Selecting only one service delivery or management issue helps to focus performance support efforts.
- Gender issues often play a key role in retention and productivity of health workers.

Read *Supporting Health Worker Performance with Effective Supervision* (available at www.capacityproject.org).

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Knowledge Management

Background and Strategy

The Capacity Project's approach to knowledge management (KM) supported the Project by creating mechanisms and systems to gather, assess and distribute HRH knowledge, facilitate the development and use of evidence-based practices in the HRH field and document Project results. Strategies included:

- Collecting and evaluating the utility of existing promising practices and tools
- Creating opportunities for others to access, share and use the best HRH tools, information and resources
- Collecting and disseminating results and lessons learned and sharing stories about the Project's impact.

The Project's KM work included a broad range of activities and processes, both internal and external. Documenting and sharing information and resources via a website, listservs, publications and participation at conferences and meetings—so that others may build on the Project's experiences—were the Project's fundamental contributions to the body of HRH knowledge. The Project also supported several special studies to explore innovative HRH strengthening strategies, including an evaluation of the Kenya EHP, an assessment of the prevalence and factors associated with workplace violence in Rwanda, an inquiry into the feasibility of attracting men to HIV caregiving and a study exploring barriers to treatment for HIV-infected health workers.

Results

HRH Global Resource Center

Through the HRH Global Resource Center (GRC), the Project was highly successful in increasing global access to the HRH knowledge base. The GRC (www.hrhresourcecenter.org) is an online digital library created to maintain a global exchange of HRH evidence, tools and innovation. The Project developed and expanded the GRC to over 2,000 resources. It is the world's leading HRH resource knowledge base and the largest online HRH collection.

The Project designed the GRC to assist a broad spectrum of users, while taking into consideration the technological requirements of HRH practitioners in developing countries. Users can browse resources by subject, geographic focus or resource type as well as conduct targeted searches, even in areas with low bandwidth. Engaging with the site's users proved the most critical element of success. Other key success factors included a dedicated professional librarian and continual collection development. The GRC also supported HRH knowledge-sharing in offline environments by hosting documents for organizations in developing countries that do not have websites and by providing resources on CDs for groups that lack reliable Internet access. In Southern Sudan the HR policy task force used the GRC to design the country's HRH policy and national training plan. In Bangladesh, MOH officials used the site to inform the development of the country's community health care initiative. A regional foundation in Nigeria, the region's only resource center with Internet access that serves an area with a dozen health and educational institutions, uses the GRC to provide health information to the foundation's members.

At a Glance: HRH Global Resource Center

- *Average site visits per month: 29,725*
- *Number of countries with user visits: 174*
- *Number of resources: 2,122*

These figures are from the period of April-June 2009.

"Ensuring that all the resources for HRH are in the same place makes everyone's lives much easier. It's a one-stop search for HRH. It ensures the most up-to-date policies are available."

—Hattie Begg, research and advocacy officer, AMREF UK

"[The KM Portal] virtually contains the most important documents and the valuable ones, and it will save [MOH officials] from coming down to the office. Even those who are going for conferences won't be going with documents, because you just open the portal. All our policy documents are already there, and those are the key things that people need when they go for those conferences."

—Moses Doka, Uganda MOH Library

National HRH Knowledge-Sharing System in Uganda

The Project identified Uganda as an ideal country to pilot an HRH knowledge-sharing system that integrates the GRC, the HAF and the iHRIS software suite with a web-based file-sharing and collaboration portal. Managed and maintained by MOH staff, the portal integrates these three Project tools and resources with a digital library for MOH documents and links to relevant journals in a unified and simple interface. The portal has a public space to provide general access to key resources such as data from the Uganda Nurses and Midwives Council and a private, secure environment for internal document-sharing.

Project Publications and Dissemination

The Project also expanded HRH knowledge through its leading role in development of the HAF website, and reached key audiences with its own publications and resources via dissemination through technical staff, at key events, via the Project website and GRC and through a listserv with 1,400 subscribers. Highlights include the following:

- *Technical briefs:* These concise publications synthesize information and provide practice recommendations on key HRH topics. The Project also contributed a technical brief, *Addressing the Crisis in Human Resources for Health,* to the "Global Health Technical Brief" series for the Maximizing Access and Quality Initiative.

"[The HRH Global Resource Center] addresses the most relevant issues in such an effective manner. The valuable information is directly useful in strengthening the response to the containment of HIV/AIDS besides addressing the health system strengthening issues."

–Dr. Rajesh Gopal,
Gujarat State AIDS
Control Society, India

- *Resources and tools for HRH practitioners:* Responding to gaps in available HRH resources, the Project published a variety of topical resources to support HRH planners, decision-makers and practitioners to strengthen the health workforce in developing countries. These range from LFP and a promising practices series to resources on integrating gender in HRH and supporting HRH partnerships.
- *Voices from the Capacity Project:* This monthly series focusing on stories about the Project's impact and results was disseminated through the Project listserv as well as through the Project website, GRC and other outlets.
- *Legacy series:* These briefs highlight key results and lessons learned over the life of the Project.
- *Promising practices:* As part of the Health Workforce "Innovative Approaches and Promising Practices" Study, the Project produced four papers detailing examples from Ghana, Malawi, Namibia and Uganda along with a synthesis paper.
- *Resources in French and Spanish:* Translations of technical briefs, Voices and other materials are available on the website and in print.

All materials are available on the Project website and the GRC. The Project sent its materials (both when they were newly published and when older documents were applicable to an event or purpose) to its field offices, distributed them at key international conferences, used them at HRH Action Workshops (which reached the Project's key target audience) and made them available to its technical team members, who used them in the field to support their technical assistance.

The Project tracked primary and secondary distribution of its external publications. Primary distribution includes print and the Project's listserv; secondary distribution includes electronic access of publications on the Project and IntraHealth websites. These figures totaled over 344,000 as of July 2009. The most frequently accessed technical brief was *Retention of Health Care Workers in Low-Resource Settings*, followed by *Task Shifting for a Strategic Skill Mix. Kenya's Health Care Crisis: Mobilizing the Workforce in a New Way* was the most frequently accessed *Voices from the Capacity Project* article.

Lessons Learned

- **One key to the success of the GRC was the availability of technical staff to suggest resources and provide periodic quality checks of resources.**
- **A good KM system is developed iteratively in response to user feedback and evolves as the people, processes and technology involved in the system evolve.**
- **It is important to make it easy for stakeholders to seek just-in-time information. While most people understand the value of making more informed decisions, many will not invest the time in learning a new system until the moment when they need information.**
- **People have a natural tendency to seek out people they know to answer questions. Knowledge managers can capitalize on this by introducing initiatives to groups with similar needs and roles and by making good use of local facilitators (e.g., librarians, workshop facilitators, peers with more advanced KM skills) who can help someone seeking critical or urgent information.**
- **KM should be integrated into workflow processes. Make it easy for people to find and retrieve information. Do not expect people to learn and access multiple systems to find information.**

The Capacity Project's full series of external publications is available at www.capacityproject.org.

Gender Equity and Equality

Background and Strategy

The public health workforce in developing countries is predominantly female. Addressing gender inequality and discrimination in HRH policy and planning, workforce development and workplace support is essential in tackling the complex challenges of improving access to services, by positively influencing HRH recruitment, retention and productivity.

The Capacity Project focused systematically on the relations between men and women and how these may affect differences and inequalities in opportunity for education, training, occupation and health labor market participation. The Project emphasized integration of gender into HRH planning and leadership, workforce development and performance support to ensure that men and women contribute to social and economic development through active involvement in public life and in the labor market, address workforce shortages by maximizing opportunities and address poverty alleviation through employment. The Project's gender strategy objectives for each IR included:

- Strengthen HRH planning and leadership to promote gender equality
- Increase gender integration in education, training and work
- Create supportive, fair and safe work environments.

