



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

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August 2003

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

**Submitted to:
The United States Agency for International Development
Under USAID Contract No. HRN-C-00-00-00007-00**

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Evaluation of USAID Human Capacity Development in Health was made possible through support provided by the United States Agency for International Development (USAID) under the terms of Contract Number HRN–C–00–00–00007–00, POPTECH Assignment Number 2003–134. The opinions expressed herein are those of the authors and do not necessarily reflect the views of USAID.

ACKNOWLEDGMENTS

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

ACRONYMS

AIHA	American International Health Alliance
CA	Cooperating agency
CDC	Centers for Disease Control and Prevention
CIDA	Canadian International Development Agency
CTO	Cognizant technical officer
DFID	Department for International Development, United Kingdom
DHHS	U.S. Department of Health and Human Services
EU	European Union
GH	Bureau for Global Health
GH/HIDN	Office of Health, Infectious Diseases, and Nutrition
GH/OHA	Office of HIV/AIDS
GH/PRH	Office of Population and Reproductive Health
GH/RCS	Office of Regional and Country Support
HCD	Human capacity development
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HR	Human resources
HRM	Human resources management
IMF	International Monetary Fund
IR	Intermediate Result
JSI	John Snow, Inc.
MAQ	Maximizing Access for Quality
MCH	Maternal and child health
MOH	Ministry of Health
NIH	National Institutes of Health
PHN	Population, health, and nutrition
PHR <i>plus</i>	Partners for Health Reform <i>plus</i> (Abt Associates, Inc.)
QAWD	Quality Assurance/Workforce Development Project, URC
SO	Strategic Objective
URC	University Research Co., LLC
USAID	United States Agency for International Development
WHO	World Health Organization

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EXECUTIVE SUMMARY

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

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

Much of the evidence compiled for this evaluation was derived from in-person and telephone interviews. The team interviewed GH senior management staff, country coordinators, GH cognizant technical officers (CTOs), USAID population, health, and nutrition (PHN) staff residing in overseas Missions, and cooperating agency (CA) representatives. A short, online survey of HCD was sent to the same individuals that participated in the qualitative interview sessions. The survey collected information on current HCD activities, future HCD needs, and actionable short and long-term HCD priorities that might be considered for incorporation by USAID into future activities.

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

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

The most important HCD needs typically identified by survey respondents were inservice training, staff deployment, employee incentives, conditions of service, and preservice training. Instituting better time/attendance reporting and the training of human resource specialists were ranked as the lowest priority areas.

When survey respondents were asked whether USAID could be effective in changing specific policies and practices in HCD (given host country political, regulatory, and legal environments), there was considerable skepticism concerning the Agency's ability to

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

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

LEGAL, POLICY, AND FINANCIAL

Bureau Structure

The vertical organizational and appropriations funding structures of GH are seen to present problems for focused, strategically directed, HCD emphasis and/or initiatives across bureaus. A lack of open communication between offices was cited by CA, Mission, and GH respondents alike as being an obstacle in interoffice HCD areas. Because of the vertical nature of GH's structure, a variety of CAs and bilateral organizations under different programs currently work independently on HCD issues. They often do not collaborate, and this current fragmented approach is viewed as costly in terms of expended resources and time.

Recommendations

1. Advocacy by senior management levels of GH is required for undertaking HCD initiatives.
2. Establish a consensus on joint programming and funding for HCD initiatives in GH.

Salary Structures

In many country programs, limitations to host country salary structures and their companion civil service regulations were cited as almost insurmountable barriers to HCD. A number of respondents reported salary imbalances as the root causes for current service provider supply and retention problems. Antiquated personnel administration systems are reported to be in place in many countries, often deeply entrenched in the governmental culture. Performance appraisals are reported as largely nonexistent and are certainly not linked to actual quality or quantity of performance.

Recommendation

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

Essential Commodities

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

Recommendation

4. As procurement requirements in GH/OHA continue to be delineated, GH should expand existing logistic management systems rather than create new ones. Coordination within GH must be strengthened using previous lessons learned (e.g., established purchasing, warehousing, and distribution systems).

HUMAN RESOURCES MANAGEMENT (HRM)

Country Strategic Plans

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

Recommendations

5. In collaboration with USAID field Missions, consider undertaking HCD needs assessments in those countries with potential for success that will generate information on priority HCD needs in health.
6. Based upon the HCD needs identified through these assessments, mechanisms for incorporating HCD activities into USAID's country strategic plans should be proposed.

Integrated Broad-Scale HCD Programming

This evaluation noted that numerous and scattered HCD activities are being conducted throughout most CA projects and in bilateral agreements. However, broad-scale, integrated HCD efforts were not reported. Disjointed CA and bilateral HCD efforts are achieving output objectives, and although contributing to HCD practice improvement to

varying degrees, they are not reported to be achieving long-term sustainability in HCD. Additionally, very little if any operations research or evaluation to assess HCD approaches has been conducted.

Recommendations

7. Broad-scale, integrated HCD should adopt a systems development approach in its programming.
8. Integrated HCD should include evaluation and operations research to determine the effectiveness of different HCD approaches and the potential for replicating successful models.

Realignment of Service Provider Categories/Cadres

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

Recommendations

9. Expand and realign the categories of service providers in the health workforce (e.g., community health workers, paramedics, auxiliary health workers, pharmacists, and home care workers).
10. Redesign the required skill sets for capacity development and supervision systems needed to accommodate service provider realignment.

Training Practices

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

Recommendation

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

Preservice Education and Long-Term Training

In many of the countries canvassed, current professional leadership capacity is seen as weakening and is not being readily replaced. Professional schools are underfunded, lack needed technology and updated training approaches, and are unable to meet current

health care delivery demands. Clinical expertise is reported to be lacking in very complex HIV/AIDS prevention, treatment, and care modalities, as are expert management skills to carefully balance other essential health services (e.g., child survival, immunization, population/reproductive health, and maternal/neonatal services).

The loss of GH technical support for preservice institutions, curriculum revision, and long-term training is evident in the diminishing numbers of public health professionals and upper level managers. Collaborating with U.S.–based university programs for long-term training is at a diminished level. This has resulted in reduced training stipends and health mechanisms for health personnel (e.g., trained public health professionals).

Recommendations

12. Recommit to preservice education and long-term training, with an emphasis on supporting regional and local educational and training institutions and U.S. partnering mechanisms.
13. In order to effectively address HCD policy reforms and restructuring, USAID needs to work not only with ministries of health, but also possibly with ministries of finance (for education funding), education (for nursing and medical education), and labor (for remuneration levels, incentive structures, and conditions of work).

LEADERSHIP

HCD Category/Cadre

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

Recommendation

14. Preservice education and inservice training in HCD management should be initiated to develop an appropriate and sustainable number of managers who will address prevailing HCD issues.

Cooperating Agencies, PHN Field, and GH Staff

HCD leadership qualities and technical expertise within CA organizations were described by field and GH respondents as ranging from nonexistent to limited. CA activities in contacted countries were often seen to be repetitive in nature. The approaches were interpreted as being not customized (e.g., inservice training and supervision models) and did not address the complexity of the country’s HCD problems. There currently is no sharing of HCD experience or active collaboration among organizations. Bringing together many of the GH technical expertise areas (e.g., quality assurance, performance improvement, curriculum design, training of trainers, and management and supervision) to collectively resolve service provider performance dilemmas would help ensure strengthened HCD systems supportive of various program achievements.

Recommendations

15. Increase the general awareness of HCD issues within GH and across CA organizations, and establish consultative mechanisms for sharing project experiences and identifying best practices, including those from the Maximizing Access to Quality (MAQ) Initiative, performance improvement, and quality assurance.
16. Clear language in CA annual work plans regarding the range and type of CA efforts in HCD is highly desirable. This would bolster awareness of and confidence in HCD capacities within CA organizations, throughout the CA community, and in field offices.

PARTNERSHIPS

Donor Coordination in HCD

Few respondents reported actual collaboration with other donors in the HCD sphere (e.g., the World Bank, European Union [EU], Department for International Development [DFID], or the Canadian International Development Agency [CIDA]). The potential for donor partnering is reported to be within the HCD components of personnel administration (salaries paid) and integration of human resources (HR) and health system objectives (civil service reform).

U.S. organizations were also identified as either having the presence or the potential for in-country collaboration (e.g., Centers for Disease Control and Prevention [CDC], Department of Health and Human Services [DHHS], National Institutes of Health [NIH], and U.S. foundations [Bill and Melinda Gates, William and Flora Hewlett, and David and Lucile Packard]). Several respondents were concerned by the lack of consistent, senior-level participation of GH in discussions with these organizations to assure that USAID is seen and acknowledged for its technical assistance capacity.