Results

Increased Staff Capacity to Implement Gender Work

During the Project's start-up phase, the USAID Interagency Gender Working Group (IGWG) Training Team provided technical expertise and support. IGWG members helped the Project develop a gender and HRH orientation module for staff and adapt existing IGWG gender integration training materials for reproductive health programs to the area of HRH, including an advocacy module. This collaboration raised staff awareness about gender and HRH, providing a common language and identifying potential entry points in country projects under development. Other activities included conducting a literature review on the extent to which gender-based violence exists in the workplace; sensitizing Project staff to gender-based violence to facilitate integration in key technical areas; preparing a resource paper on best practice training modules for gender-based violence; developing a gender-based violence sensitization module for HRH leaders; and producing a compendium of gender-sensitive HR policies that could be adapted to country settings.

Workplace Violence Study in Rwanda

The Project conducted a study on workplace violence and sexual harassment in Rwanda in collaboration with the ministries of health, labor, gender and justice and the health workers union. The study's purpose was to determine the contributors to, and HRH consequences of, workplace violence in the Rwandan health sector, examine the role played by gender discrimination and assist government ministries and other stakeholders in planning improvements to safety, security, equity, productivity, job satisfaction and retention at work. The study produced sobering results: 39% of Rwandan health workers surveyed had been subject to at least one form of workplace violence in the last year. Sexual harassment, while not the most prevalent among respondents at 7%, was the most frequent form of

Read *Workplace Violence and Gender Discrimination in the Health Sector in Rwanda* and the related study report (available at www.capacityproject.org).

violence experienced. Evidence showed discrimination because of pregnancy and other forms of gender discrimination such as negative stereotypes of female health workers (e.g., a perceived unwillingness to speak up, weakness, indecisiveness and incompetence) and vertical segregation of the health facility director's job ("the glass ceiling"). The study showed workplace violence impacted mainly on workers' psychological health, followed by absenteeism, poor interpersonal/work relations and resignation by female workers following bullying and sexual harassment. Gender equality was associated with lower odds of experiencing violence.

Based on these findings, the MOH recommended conducting an in-depth study on pregnancy discrimination, developing a workplace violence policy for the health sector and implementing a training program on workplace violence for health providers and managers. The Ministry of Labor asked the Project to provide technical assistance to apply study results in the formulation of a national Workplace Safety and Security Policy that addressed gender discrimination. Study results were channeled through the Rwanda Medical and Nurses Association, which increased support for a health sector policy for the prevention and management of violence at work. Later, the results contributed to the revision of a national law with specific articles prohibiting gender-based violence and gender discrimination in the workplace.

Prevalence by Type of Violence (N=297)

Type of Violence	Prevalence
Verbal abuse	80 (27%)
Bullying	48 (16%)
Sexual harassment	21 (7%)
Physical violence	12 (4%)

The types of violence in the table above are not mutually exclusive.

Men as Providers of HIV/AIDS Care in Lesotho

The Project collaborated with the Lesotho MOHSW on a study to develop, implement and evaluate strategies to attract men into the HIV community health worker cadre in order to increase men's participation in a "female identified" job and, in so doing, address the critical shortage of health workers. The study reinforced the Ministry's capacity to plan for a larger, less gender-segregated HIV/AIDS workforce by applying Lesotho's Gender and Development Policy within the context of the national HIV/AIDS strategy, which promotes men's sharing the burden of HIV/AIDS care through gender redistributive actions at national, district and community levels.

The study found that caregiving is not gender-neutral. Men were extremely underrepresented in the unpaid, largely invisible caregiving workforce because of a nexus of gender stereotypes about essential "male" and "female" traits and status beliefs that kept women in the job and men out of it. Female community health workers reported feeling crushed by the burdens of community caregiving and their own household responsibilities, and younger recruits were unwilling to enter this job. The Project trained study stakeholders in gender and HRH at the time of results dissemination. Recommendations to policies and programs included

that they needed to explicitly promote an equal or more equitable division of responsibilities between women and men; provide standardized resources, incentives and protections; and continue to strengthen women's capacity to care for those affected by HIV/AIDS.

Lesotho's Ministry of Gender, Youth, Sports and Recreation (MGYSR) reported that the study contributed to proposed revisions of The Gender and Development Policy of 2003, which will address HIV/AIDS care and support as an area of priority under Gender and Health, serve as a basis for advocacy programs to promote the value of caregiving and set a stage for educational or capacity-building programs to educate men and boys on sharing of care responsibilities as well as promoting positive images of men and boys engaged in care work. The study has also contributed to discussions between the MGYSR and the National Curriculum Development Centre on the need to improve the gender sensitivity of health provider training curricula.

Read *Alleviating the Burden of Responsibility: Men as Providers of Community-Based HIV/AIDS Care and Support in Lesotho* and the related study report (available at www.capacityproject.org).

Lessons Learned

- **Gender is a key factor in planning, developing and supporting the health workforce in low-resource settings.**
- **Finding leadership champions at headquarters and in the field, providing accountability mechanisms and leveraging funding are keys to successfully integrating gender equality into an HRH project.**
- **Addressing specific workplace/health worker issues that linked gender inequalities to recruitment, productivity and retention contributed to policy change.**
- **Developing women's leadership capacity through professional associations and strengthening their communication and advocacy skills helps them to articulate HRH issues and push for policy changes.**
- **Investments in sex-disaggregated HRIS and other data and capacity-building are key to further developing HRH strategies, policies and interventions that address gender inequality as it impacts workforce recruitment, productivity and retention.**

Read *Addressing Gender Inequality in HRH* and *Gender Discrimination in HRH* (available at www.capacityproject.org).

VISION
TO BE A CHRISTIAN BASE
OF EXELLENCE OFFERING
HEALTH CARE SERVICES
GLORY OF

Integrating FBOs

Background and Strategy

In many countries in Africa, FBOs provide between 30–70% of health care services. Since FBOs often continue to be grouped with private or NGO health care providers, they remain under-recognized for their immense contribution to the national health sector, accounting for between 30–80% of nonphysician health worker training in many African countries. FBOs are thus a key link in sustainability of accessible health care and represent huge potential in the effort to strengthen HRH.

The Capacity Project worked to increase the number of countries in which FBOs are building national capacity in HRH. The African Christian Health Associations (CHAs)' Technical Working Group (TWG) on HRH provided an entry point and structure for the Project's technical assistance. During an initial regional meeting of CHAs in 2004, 14 CHAs representing 12 countries committed to focus on HRH. Nearly five years later, the number of CHAs participating had increased to 17, representing 15 countries. The Project's FBO partnerships strengthened HRH advocacy efforts as evidenced by seven of the CHAs elevating the role of HR manager to a senior position.

Results

Christian Health Association Technical Working Group on HRH

Beginning in 2006, the Project coordinated the secretariat for the CHA TWG on HRH. In this role, the Project supported three regional HRH meetings that facilitated sharing of lessons learned and best practices among the CHAs. Over 30 *Hotline HRH* newsletters on HRH issues and best practices were sent out to FBO staff, and more than 300 HRH reports and documents made available to members through an Internet portal. In Year 5, the Project transferred the HRH TWG secretariat to the Africa Christian Health Association Platform, which formed in 2007 as a network and advisory organization of CHAs. As secretariat, the Project assisted the CHAs to increase interaction and visibility with GHWA, which subsequently agreed to distinguish FBOs separately, rather than as part of the private sector, in its meetings and publications. The Project worked with other donor partners to broaden the support for HR activities within CHAs and to ensure that HR issues will continue to be addressed through funding of the Africa CHA Platform, which is now an established, dues-paying membership network endorsed by WHO and coordinated by CHA/Kenya.

Read *African Christian Health Associations: Joining Forces for Improving HRH* (available at www.capacityproject.org).

HRH Mapping in Tanzania

The Project provided technical assistance to the Christian Social Services Commission (CSSC) and its network of dioceses, hospitals, health centers and dispensaries beginning in 2006 in an effort to improve data collection and analysis of all FBO health facilities, health care staff and programs. Using geographic information system (GIS) mapping and data on over 15,000 health care providers and 850 facilities, senior CSSC staff are able to more effectively advocate for additional resources with the Tanzania MOHSW. Overall, this activity created compatible HRIS that can be integrated into, and used to assist with, national health assets planning and policy development.