Recommendations

17. Host country representatives and organizations should be seen as full partners in developing and implementing any HCD initiatives.
18. Substantive liaison between USAID GH and potential partners such as the World Bank, World Health Organization (WHO), and EU would greatly increase the potential for success in HCD.
19. Participation at senior management levels with other U.S. organizations (e.g., CDC, NIH, and DHHS) is required for administrative and programmatic collaboration in health HCD efforts.

NEXT STEPS

Based upon the assessment findings and recommendations, the following concrete next steps were identified for consideration by the GH task force on HCD:

- Develop an HCD strategy that articulates HCD needs and identifies the scope and depth of priority HCD initiatives that GH may be prepared to support (both within each office and jointly). This strategy should be guided by USAID’s programmatic experience, current technical capabilities, and careful assessments of the potential for success. This is an overarching recommendation for the evaluation.
- Implement an integrated HCD country initiative. This activity would address priority HCD needs in selected countries where the potential for programmatic action appears promising. The objective would be to field test various HCD initiatives in diverse country environments in order to identify successful models for action, best practices in HCD, and interventions that appear to have good potential for replicability.
- Review the status of GH’s internal and contractual mechanisms for supporting long-term training in the United States.
- Evaluate the potential of professional exchange programs and collaboratives in health as effective HCD strategies.
- Position USAID to assume a more prominent global leadership role in HCD for health.

I. INTRODUCTION

PURPOSE OF THE EVALUATION

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

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

This evaluation was undertaken for GH's Task Force on Human Capacity Development. The task force includes representatives from all four offices within GH. As stated in the scope of work (appendix A), the purpose of this evaluation was to "present a series of options for the HCD task force related to USAID's manageable interest regarding the type, extent, and level of involvement in HCD in the health sector as it relates to service delivery." Specific activities for this evaluation were as follows:

- finalize questions pertaining to HCD that will be asked of Missions, cooperating agencies (CAs), and GH staff in response to current HCD activities and facilitate an exercise that reviews and revises (where needed) the goals and objectives of the HCD task force;
- conduct a survey of global health and bilateral projects to determine what is being done in HCD; and
- make a series of recommendations (in the forms of options) to the task force as to how GH should support HCD in the future.

BACKGROUND

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

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

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

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

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

While HCD needs have reached crisis proportions in many developing countries, especially those significantly affected by HIV/AIDS, concerns about how to best train, deploy, and retain service providers have bedeviled international health experts for decades. Much donor-driven HCD activity has focused on the inservice training of individual practitioners with respect to specific program areas (e.g., family planning and reproductive health, maternal and child health, and the diagnosis, treatment, and prevention of specific infectious diseases, such as malaria, polio, and tuberculosis). While these efforts have no doubt been useful, they are increasingly viewed as inadequate in terms of improving the overall functionality and performance of health systems and enhancing the delivery of health care in resource-poor settings.

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

sensitive to in-country managerial and resource realities, programmatic need, and political sensitivities in order to be successful.

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

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

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

The GH task force has identified five major HCD components in considering current and future HCD needs in health service provision.¹ Similar typologies have been adopted by other international and bilateral donor organizations (e.g., the World Health Organization [WHO], the World Bank, the Department for International Development [DFID], and the Canadian International Development Agency [CIDA]) in their efforts to respond to HCD needs in health. These components are described in exhibit 1 on the following page (Heiby, 2003).

As is apparent, the five HCD components listed in exhibit 1 constitute a broad, perhaps unmanageable, programmatic agenda. Not only are HCD agendas far ranging, but they often involve sensitive issues pertaining to program ownership, domestic legal and regulatory practices, cultural bureaucratic environments, and ultimately national sovereignty. However, if these crucial health input issues are not adequately resolved in the future, it is unlikely that health systems will be capable of generating the appropriate results. Picazo et al. (2003:36) summarize the dilemma of HCD in terms of the immediate health challenges facing Africa:

A key factor in the neglect of health workers' (HCD) issues is the view held by governments and donors that HR (human resources) is too big, too complex, and too intractable to be solved by one donor or by the government alone depending on its meager resources. A second factor is the tradition that donor projects can only provide resources for capital costs or for foreign exchange requirements (e.g., drug imports, international technical advisory services, or staff training abroad), but not for recurrent costs, and certainly not for salary support or enhancement. A third factor is the continuing fragmentation of African health systems, largely balkanized by donor projects, each having its own overlapping set of HR subsystems, incentive structures, training

¹ For further elaboration of the organizational scheme presented in exhibit 1, see Martinez and Martineau (1998), "Rethinking Human Resources: an Agenda for the Millennium," *Health Policy and Planning*, 13(4).

programs, and disease priorities. Clearly, the HR problem is the elephant in the room that both donors and African governments have ignored and that is now throwing its weight around.

Exhibit 1 Major Components of Human Resources in Health

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

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

METHODOLOGY

A two-person team experienced in HCD, manpower planning, and service provision in developing countries undertook this evaluation. Much of the evidence compiled by the team was derived from in-person interviews and telephone calls. The team interviewed GH country coordinators and cognizant technical officers (CTOs), USAID population, health, and nutrition staff members residing in overseas Missions, and CA representatives. A complete list of persons contacted is shown in appendix B.

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

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

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

II. FINDINGS FROM THE EVALUATION SURVEY ON HUMAN CAPACITY DEVELOPMENT

A short survey of human capacity activities and future priorities was undertaken as part of this evaluation. The survey was administered to GH country coordinators; CTOs; population, health, and nutrition officers in USAID field Missions; and representatives from USAID’s CA community. The countries and CAs selected for inclusion in this survey are shown below. While the number of respondents was not large (and the level of response among GH country coordinators and CTOs somewhat disappointing), it is still possible to a degree to identify essential characteristics of current HCD activities and future need. Results from the survey are presented in the appendices.

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

Table 1
Countries and Cooperating Agencies Contacted for the Survey on
Human Capacity Development

Countries Contacted	Cooperating Agencies Contacted
Bangladesh	Abt Associates/PHR <i>plus</i>
Cambodia	BASICS II
Egypt	CATALYST
Indonesia	EngenderHealth
Kenya	JHPIEGO/TRH
Malawi	JSI/DELIVER
Nigeria	MSH/Management and Leadership Program
Senegal	Pathfinder International
South Africa	PRIME II
Uganda	URC/QAWD*
Ukraine	
Zambia	

*Quality Assurance/Workforce Development Project

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

All respondent types reported the priority HCD problem areas to be the high ratio of urban to rural providers, the high ratio of doctors to nurses, and that few new service providers are entering into service.

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

There is general agreement that the impact of HIV/AIDS has greatly increased the need to train additional service providers and address HCD issues. This view is especially pronounced among USAID Missions in Sub-Saharan Africa. The growing appreciation for HCD issues in health service delivery may also be reflected in the large percentage of developing countries that have recently requested assistance in addressing HCD needs. For example, 89 percent of all USAID Missions and 88 percent of CA representatives report that they have received requests for technical assistance in HCD. Respondents also report that other donors are becoming more active in HCD work. However, donor coordination on HCD issues is generally weak and appears to be highly country specific.

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

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

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

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

All respondents agreed that future HCD needs in service provision would be concentrated in HIV/AIDS, maternal and child health, infectious diseases, and other reproductive health services (e.g., adolescent programs and postabortion care). Family planning was not ranked highly as a future HCD priority area.

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

Table 2
Program Areas in Which Future Demands on Service Provider HCD Will Be Most Critical

GH Country Coordinators and USAID Mission Staff	GH CTOs and CA Representatives
HIV/AIDS	HIV/AIDS
Maternal and Child Health	Infectious Disease
Other Reproductive Health Services	Maternal and Child Health

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

Table 3
Current Priority HCD Needs as Reported by Survey Respondents

GH Country Coordinators and USAID Mission Staff	GH CTOs and CA Representatives
Inservice Training	Staff Deployment
Employee Incentives	Employee Incentives
Conditions of Service	Preservice Training

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

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

Table 4a
HCD Components in Which USAID Resources and Technical Assistance
Could Likely Have an Impact

GH Country Coordinators and USAID Mission Staff	GH CTOs and CA Representatives
Preservice Training	Inservice Training
Certification/Accreditation	Preservice Training
Inservice Training	Certification/Accreditation

Table 4b
HCD Components in Which USAID Resources and Technical Assistance Would Likely
Have Little or No Impact

GH Country Coordinators and USAID Mission Staff	GH CTOs and CA Representatives
Staff Retention	Staff Recruitment
Time/Attendance Reporting	Time/Attendance Reporting
Civil Service Reform	Conditions of Service

III. INTERVIEW FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

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

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

LEGAL, POLICY, AND FINANCIAL

Bureau Structure

The vertical organizational and appropriations funding structures of GH are seen as presenting problems for focused, strategically directed, cross-bureau HCD initiatives. CA, Mission, and bureau respondents alike cited a lack of permeability between offices as being an obstacle to cross-office HCD actionable areas. These HCD areas include standardization in service delivery supervision, personnel deployment, frontline worker task and skill requirements (job descriptions), and training management, logistical, and supply management systems.