Read *HR-GIS Data Development and Systems Implementation for the CSSC of Tanzania* (available at www.capacityproject.org).

FBO HRH Strengthening Model in Kenya

The HRH strengthening progress in the FBO subsector in Kenya, supported by the Capacity Project, serves as an excellent regional model. First, the Project supported an HR assessment that collected pertinent data on HRM capacity at 64 FBO health facilities, profiled the key priority areas in the subsector and made action plans to address them. The Project hired a full-time HR manager to provide the required technical assistance to implement this action plan. The HR manager developed a generic HR policy manual and HIV/AIDS Workplace Policy for CHA/Kenya and Kenya Episcopal Conference health facilities that are compliant with both the newly enacted Kenyan labor laws and the national HRH strategic plan. The policy and manual have already significantly improved members' HRM systems. In addition, the Project trained approximately 100 FBO health facility staff on the new labor laws, the HRM and HRH strategic plans and the development of an HRM consultancy database for use by FBO health facilities to ensure sustainability and access to local professional HRM services. These staff also received technical assistance in the recruitment process and review of job descriptions for key positions in the FBO umbrella bodies. These activities are expected to support FBOs to promote the HRH agenda effectively.

Lessons Learned

- **International donor misconceptions about FBO networks and their capacity to contribute to HRH solutions must continue to be addressed.**
- **FBOs should be fully integrated into MOH policy and programs.**
- **HR positions within FBOs should be elevated in light of the emerging data on HRH promising practices and the key role HR plays; they should also be included in building HRM reference groups with the public sector and NGOs.**
- **FBO documentation and reporting should be strengthened.**
- **The role and importance of FBOs, especially in under-served areas, is very important to addressing HRH shortages.**
- **FBOs are an important vehicle for longer-term sustainability of HRH-related efforts.**
- **FBOs can often leverage resources that strengthen HRH efforts (e.g., the Project-assisted training and deployment of 11 Sudanese diaspora doctors in Southern Sudan).**

Read Strengthening the Role of FBOs in HRH Initiatives (available at www.capacityproject.org).

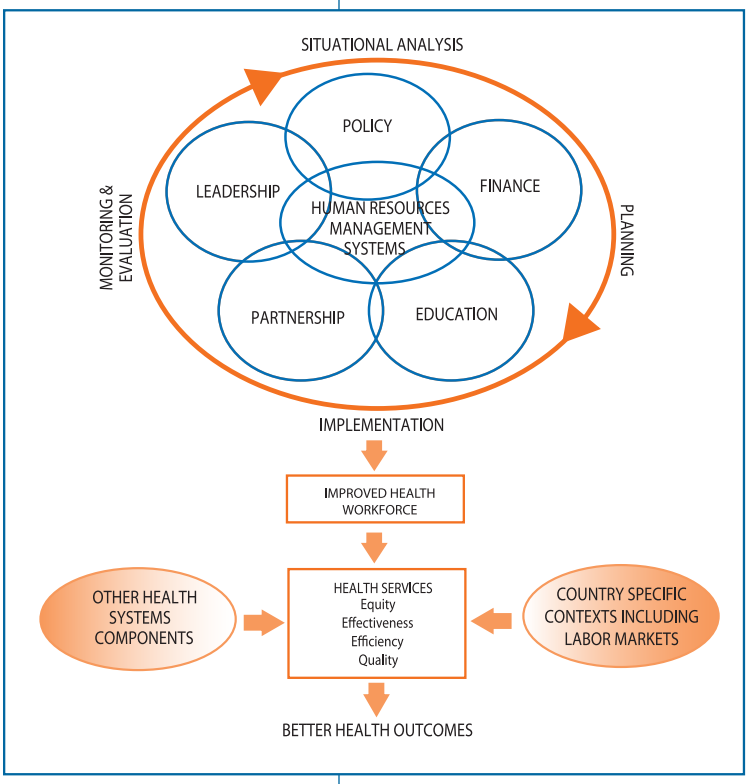
Global Partnerships

Background and Strategy

The Capacity Project took a leadership role in enriching the global HRH dialogue and the related research, innovation and new technologies required to establish an evidence base for expanded work. Global partnerships were a key component in the Project's success, both in engaging the global community in a nascent area that has become a high-priority issue, moving global and country-level action planning forward, gaining access to key decision-makers and successfully leveraging significant funds and human resources. The Project fostered collaborative global partnerships for three strategic purposes:

- Reaching out to other global, regional and national entities to learn what was being planned and implemented so as to avoid duplication of efforts or unnecessary confusion in HRH approaches and application of tools
- Bringing greater synergy to resolving complex problems
- Strengthening HRH initiatives through effective knowledge sharing at all levels—globally, regionally and nationally.

HRH Action Framework



Results

The HRH Action Framework (HAF)

Designed to help governments and health managers build an effective and sustainable health workforce, the HAF is a global effort to bring a shared approach and resources to complex HRH issues at the country level. By using a comprehensive approach, the HAF assists in addressing staff shortages, uneven distribution of staff, gaps in skills and competencies and low retention and poor motivation, among other challenges.

The substantive work to develop the HAF began at a meeting in 2005 sponsored by USAID and WHO and hosted by PAHO. Representatives from multilateral and bilateral agencies, NGOs and the academic community brought a variety of experiences and perspectives, and together they developed a common technical framework for HRH. The Capacity Project played a key role in developing and refining the HAF, building it into a website (hosted by the Project) and sharing and applying it at the country level.

The HAF website disseminates the framework and operates as a dynamic planning and knowledge-sharing tool. It is available in English, French and Spanish. Versions on CD or in booklet format are available for audiences without Internet access. The framework guides those tasked with addressing HRH issues through the components or action fields that need to be addressed in a comprehensive HRH strategy.

Country applications of the HAF proved successful. In Uganda, for example, the MOH established five Analysis Subgroups corresponding to the HAF Action Fields. Recommendations from these groups contributed to refinement of the country's HRH Strategic Plan 2005–2020 through a supplement to the plan. Outcomes of the HAF application in Uganda also led to the addition of concrete recommendations on the health workforce into the Health System Master Plan requested by the President's Office.

In May 2009, 30 leading regional and national HRH experts convened to share information about the many ways the HAF has been used, identify strengths and weaknesses of different approaches and discuss dissemination initiatives to broaden HAF use. Participants reviewed HAF application experiences in Vietnam, Uganda, Kenya, Botswana, Afghanistan, Mozambique and the PAHO region (Peru in particular) and explored the value of using the HAF in HRH strengthening for tuberculosis control. Participants made recommendations for strengthening the HAF as a tool and a website and took responsibility for the implementation thereof.

HRH Action Workshops

In many countries, HRH staff described their HRH systems as under-supported and fragmented, leading to few opportunities for them to come together and develop a common vision, share tools and resources or advocate effectively for HRH needs and initiatives. To address the need for an interactive mechanism that would promote south-to-south dialogue among HRH staff in African countries, the Project held HRH Action Workshops in South Africa and Ghana. Highly participatory, these workshops facilitated knowledge-sharing across countries. The first workshop involved 38 participants from 11 countries, while the second—conducted in partnership with GHWA, WHO and West African Health Organization—engaged 41 participants from 24 countries. Almost all of the participants in the two workshops were senior HR directors or practitioners working at the operational level within the MOH in their respective countries.

A year and a half after the first workshop, the Project assessed progress on country-level action plans developed during the workshop: 64% of planned activities had been completed and 29% were ongoing. In Tanzania, participants used their action plan to write a successful proposal to the Global Fund for an emergency hiring program.

Many participants considered the meeting methodology itself very effective. In Uganda, HRH leaders replicated the action workshop model at the national and district levels. The national workshop convened high-level country actors to share information and raise awareness about HRH issues, gather information to form a systems analysis and develop an HRH national agenda and prioritize HRH issues. The workshop proceedings led the development of the country's HRH strategic plan. The district-level workshop raised district planners' awareness of current HRH issues, and allowed them to develop district-specific action plans for local implementation. Although it was not clear that district managers received more HRH funds as a result of the workshop, the HR director reported anecdotally that the problem-solving process had substantially improved.

"[Most helpful about the workshop was] sharing concepts, taking ideas from each other and starting with a plan… We learned from the mistakes of others about processes that have worked and did not work."

–Ann Rono, director of HR, Kenya MOH

Lessons Learned

- Global partnering is essential because the magnitude and complexity of HRH challenges require multi-institutional and cross-sectoral collaboration and information-sharing. This means HRH leaders and practitioners must think and intervene more holistically, transcend traditional organizational boundaries and actively contribute to global, regional and country alliances as everyday aspects of HRH work. Almost all of the Capacity Project's long-term initiatives were done in partnership, either at the global or local level.
- The HAF is a very powerful tool to help countries plan and intervene to address HRH challenges. It is important to stress that this type of resource could not have been developed by one organization acting alone. Collaboration produces a better product, and the act of collaboration means that it is far more likely to be adopted and used by a broad array of partners and leaders at all levels.
- Building networks of HR professionals is a very important component in creating a critical mass of HRH champions at the regional and country level. The HRH Action Workshops helped in this process, and must be supplemented by follow-up support to make the work sustainable. In countries where the Project had a presence, this support was available and the results more identifiable.
- Donor leadership sets an important tone in promoting global partnerships, and USAID's support for the Project's global and regional partnering efforts proved instrumental in their success.

Read *Global Partnerships: Strengthening HRH Approaches Together* (available at www.capacityproject.org).

Support to the Global Fund to Fight AIDS, Tuberculosis and Malaria

Background and Strategy

In the spring of 2006, the Capacity Project was asked to become part of an initiative led by the Office of the Global AIDS Coordinator (OGAC) to provide technical assistance to selected countries with faltering performance on their grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). These grants are performance-based, which means that funds are released when agreed-upon interim performance targets have been achieved. When targets are not met, additional funding is withheld and the services being provided by the grant are suspended. Through funding from the OGAC initiative, the USAID LAC Bureau and field missions, the Capacity Project provided technical assistance to strengthen grant performance in Belize, Central African Republic, Ecuador, Guyana, Indonesia, Lesotho, Kenya, Nepal, Malawi, Pakistan, Romania, Swaziland, Senegal, Sudan, Tanzania and Togo as well as regional grants in the Caribbean.

The Project completed situation analyses to determine the critical barriers hampering grant performance and made recommendations to both Principal Recipients (PRs) and Country Coordinating Mechanisms (CCMs) for actions needed to strengthen grant performance. The Project worked with CCMs to ensure that they were operating in compliance with GFATM regulations, and if they were not, made recommendations on actions that were required for compliance.

CCM members received training to ensure they understood how performance-based grants work, and had clarity on the role and responsibilities of the CCM for providing grant oversight and the skills, knowledge and responsibilities required of members. The Project helped clarify the different roles of the CCMs and the Principal Recipient, developed guidelines for how the two worked together for successful grant implementation and assisted CCMs to develop their Operations Manual for CCM Grant Oversight. Additionally, the Project helped Principal Recipients to identify grant management problems that were causing serious project implementation delays, and provided the technical assistance to strengthen financial management systems, monitoring and evaluation (M&E) reporting systems and procurement and supply management systems.

Results

Results were measured in both output and outcome indicators. In all countries, the Project achieved 100% of its output indicators. Outcome indicators were more dependent on the country's ability to use the technical assistance to substantially improve performance. The Project achieved expected outcome indicators in all but three countries, which all had grant performance issues that were more serious than technical assistance could address. In the remaining countries, the Project contributed to significant progress such that recipients were again eligible for GFATM funding. In reference to the Project's work in Pakistan, the GFATM portfolio manager indicated that the "PR is much stronger" thanks to the Project's assistance.

As a result of this pilot, OGAC concluded that US Government-funded technical assistance support could have a significant impact on GFATM grant performance. OGAC issued a new procurement and fully funded a five-year contract, Grant Management Systems, to provide ongoing technical assistance to troubled grants.

"Differences can actually be complementary factors toward success. We all have unique views, but if we all are working toward the same goal we can use our differences to come out with gold—a productive explosion coming from our creative use of the differences."

—Member of Swaziland's National Emergency Response Council on HIV/AIDS, on the Project's work to help the organization strengthen its role in a GFATM grant

OF FAMILY PLANNING
PILLS
COC's
DEVICE
SURGICAL METHO
- Vasectomy
- Tubal ligat

Impact on Family Planning and Other Reproductive Health Programming

Background and Strategy

Access to quality FP and other RH information and services remains limited in many developing countries. Challenges include insufficient or nonexistent health workers, cadres that are poorly prepared to provide information and services and work environments that discourage undertaking FP/RH tasks. Weak infrastructure and distribution systems complicate access to FP services, especially in the poorest and most rural areas. Government health care outlets are often few and inadequately dispersed, and private-sector services are more likely to be found in areas with higher economic opportunities. Mechanisms for tracking the currency of health workers' skills as well as for retraining and supportive supervision are often lacking, along with appropriate supplies and equipment to meet the needs of clients. Workplace planning for FP service provision, alignment, development and support is often inadequate, but is essential to address FP/RH needs and is directly linked to improved service delivery.

The Capacity Project's strategic approach to FP in the area of workforce planning and leadership was to support ministries of health and other stakeholders to align their national FP workforce with their national FP priorities. This involved a range of activities such as assessing the current FP/RH workforce and its distribution (Tanzania), developing HRH strategic plans that include FP projections and solutions, developing and sharing HRH planning software to support data-driven national-level planning (numerous countries), supporting workforce task shifting (Mali) and encouraging a wide range of FP stakeholders to work together to prioritize and implement national FP workforce strengthening initiatives (Kenya, Rwanda).

In the area of workforce development, the Project's strategic approach to FP was to work at the national and global levels to strengthen FP education and training. At the national level, the Project worked with ministries of health and other key stakeholders to improve the FP skills and knowledge of the health workforce by strengthening national systems that support pre-service education, in-service training and professional associations. The strategy involved facilitating national stakeholder groups to meet and discuss FP training priorities (Mali, Rwanda, Kenya); developing national FP training plans that link pre-service and in-service training and guide future training (Rwanda, Kenya); strengthening skills of tutors to transfer FP skills and knowledge (Tanzania, Mali, Uganda, Kenya, Rwanda); providing materials and equipment to strengthen clinical practice sites (Rwanda); and strengthening the FP component of national pre-service and in-service training curricula (Mali, Rwanda, Kenya), including integrating FP into HIV service strengthening training (Rwanda, Ethiopia, Namibia). The Project used performance-based approaches to curriculum development and encouraged the inclusion of the three Healthy Timing and Spacing of Pregnancy messages (Rwanda, Mali, Tanzania, Uganda, Kenya).

Having inadequate numbers or the wrong skill mix of health workers at the service delivery level severely curtails or eliminates FP/RH work. As one group of HRH managers noted, "When the system is stressed through a lack of sufficient health care worker coverage, only

emergencies get treated." The Project's strategic approach to FP in the area of workforce performance support was to create conditions in which performance and productivity are optimized, qualified health workers remain in the workforce and there is a greater likelihood that critical FP/RH services will be provided and integrated. To create these conditions, the Project implemented a broad array of approaches to strengthen HRM systems and worker retention strategies at the national and district levels. HRM strengthening included training key FP decision-makers in leadership and management to become more effective champions for FP (Tanzania/mainland), designing and implementing interventions to increase worker productivity (Tanzania/Zanzibar), supporting the recruitment and deployment of essential staff to fill funded RH positions (Uganda) and developing and using FP performance standards within the context of HIV care for performance support, including supportive supervision and performance improvement (Belize, Costa Rica, El Salvador, Guatemala, Nicaragua, Panama).