One respondent described the need within GH as “a lack of a corporate consensus regarding HCD.” That a bureauwide task force has been commissioned to assess HCD needs and activities was welcome new information for respondents. Of special importance to Mission respondents was the possibility for funds to be commingled across bureau offices to effect broader changes in HCD to meet overlapping service demands and the needs of an integrated (polyvalent) workforce found in most country programs. Recent shifts in program priorities were reported as causing imbalances in previously emphasized service areas (e.g., infectious disease, family planning).

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

Mostly, field officers understand the need for HCD although they vary in their assessments as to which of the five HCD components apply in their situation. Several respondents noted that the creation of a GH task force charged with exploring HCD issues was in itself a sign that these issues are emerging as priorities for GH.

Conclusion

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

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

Recommendations

1. Advocacy by senior management levels of GH is required for undertaking HCD initiatives.
2. Establish a consensus on joint programming and funding for HCD initiatives in GH.

Salary Structures

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

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

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

Conclusion

Delays in or avoidance of civil service reforms continues the problems of salary inequities, employee retention, deployment imbalance, and poor job performance. It is acknowledged that HCD policy restructuring is not always within the exclusive control of the Ministry of Health (MOH). Other ministries are frequently involved, such as finance and labor. Therefore, whole-scale MOH transformation is undoubtedly not possible in most countries; rather, incremental changes might be effected in selected countries.

In a few select countries where the potential for broad infrastructure interventions is highest, collaborating with other donors to address root cause factors would be the most beneficial. GH need not assume full responsibility, but rather it could provide the technical expertise for which USAID is best positioned and partner with those donors able to provide funding (e.g., DFID and the World Bank).

Recommendation

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

Essential Commodities

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

Conclusion

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

Recommendation

4. As procurement requirements in GH/OHA continue to be delineated, GH should expand/consolidate logistic management systems rather than create new ones. Cross-bureau coordination should be strengthened using previous lessons learned (e.g.,

established purchasing, warehousing, and distribution systems) to prevent duplication or parallel systems design.

HUMAN RESOURCES MANAGEMENT (HRM)

Country Strategic Plans

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

Conclusion

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

Recommendations

5. In collaboration with USAID field Missions, consider undertaking HCD needs assessments in selected countries with success potential that will generate information on priority HCD needs in health.
6. Based upon the HCD needs identified through these assessments, propose mechanisms for incorporating HCD activities in USAID's country strategic plans.

Integrated HCD Programming

In response to whether activities were in progress or recently completed in any of the five HCD components, numerous and scattered HCD activities were reported as being conducted throughout most CA projects and bilateral agreements. These activities included large numbers of inservice training activities; some activities in supervision strengthening (Malawi, Zambia); one bilaterally funded preservice curriculum reform initiative (Egypt); and a few CA activities in decentralized HCD strengthening (Zambia).

Of special note are those CAs whose objectives already include HCD components. An illustrative list includes IntraHealth International/PRIME II, University Research Co., LLC (URC)/Quality Assurance/Workforce Development Project (QAWD), JHPIEGO/Training in Reproductive Health (TRH), Abt Associates/PHR*plus*, and Pathfinder International/CATALYST Project. Additionally, other CA organizations without specific HCD objectives report involvement in some aspect of the five components (e.g., BASICS II and EngenderHealth). Yet, broad-scale integrated HCD efforts were not reported.

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

Disjointed CA and bilateral HCD efforts are achieving output objectives, and although contributing to HCD practice improvement to varying degrees, they are not reported to be achieving long-term sustainability in HCD. Delivery infrastructures are reported as crumbling and are not able to sustain new service demands being placed on frontline workers. Additionally, little if any operations research or evaluation to assess HCD approaches was reported as having been conducted. Low awareness levels of study findings conducted in quality assurance, MAQ, supervision, and performance improvement seem to exist within field offices.