The Project's strategic approach to improving FP services through HRH systems strengthening also incorporated the cross-cutting areas of global partnering, KM, gender and FBOs.

Results

Kenya: National FP Training Plan

The Project-seconded MOH staff member led the national effort to strengthen Kenya's FP training by developing and implementing a national FP training plan. The Project drafted the plan and built stakeholder alignment, then supported the development of the FP continuing education process. The Project also strengthened the RH component of the national pre-service nursing/midwifery curriculum to improve FP-related performance of graduates. A Project secondment led the national effort to integrate updated FP/RH content into the nursing/midwifery curriculum in alignment with the new RH training plan. The Project worked with the MOH to train pre-service tutors as master trainers, who then train new hires and colleagues on FP-HIV integration in alignment with the country's national RH training plan.

Rwanda: Comprehensive FP Service Strengthening

The Project partnered with key government leaders to address a 2006 situation analysis that revealed only 15% of Rwandan health center providers were trained in FP and no facilities offered comprehensive FP services. The Project worked to make a full range of FP services, including long-acting and permanent methods and healthy timing and spacing of pregnancies, available in health facilities by providing clinical training, supportive supervision and essential informational materials and supplies. All public health facilities in the 11 districts supported by the Project now offer a full package of FP services. FP has been integrated into the pre-service education curriculum for nurses and midwives, two master trainers are deployed in each of the country's 30 districts, 161 on-the-job trainers are rolling out training in public health facilities, and district health networks have been trained to plan, develop, implement and evaluate FP programs. Project staff used the LFP approach to adapt the national FP curriculum to an OJT training approach that can be used by all FP organizations working in Rwanda. The Project also worked with partners to develop and carryout facility-based interventions to increase male involvement in FP services. Access to up-to-date clinical FP providers at health facilities throughout

Rwanda as a result of the government's work with development partners, including the Capacity Project, has ushered in a dramatic increase in modern contraceptive prevalence among married women, from 10% in 2005 to 27% in 2007 [Ministry of Health, 2007].

Rwanda: No-Scalpel Vasectomy Program

The Project developed a vasectomy in-service training program at two hospitals in Rwanda's Gicumbi and Nyabihu Districts. Prior to the intervention, providers in the two districts had not been trained or equipped to provide vasectomies, and doctors typically received only a half-day focus on theory without practical demonstration during pre-service education. The Project trained selected physicians and nurses in the no-scalpel vasectomy (NSV) procedure and provided the surgical training equipment and supplies. After completing the training, the providers developed action plans for continuing to offer vasectomy services. Two physicians performed extra cases and became coaches. To foster sustainability, the Project trained three physicians and four nurses as trainers, who were then able to train seven physicians and ten nurses at hospitals in four other districts.

The Project supported vasectomy teams to make outreach visits from the hospitals to six health centers (three each in Nyabihu and Gicumbi Districts) that were selected based on high client demand for the service in the surrounding communities. Given the long travel times between health centers and hospitals in some districts, sending NSV teams with surgical equipment and supplies into the health centers removed a serious logistical barrier to parts of the population.

Before the program, demand for vasectomies at Shyira Hospital was very low (five requests per month) and nonexistent at Byumba Hospital. However, demand for NSV became so high that clients had to be wait-listed. During a sample taken in the two districts in August 2008, 211 clients were on the waiting list; 172 clients had undergone a vasectomy. As of June 2009, Project-trained physicians and nurses had performed 390 NSVs, 56% performed at health centers and 15% with HIV-positive clients. A major contributor to the program's success appears to be the logistical and financial support for NSV teams to work at health centers. Many potential clients do not live within easy walking distance of a hospital, so the financial and opportunity costs involved in getting an NSV remain a very real constraint. Of the respondents sampled in the client satisfaction survey, almost all (98%) reported satisfaction with the procedure.

Study on Bottlenecks to Implementing Updated FP/RH Guidelines

USAID, the United Nations Population Fund, WHO and the cooperating agency community, among others, have invested considerable effort updating and improving norms and standards for RH and FP services and training materials. Despite these efforts, there is a lack of documented evidence on the actual implementation and impact of FP/RH guidelines. The Project conducted a study on bottlenecks to implementing updated guidelines at the country level and contributed to the FP Training Resource Package website. A primary finding is that efforts limited to dissemination of norms and standards alone, reliance on training alone or even more frequent supervision alone will be insufficient to change practices at the clinic

"We have to acknowledge the Capacity Project as a real champion, especially in strengthening the capabilities of family planning providers. This has improved the quality of services offered, which brought about the public's acceptance."

—Dr. Camille Manyangable, government FP representative, Rwanda

"I chose this method because my wife and I live with HIV. I am under ARVs [antiretroviral drugs] but my wife is not. Although we have been using condoms, we decided not to take the risk of pregnancy to avoid having an infected newborn. We already have three children and all of them are HIV free."

—NSV client in Rwanda

Read *Repositioning FP: Rwanda's No-Scalpel Vasectomy Program* (available at www.capacityproject.org).

Read *Implementing Updated FP and RH Guidelines through Organizational Change* (available at www.capacityproject.org).

level. Multiple interventions are the key to impact, combining training in technical knowledge and skills with the training in human dynamic skills that empower staff to effect change in their day-to-day environment. A related paper and technical brief supplement this work.

Lessons Learned

- **Without addressing the broader HRH issues, access to key services such as FP will remain limited or unavailable.**
- **Countries need to align national FP workforce planning with national FP priorities.**
- **Strategic placement of seconded staff within ministries of health can strengthen the national FP training by mobilizing support for the development and implementation of a national FP training plan.**
- **Addressing logistical and financial support may be as important in increasing FP service access as information and counseling.**
- **There is a lack of documented evidence that increasing training materials improves the actual implementation and impact of FP/RH guidelines.**

Impact on HIV/AIDS Programming

Background and Strategy

Health workforce shortages are a significant bottleneck to providing ART to all those who need it. Much of the Capacity Project's work focused on improving workforce productivity and numbers, and thus had particular relevance and urgency in the response to HIV. The challenge of delivering ART to the large number of people requiring treatment in sub-Saharan Africa has highlighted the real danger of health workforce shortages on the continent. Many current initiatives to scale up the workforce and improve productivity prioritize the prevention and treatment of HIV/AIDS as one important and specific goal. For this reason, the Project's activities in workforce strengthening had particular relevance to HIV service delivery, and many of the Project's activities had a measurable impact in this area.

"We quickly realized that not all ministries had data or budget lines for HIV. My role was to ensure that the MPND worked through the planning framework and the budget system to get every unit money for HIV/AIDS."

–Meshak Ndolo, HIV/AIDS and development program advisor, Kenya MPND

Results

Kenya: Emergency Hiring Plan

An analysis of EHP evaluation data from a sample of ten of the 193 facilities targeted for new hires revealed enhanced facility services. Eight of the ten facilities reported that the presence of the new hires allowed services to be added at times of day when they were previously unavailable, and that the overall workload was reduced. Seven facilities reported that the number of clients served increased; six reported that the number of clinic sessions increased and the types of services offered had changed; and three reported that hours of clinic services had been extended. In addition, one facility reported that the facility image improved, clinic revenue increased, waiting time decreased and more clients learned their HIV status. A comparison of facility statistics compiled within the first three months of new hire deployment and one year post-deployment found the following:

- Post-exposure prophylaxis service availability increased from 74% of facilities to 100%
- Availability of outpatient VCT services increased from 75% to 84% of facilities and the average numbers served increased from seven men and ten women to ten men and 12 women per facility per week
- Availability of outpatient PMTCT services increased from 85% to 94% of facilities, and the average number served increased from an average of ten to an average of 32 women per facility per week
- The average number of new inpatient ART clients increased from two men and five women to four men and eight women per facility per week.

The Project's secondment of an advisor to Kenya's Ministry of Planning and National Development (MPND) resulted in mandated budgeting across government ministries for mitigation of the socioeconomic impacts of HIV/AIDS and increased funding for strengthening central-level HIV/AIDS planning and programming, and contributed to an overall 150% increase in government funding allocations for HIV/AIDS.

"The whole Capacity Project is important to strengthen public health education about HIV/AIDS, and the approach is user-friendly. It is a multidimensional approach that helps to streamline the national approach, whether public or private."

–Starla Acosta, social worker, University of Belize Faculty of Nursing and Allied Health

Central America: Performance Support

HIV services have been available in Belize, Costa Rica, El Salvador, Guatemala, Nicaragua and Panama only at primary-level hospitals in main urban centers. Working with health ministries in each country to increase HIV service access, the Capacity Project supported the decentralization of HIV services to secondary hospitals through a combination of capacity-

strengthening activities. First, the Project helped create technical resource teams, with experts on various aspects of HIV and tuberculosis, to support selected hospitals to implement performance improvement processes. The Project also led a process to draft and review HIV service performance standards with MOH officers and health providers from hospitals that will deliver decentralized HIV care and treatment. With Project support, facilities used the approved performance standards in baseline and regular assessments of decentralized HIV services to strengthen the quality and access of HIV services throughout the region.

The intervention caused notable changes in provider performance. For example, in Costa Rica, local teams identified gaps between expected and real performance in service provision, then prioritized deficiencies, analyzed causes and developed action plans. Meanwhile, national and regional authorities led similar processes to support local plans and identify issues that can be addressed through central-level interventions. A baseline assessment reported that participant hospitals achieved 55%, 35% and 43% of performance standards for HIV services. A follow-up assessment showed that those figures had risen to 90%, 84% and 91%, respectively. It is notable that all three hospitals made such a leap in a short time period and with very few additional resources.

Rwanda and Namibia: Clinical Service Delivery

In Rwanda, fewer than 300 physicians work for the public sector, and 70% of physicians work in Kigali where just 10% of the population lives. Therefore, to provide better HIV-service access to rural areas, the Project launched an innovative mobile district physician scheme. In this approach, district physicians travel to rural health centers two to three times a week to deliver essential ART. During these visits, the physicians see newly-referred clients being evaluated to start ART, provide initial follow-up of clients and review clients with complications. The Project also initiated a physician-nurse mentoring program to train ART nurses to provide ongoing support to clients during their treatment regimens.

In Namibia, the Project reviewed information related to the efforts of FBOs to integrate FP/RH information, counseling and referral into HIV programming. In a follow-up review, patient data showed that in health facilities run by FBOs, nearly 100% of pregnant women were receiving counseling on HIV testing and chose to be tested; 20% of tested pregnant women were found to be HIV-positive; and most were enrolled in PMTCT services as part of the Project's integrated care services within the FBO facilities. Furthermore, the review showed that the FBO facilities emphasized care and treatment, prophylaxis and breastfeeding education, and many provided HIV-positive women with FP counseling and referrals during their first postnatal visits.

Building Systems for Orphans and Vulnerable Children

One of the main challenges to successfully address the situation of orphans and vulnerable children (OVC) is the lack of skilled HR in public social services and civil society sectors. While guidance on OVC services is reflected in a country's National Plan of Action (NPA) and other policies and strategies, the levels and types of human capacity and HR support needed to implement them are not well understood.

To meet this need, the Project created and tested the HR Assessment Kit for OVC policy and programming, in collaboration with USAID/Africa Bureau, to provide implementers with a concrete process, methodology and tools to assess government HR capacity to lead and manage effective implementation of the NPA. The Project field-tested and adapted the HR Toolkit in three countries: Tanzania, Namibia and Malawi.

Tanzania: The government used HR assessment findings to improve Department of Social Welfare management, influence NPA operations, inform responsibilities of new national-level government staff, train local-level workers in appropriate skills and knowledge, strengthen district supervision and support for current workers and develop long-term plans to dramatically increase the OVC workforce.

Namibia: The Ministry of Gender Equality and Child Welfare used the assessment findings as part of the government's official launch of the NPA and has begun implementing several recommendations. First, to position OVC as a national priority copies of the NPA are being reprinted and will be disseminated at regional and constituency levels. Second, to improve coordination for the NPA, a meeting was conducted to review and strengthen the terms of reference for the Permanent Task Force. Third, to improve capacity of staff, a manual for training new staff in OVC services at regional and constituency levels is being developed.

Malawi: The initial focus on OVC expanded to an HR capacity analysis for all services and departments of the entire Ministry of Women and Child Development, including those related to OVC. The OVC NPA HR assessment toolkit was used to develop the interview questions as they pertained to the OVC components and to the larger spectrum of services. The assessment was implemented by a multidisciplinary in-country team and was conducted via interviews and focus group discussions at the national, district and local levels. The Ministry intends to use the recommendations from the HR assessment to support a functional review of the Ministry and to implement an HR capacity-building plan.

"Before I came here, I was not even sure how to administer ARVs to children. With the knowledge I have gained, I feel equipped to manage a comprehensive care center."

—Joseph Chebii Kiano, health worker hired and trained on HIV care through the Project's EHP in Kenya

Lessons Learned

- **Implementing the Kenya EHP resulted in enhanced facilities services and greater use.**
- **Use of approved performance standards in baseline and regular assessments of decentralized HIV services can strengthen the quality and accessibility of HIV services.**
- **Mobile district physicians can increase access to HIV prevention, care and treatment in rural settings.**
- **Working at the district level is vital in addressing health issues, such as HIV, in decentralized settings.**
- **HRH successes in addressing HIV serve as important models for other emerging epidemics and pandemics.**

Management and Partnership

The Capacity Project managed to synchronize activities from multiple funding sources; leverage funding and technical support from global partners; and take advantage of its diverse yet complementary partnership. The Project addressed structural and management challenges without any significant impact on achieving the Project's objectives. The main challenges involved balancing competing priorities, aligning core-funded and field-supported work and strengthening staffing, partnerships and financial systems.

Sustaining focus in a groundbreaking technical area in the context of pressure for quick results versus the need to carefully and fully analyze the HRH issues and then plan and monitor promising solutions demanded management vigilance. Considering the Project's scope and scale, the Project managed both structural and management challenges with few obstacles. Most of the challenges were not unique to this Project but rather reflect the changing environment in which global health activities are taking place. The areas that required regular management attention were:

- Balancing USAID/Washington and field priorities
- Balancing FP/RH and HIV priorities
- Aligning technical leadership activities with field-supported work
- Identifying and retaining appropriate staffing
- Establishing and sustaining effective partnerships
- Strengthening financial systems
- Managing the complexity of USAID processes and procedures.

The Project endeavored to take advantage of management opportunities that arose from these challenges. These included the following:

- *Synchronizing activities supported by both the Office of Population and the Office of HIV/AIDS:* Because of the multiple funding sources and related USAID senior-level support in Washington and the field, the Project was able to explore HRH issues more deeply than it would have otherwise; thus it was able to make recommendations regarding promising practices in areas such as planning systems, retention, productivity and incentives that enabled a much broader application to programs.
- *Leveraging funding and technical support:* The Project was able to work on key issues in collaboration with the WHO, GHWA, World Bank and UNAIDS among others to synthesize and disseminate the technical work. This was possible, in part, because of the shared leadership of the Project and its flexible structure that enabled it to respond in a timely way to opportunities both globally and in the field.
- *Fostering a diverse and effective partnership:* The Project benefited by gaining easy access to the diversity, technical expertise and experience and management capabilities of its partners. The shared technical leadership also balanced the demands on the Project leadership team because the partnership could shoulder a greater range of technical competencies.
- *Synchronizing technical assistance including innovative approaches to HRH:* The Project's strong field teams and their collaboration with headquarters in responding to requests enabled the Project to take advantage of opportunities as diverse as repositioning FP in Rwanda and exploring the feasibility of applying the HAF in Vietnam.