Conclusion

Over the years, USAID inservice and preservice investments have been well received and recognized as being beneficial, yet training and education alone do not guarantee quality of service practice or better health outcomes. A range of events in many countries has led to deterioration in health service infrastructures and consequently, erosion of USAID prior investments. Close attention is needed to assure that CA interventions are responding to strategic HCD needs.

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

Recommendations

7. Broad-scale integrated HCD should adopt a systems development approach in its programming.

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

Realignment of Service Provider Categories/Cadres

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

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

Conclusion

Traditional professional cadres (e.g., physicians, nurses, and nurse-midwives) can no longer be considered as the frontline workers through which the bulk of services can be provided. The numbers are dwindling, replacement numbers are not keeping up with attrition, new skills and tasks are being required, cost-effectiveness in workforce expenditures is paramount, and management capacity is vitally needed.

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

Recommendations

9. Expand and realign the categories of service providers in the health workforce (e.g., community health workers, paramedics, auxiliary health workers, pharmacists, and home care workers).
10. Redesign required skill sets for capacity development and supervision systems required to accommodate service provider realignment.

Training Practices

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

Conclusion

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

Recommendation

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

Preservice Education and Long-Term Training

Respondents frequently cited regret regarding the erosion in previous USAID preservice and U.S.-based long-term investments that has occurred over recent years. This appears to be due to a policy shift in GH financial support that no longer supports long-term education or training. As leadership ranks within country programs dwindle, the need to attend to the supply side of HCD needs to be addressed.

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

Loss of GH technical support for preservice institutions, curriculum revision, and long-term training is evident in the diminishing numbers of public health professionals and upper level managers. Collaborating with U.S.-based university programs for long-term training is at a diminished level. The result has been a reduction in training stipends and

mechanisms for health personnel (e.g., trained public health professionals and clinical specialists).

Conclusion

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

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

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

GH partnership and collaboration with country-based training and educational institutions have diminished over the years. Additionally, U.S.-based universities have seen their presence diminish within countries, and GH education stipends for health professionals (e.g., public health) at U.S. universities has been greatly reduced. Institutional collaboration among similar developing countries has often been discussed as ideal yet actual agreements between identified centers of excellence seem to be few, if any. Field office respondents reported that the following institutions, among others, could be potential centers of excellence:

- Benin Institute for Public Health, Diop Medical School in Senegal (French), and
- Makere University, Uganda; Nairobi University, Kenya (nursing); universities in Eastern Cape, South Africa (clinical management, nursing) (English).

Recommendations

12. Recommit to preservice education and long-term training with emphasis on supporting regional and local educational and training institutions and U.S. collaborative mechanisms.
13. In order to effectively address HCD policy reforms and restructuring, USAID needs to be working not only with ministries of health, but also possibly with ministries of finance (for education funding), ministries of education (for nursing and medical education), and ministries of labor (for remuneration levels, incentive structures, and conditions of work).

LEADERSHIP

HCD Category/Cadre

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

Conclusion

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

However, sustainable HCD changes cannot be achieved nor maintained without good leadership and management. In its leadership capacity, the primary role of GH regarding HCD involves advocating for HCD for service providers in Mission programming and in CA agreements. GH advocacy for HCD to be effective needs placement at the senior management level.

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

Recommendation

14. Preservice education and inservice training in HCD management should be initiated to develop a sustainable and appropriate number of managers dealing with prevailing HCD issues.

Cooperating Agencies, PHN Field Staff, and GH Staff

Field and GH respondents described HCD leadership qualities and technical expertise within CA organizations as ranging from nonexistent to limited. As previously noted, often CAs were described as not always responsive to Mission Strategic Objectives. In contacted countries, CA activities were often seen to be repetitive in nature. The approaches were interpreted as not being specialized for the situation (e.g., inservice training and supervision models and not addressing the complexity of the country's HCD problems).

However, GH staff generally described Mission staff as lacking in vision and in the ability to judge HCD needs. Field staff was unsure as to GH scope of technical assistance capacity in HCD. The interviewers found a number of field staff that once made aware of this evaluation's scope of work and the HCD typology being applied, did indeed recognize their HCD needs and status of activities. However, they often believed that their options for sourcing appropriate technical input were limited and at times confusing (e.g., too many CA organizations offering unclear approaches without documentation of previous success).