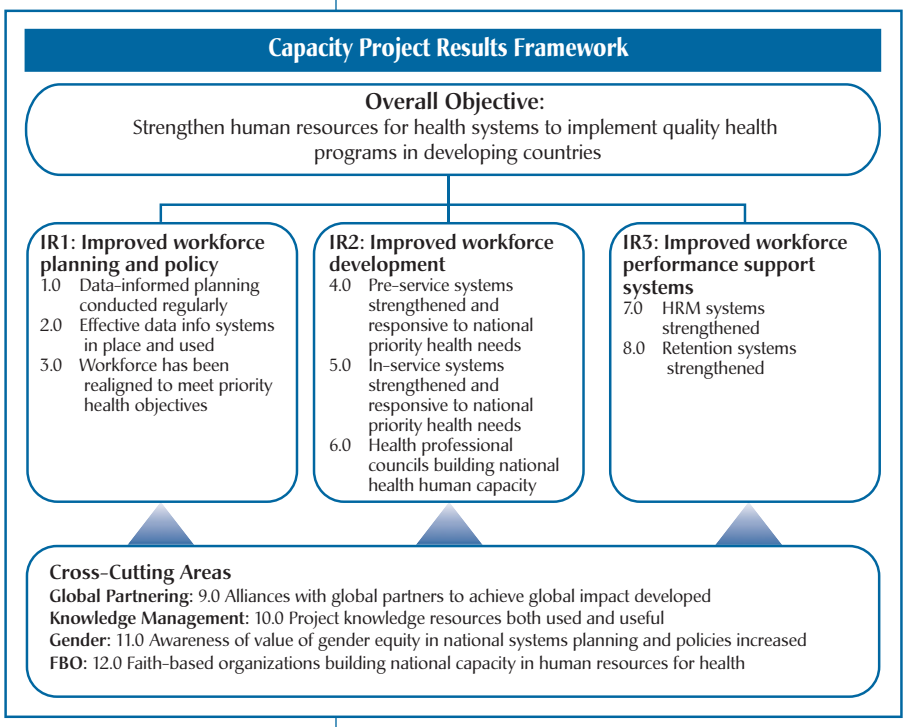
Under guidelines established as part of the cooperative agreement, the Capacity Project's leader and its partners agreed to a cost-share equivalent to ten percent of all core and field support expenditures. The Project achieved remarkable success in not just meeting but

exceeding the cost-share requirement. As of July 2009, the Project had achieved a cost-share equivalent to 16 percent of all core and field support expenditures. This is a significant accomplishment that demonstrates the Project's effective management and operations functioning.

Monitoring and Evaluation

The M&E activities of the Capacity Project were guided by the Project's performance monitoring plan (PMP) and designed to ensure that Project interventions were effectively monitored and results were assessed, documented and disseminated. The PMP consisted of 12 key indicators and 40 sub-indicators. These indicators monitored the immediate and intermediate effects of Project activities in its core global technical leadership areas.

Capacity Project Results Framework



As illustrated in the Capacity Project Results Framework (left), the PMP indicators captured changes in health human capacity-building, and focused on the Project's three global technical leadership areas (workforce planning, development and support) and four cross-cutting areas (global partnering, knowledge management, gender, FBO/NGO integration). In general these indicators assess change at the national or sub-national levels[1] and typically measure the existence or strength of HRH-related systems (immediate outcomes). The *Capacity Project Results Reporting Manual* provided detailed definitions for all Capacity Project key and sub-indicators to ensure reliable measurement.

The Project's main M&E activities included:

- Monitoring changes in core performance indicators to assess the effects of the Project's work on national- and sub-national-level HRH systems
- Coordinating data collection activities designed to create new technical knowledge, such as evaluating the effects of innovative HRH strategies
- Providing M&E technical assistance to field supported programs to link field results to the core Project framework
- Ensuring adequate documentation of Project contributions to USAID, Office of Population and Reproductive Health and PEPFAR objectives.

Benchmarking

Although the Project's overall objective—to strengthen HRH systems to implement quality health programs—was the same for each country, each country's starting point was different and each country's progress trajectory was unique. To ensure accurate monitoring required a set of benchmarks sensitive enough to measure progress from the most humble beginnings of any HRH system to the ultimate HRH "standard of practice."

For example, for HRH planning the ultimate standard was "regular (usually annual) data-informed workforce planning." Benchmarks along the way included 1) implementing an appropriate national or sub-national workforce assessment to provide information for planning, 2) convening stakeholders to review available data, establish priorities and develop a reasonable, costed workforce plan, 3) stakeholders addressing together the identified HRH issues and revising policies, 4) stakeholders approving the workforce plan and 5) creating a process for regular review and revision of the HRH workforce plan. When the Project began, some countries, such as Kenya and Uganda, had data from numerous workforce assessments to guide planning, and had draft workforce plans, but stakeholders had not moved priority work forward in an organized way. Southern Sudan had no HRH policy or plan, and no data upon which to begin drafting a plan. Although some countries, such as Namibia and Rwanda, had made plans for regular review of HRH workforce plans, they did not have sufficient data systems in place to inform annual planning. The benchmarks therefore provided a means to reflect progress on the way to the ultimate goal of annual data-informed workforce planning.

Complementing National Level Qualitative Monitoring with Focused Studies

As illustrated in the HAF[2], interventions like those supported by the Capacity Project, designed to strengthen HRH (such as strengthening leadership skills, developing stakeholder groups to support partnerships, strengthening pre-service education systems), are expected to have an ultimate impact on the health of a population. The PMP measured the implementation of those interventions (process indicators) and their short-term effect to improve the health workforce (immediate outcomes) and, to some extent, increased service access (intermediate outcomes). The impact of Capacity Project work on improved public health, although anticipated in the long term, was not measured directly.

To complement the PMP's focus on national or sub-national HRH system change, the Project designed several focused studies to look at the effectiveness of innovative HRH interventions, and to link HRH interventions to service delivery and public health outcomes. For example, the longitudinal EHP study, by selecting a sample of ten of the nearly 200 sites with EHP new hires, cost-effectively tracked changes in health services over time, and provided client and community satisfaction information, which would have been prohibitive on a national scale.

Varied Qualitative Data Sources Don't Run Dry

Measuring the Project's PMP indicators, and assessing system changes at a national or sub-national level, is by necessity largely qualitative. To reflect the broadest possible understanding of these changes the Project triangulated a variety of data types and sources, including key informant interviews, stakeholder meeting minutes, action plans, conference proceedings, country documents, national HRH assessments, HRIS reports, special study results, project documents and direct observation. One of the most essential data sources

was interviews with a wide range of high-level stakeholders across ministries and institutions. However, access to high level informants can be challenging and turnover of personnel can be high. The Project's strategy therefore included as wide a variety of data sources and informants as possible to develop the most complete picture of the Project's impact over time. Each source provides one component and together one can synthesize a detailed picture of the system changes.

Close Communication between Monitoring and Technical Teams

Technical staff worked closely with ministries of health and other partners to design HRH initiatives that were aligned with country priorities, consistent with resources and political will, and started from the reality of the current HRH systems. Early in the project M&E staff backstopping country programs at headquarters worked with technical staff to select appropriate core indicators and create relevant M&E plans. Because the area of HRH system strengthening was somewhat new in some countries, over time the technical focus of country programs often evolved, expanding to include a wider range of topics or a more integrated agenda. The monitoring team therefore met frequently with country point people to adjust monitoring plans in pace with the evolving country programs. Although such close communication between monitoring and technical teams is ideal regardless of the content area, with newer technical areas, and where programs are likely to shift with changes in country priorities, this closeness is even more vital.

Technical Team Provides Vision for "Next Generation" Indicators

Evaluating the effects of health capacity-building interventions has been called more of an art than a science. The Project developed and tested indicators and approaches to monitor and evaluate interventions to plan, develop and support the health workforce. These indicators and approaches worked well to capture progress toward our stated objectives. But because the technical area and associated indicators were rather young, the Project also planned to take stock of lessons learned to inform future M&E in this area. During its final year the Project conducted interviews with 30 program experts and senior technical staff, both at headquarters and in the field, to understand the technical evolutions and implications for monitoring. Informants described the growth of their technical approach over the life of the project and discussed their definitions of "success" across the HRH capacity-building areas in which they worked. Analysis of this information provides a vision for the next generation of HRH system strengthening indicators. Results advocate for an even broader set of HRH-related indicators, requiring similar flexibility and benchmarking but tracking country agenda-setting, a culture shift in how HRH issues are prioritized and ownership of the tools of change.