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

Another leadership layer that is needed is GH internal and CA technical assistance capacity in HCD. Several respondents stated that GH CA organizations do not have a systems perspective (e.g., training skills but not skills in development of broad-scale training management systems). Additionally, some GH staff is not well versed in technical aspects of HCD approaches (e.g., performance improvement, workforce planning) and sensitive to the matching of a given approach to a prevailing situation. These perceived technical assistance shortcomings seem to be contributing to the lack of progress in HCD and the development of leaders and managers in the field.

Conclusion

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

Recommendations

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

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

PARTNERSHIPS

Donor Coordination in HCD

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

U.S. organizations were also identified as either having presence in HCD issues or the potential for in-country collaboration (e.g., Centers for Disease Control and Prevention [CDC], the Department of Health and Human Services [DHHS], the National Institutes of Health [NIH], and western U.S. foundations [Gates, Hewlett, Packard]). Several respondents expressed their concern by the lack of consistent GH senior-level participation in discussions with these organizations to assure that USAID is seen and acknowledged for its technical assistance capacity.

Conclusion

Donors such as the World Bank and the EU have mechanisms for direct financial assistance and could provide complimentary technical assistance in these component areas. Substantive liaisons between USAID/GH and potential partners would greatly increase the success factor for substantial, sustainable HCD changes in country programs. Any HCD initiatives must be developed and implemented in full consultation with host country representatives and organizations.

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

Recommendations

17. Host country representatives and organizations should be seen as full partners in developing and implementing any HCD initiatives.
18. Substantive liaison between USAID GH and potential partners, such as the World Bank, WHO, and EU, should be explored to increase the potential for success in HCD.

19. Participation at senior management levels with other U.S. organizations (e.g., CDC, NIH, and DHHS) is required for administrative and programmatic collaboration in health HCD efforts.

OVERARCHING RECOMMENDATION

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

IV. OPTIONS FOR A FUTURE GH INITIATIVE IN HCD

INITIAL STEPS FOR CONSIDERATION BY THE GH TASK FORCE ON HCD

Based upon the conclusions and recommendations of this evaluation, the GH Task Force on HCD may want to consider the following options as potential next steps. It should be noted at the outset that the proposed initiatives outlined below need to be predicated on the formulation of an HCD strategy. Once this strategy has been adopted, future GH action in HCD will require that GH address the following three issues:

- the identification of a person (or persons) who will be seen as well qualified in HCD issues and readily identified as the advocate for GH HCD efforts. Concerted advocacy for HCD changes within existing and future programs is critical to future success;
- the need to secure staff support for GH's HCD strategy and future programmatic agendas; and
- collaboration with domestic organizations (e.g., CDC, DHHS, and U.S. foundations) and international donors (e.g., World Bank, EU, DFID, and CIDA) on HCD issues. (As noted, liaison representation in HCD should be undertaken at senior management levels.)

Integrated HCD Country Initiative

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

Initial Work Required

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

These assessments should be undertaken in collaboration with USAID field Missions and should be informed by discussions with relevant host country counterparts/organizations and other donors actively working in HCD.

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

In order to undertake this integrated HCD country initiative, GH will need to access new resources and technical competencies. There are several options that the task force should consider in deciding how this might be accomplished.

Prerequisites for an Integrated Initiative

Form an internal GH HCD working group or unit for the integrated HCD country initiative. This body would contain several staff assigned to the working group full time plus input from additional staff from GH/PRH, GH/OHA, GH/HIDN, and GH/RCS. There are several full-time staff positions already assigned in HCD (GH/OHA HCD advisor, GH/PRH performance improvement technical advisor, MAQ advisor, and GH/HIDN quality assurance advisor). The working group would assume a coordinating role in interacting with field Missions and would expedite communication between the field and the organization(s) designated to implement this activity.

Alternatively, the functions of the HCD working group could be outsourced to an external agency that would act as the liaison with GH (specifically the task force and country coordinators for countries participating in the initiative) and arrange for appropriate technical assistance through subcontracts.