Lessons Learned

- By identifying and monitoring appropriate benchmarks, projects can more sensitively measure progress toward an ultimate HRH standard of practice across countries that start at different places in strengthening HRH systems and have varying resources and commitments.
- Supplementing strong routine monitoring systems that track national level HRH system changes with focused small-scale studies provides an opportunity to reveal service-delivery impacts of HRH strengthening initiatives that national-level monitoring will miss.
- Qualitative data sources used to track national and sub-national HRH system changes should be varied and broad enough to withstand the frequent personnel changes in national and sub-national government.
- Because donor-funded national- and sub-national-level HRH initiatives are typically closely coordinated with host governments' priorities, and therefore can shift over time, M&E staff must work very closely with technical staff to adjust monitoring systems according to changes in program emphasis.
- Studying experienced senior technical staff's evolving technical approach and alternative definitions of success can provide a vision for the "next generation" of HRH system strengthening indicators.

1 A small number of indicators reflect facility-level changes, such as pre-service teaching and clinical practice site strengthening, or project products, such as technical briefs and tools.

2 Adapted from HRH Action Framework as described in World Health Organization. The world health report 2006: working together for health. Geneva, Switzerland: World Health Organization, 2006.

Looking Ahead

USAID has provided critical research and development resources in HRH, and the value of this investment is evident both at the country and global levels. USAID's continued coordinated investment within the Global Health Bureau will be key to addressing the health worker shortage as well as improving FP/RH, HIV/AIDS and other areas of service delivery.

Given the Capacity Project's accomplishments over the past five years, here are several considerations that can serve as a focus for future analysis and action:

- Given that the Project has established a strong foundation for *workforce planning and leadership, it strongly supports continued investment in this work*. In particular, the Project's HRIS strengthening work has been extremely successful in galvanizing support for more effectively tracking the health workforce, including those engaged in FP/RH activities. Continuing this work will enable donors and partners to more strategically explore opportunities for improving performance and related health outcomes. Broad-based stakeholder meetings are now mobilizing commitment regarding coordinating action plans at the national level. National leaders are now using and adapting HRIS to make more strategic decisions related to planning and decision-making, including in FP/RH, HIV/AIDS and other areas of health.
- The Project strongly recommends *continued investment in HRM systems strengthening*, and beginning to apply it more directly to service delivery areas such as FP and HIV where the potential to reinvigorate service delivery overall is significant. Building on work the Project began and work done by others, interventions can be supported to strengthen HR units and advocate for more strategic placement in ministries, to expand the number of qualified HR professionals and to fix the fragmented policies and practices. These efforts can result in health workers who are better managed and supported, which can lead to improved work climate, motivation, retention, performance and productivity. There are two specific HR systems improvement areas that need special attention because they are so important:
  - The Project supports expanding efforts to *streamline the recruitment and posting process* as they can have far-reaching results that go beyond the process itself. Improved processes can model a more transparent and fair location-based recruiting and placement system. While these types of fundamental changes take time, as they frequently involve entities outside the health sector and are often highly political, they can have a profound impact on addressing shortages, filling rural and hard-to-reach slots and retaining health workers.
  - The Project designed and implemented a number of studies and initiatives aimed at *understanding and improving retention and productivity*. While this work has produced promising results and a number of publications, as well as a better understanding of incentives, it is still clearly a critical area that needs further investment and attention. Going forward, it will be especially important to offer sufficient support for *scaling up some of the promising practices* as the initial interventions have often been done on a pilot basis or in a particular geographical area. It may also require additional attention to achieve improved access and quality in those FP/RH geographic areas where the HIV pandemic still looms large and where FP achievements have recently plateaued.

- Building on the effectiveness of the GRC and its contribution to increasing global access to the HRH knowledge base, the Project recommends interventions to *expand knowledge management work at the country level.* The Project had the opportunity to do this in one country late in the project; the results are promising, and most countries would profit from managing their own HRH knowledge base as well as linking to global efforts.

Beyond these considerations, there are some other recommendations based on what the Project knows from experience but was not able to undertake:

- Planning for ways to make more effective and efficient use of the still-small pool of health workers also requires attention to the policy and cost issues that either strengthen their work or remain obstacles to performance. For example, where FP providers and managers are encouraged to reallocate tasks without related policies that will support those reallocations, it is unrealistic to expect change to happen. As another example, developing or refining HRH strategic plans requires sound costing and, while the Project supported GHWA's work in developing and testing costing tools, it is now time for their broader dissemination as well as training people at the country level in how to apply them.
- While many donors and countries alike continue to view pre-service education as expensive, long-term and difficult to evaluate, the Project recommends that *strategic investments be made in this area as it will yield long-term results on the supply side*. As one example, the World Bank is undertaking extensive pre-service analyses and planning interventions in Sierra Leone, Liberia and Mozambique. The outcomes can serve to provide lessons learned and experience to guide a path forward.

Overall, the interest in HRH in particular and health system strengthening in general is much different than it was in 2004 when the Capacity Project began. The global health community is now much more open and committed to the need for addressing HRH challenges and strengthening health systems. USAID and the Capacity Project have helped play a role in realizing this very positive and important change, both in terms of calling attention to the importance of the issues and supporting innovative HRH work at the global and country level. In the future, USAID can play a key role by continuing to support and work with a broad range of global and country-level partners to strengthen health systems to ensure there are a sufficient number of health workers in the right places delivering quality services.

Annex A: Funding Overview: Core and Field Support

	Total Obligations
I. Core/Technical Leadership and Global Implementation	**$26,671,000**
GH/POP/RH	16,677,000
GH/OHA	7,137,000
GH/OHA/GFATM	2,657,000
GH/HIDN	200,000
II. Field Support	**$76,738,066**
Africa Bureau *FP/RH 600,000; HIV/AIDS 390,000*	990,000
Botswana *HIV/AIDS 204,300*	204,300
Ethiopia *HIV/AIDS 8,983,348*	8,983,348
Guatemala and Central America Program (G-CAP) *HIV/AIDS 2,449,850; Other 300,000*	2,749,850
Kenya *FP/RH 656,510; HIV/AIDS 17,502,274; Other 50,000*	18,208,784
The Bureau for Latin America and the Caribbean (LAC) *HIV/AIDS 1,334,000; Other 193,000*	1,527,000
Liberia *FP/RH 55,000; Other 57,000*	112,000
Mali *FP/RH 475,834; HIV/AIDS 100,000; Other 1,122,000*	1,697,834
Mozambique *FP/RH 150,000; HIV/AIDS 150,000*	300,000
Namibia *HIV/AIDS 13,108,758*	13,108,758
Regional HIV/AIDS Program (RHAP) *HIV/AIDS 1,800,000*	1,800,000
Rwanda *FP/RH 4,058,000; HIV/AIDS 9,060,192; Other 778,000*	13,896,192
South Africa *HIV/AIDS 762,000*	762,000
Sudan *FP/RH 50,000; HIV/AIDS 250,000; Other 3,000,000*	3,300,000
Tanzania *FP/RH 100,000; HIV/AIDS 4,878,000*	4,978,000
Uganda *HIV/AIDS 3,620,000*	3,620,000
Vietnam *HIV/AIDS 500,000*	500,000
III. Total	**$103,409,066**

The Capacity Project Partnership

IntraHealth International (lead partner), IMA World Health, Jhpiego, Liverpool Associates in Tropical Health, Management Sciences for Health, PATH, Training Resources Group, Inc.

Photos: Denis Akankunda, Carol Bales, Trevor Snapp, Christopher Wilson Creative

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