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

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

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

ADDITIONAL CONSIDERATIONS

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

It is not clear to the evaluation team what mechanisms currently exist within GH for supporting long-term degree training in the population and health sciences. At least one Mission (Malawi) was sending several people to the United States for long-term degree training in health, but the mechanism for doing this was not clear. Given the recommendation that GH provide more long-term training opportunities in the future, it would be useful to commission a short internal review of current administrative mechanisms (both internal to GH and through outside agencies supported by USAID) that could provide greater clarity regarding the steps GH would need to consider to become more active in supporting long-term training. In particular, it would be useful to review the current status of the Office of Professional and Career Development within GH and the Population Leadership Program (PLP) as potential mechanisms for collaborating more extensively with Missions in supporting long-term training and coordinating future partnering efforts with U.S.-based educational institutions.

Evaluate the Potential of Professional Exchange Programs and Collaboratives in Health

USAID is currently supporting several professional exchange programs in health that deserve further scrutiny as potential models for implementing HCD in the future. One potential model is the American International Health Alliance (AIHA) that forms partnerships among U.S. and foreign medical facilities and staff to collaborate on upgrading specific skill sets. AIHA's valuable work in Russia on neonatal resuscitation is one example. This mechanism has proven to be highly effective in promoting good collegial exchange, although its cost may inhibit widespread replicability in the developing world. The concept of collaboratives was widely discussed, in which health professionals in the United States and developing countries exchange knowledge and information on best practices through long-distance learning technologies. This model has not been widely assessed yet and might currently be frustrated in many developing country settings with poor Internet connectivity. However, as technology advances, collaboratives could well become central features of any HCD strategy.

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

During this evaluation, attention was drawn to initiatives of the World Bank and WHO in HCD. The World Bank's HCD efforts tend to be country based and integrated with its support for health sector reform and sectionwide approach mechanisms. WHO has an active interest in human resources development and workforce planning (e.g., through its

Global Health Workforce Strategy Group). However, WHO involvement in HCD tends to be more at the theoretical and conceptual level, with recommended actions often underresourced and inadequately implemented.

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

APPENDICES

- A. Scope of Work**
- B. Persons Contacted**
- C. HCD Survey Results: USAID Country Coordinator and Mission Responses**
- D. HCD Survey Results: USAID CTO and CA Representative Responses**
- E. Open-Ended Responses to Survey Question 18a: What are Important HCD Initiatives to Consider Implementing?**
- F. Human Capacity Development Needs and Actionable Priorities Reported by USAID Field Missions**
- G. Human Capacity Development Needs and Actionable Priorities Reported by Cooperating Agencies**
- H. References**

APPENDIX A

**SCOPE OF WORK
(from USAID)**

Scope of Work for HCD Task Force Consultant

7/1/03

Background

Need

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

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

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

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

² The Health Sector Human Resource Crisis in Africa: An Issues Paper, USAID February 2003, p. 3

³ *ibid*, p. 6

⁴ *ibid*, p. 12

HCD Task Force

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

What is Human Capacity Development?

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

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

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

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

Purpose of this consultancy

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

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

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

Specific Activities for this assignment:

1. Organize and facilitate a retreat for HCD tasks force members. The purpose of this retreat will be to finalize the questions that will be asked of Missions, CAs and GH staff in response to their current HCD activities. A list of both GH project countries and Missions needs to be determined as well. Some illustrative questions could be:
 - What is currently being done in HCD now?
 - What is the impact of the HIV/AIDS crisis on other health sectors?

- Are there any success stories? What are they? Why have they been successful?
- Is HCD an issue for the mission? If so, what are the most pressing needs to missions re: HCD?
- What can the global bureau do to solve these problems?

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

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

Deliver	Policy II	Advance Africa
Catalyst	JHPIEGO/TRH	Engender Health
Intrah	Youthnet	Call to Action – EGPAF
Synergy	PHR <i>plus</i>	Quality Assurance, Workforce Development
IMPACT	HIV/AIDS Alliance	BASICS
JHPIEGO/MNH		

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

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

Timeline:

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

Please see Human Capacity Development assignment calendar.

Total level of effort: POPTECH consultants 23-28 days

Deliverables:

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

Background Reading/background material:

1. The Health Sector Human Resource Crisis in Africa: An Issues Paper
2. Country-specific work done by HCD Task force members
3. MSH/M&L HCD Presentation

APPENDIX B

PERSONS CONTACTED

PERSONS CONTACTED

U.S. Agency for International Development

Bureau for Global Health

Margaret Neuse, Director, Office of Population and Reproductive Health
Gary Newton, Director, Office of Regional and Country Support
Willa Pressman, Africa Team Leader, Office of Regional and Country Support
Constance Carrino, Director, Office of HIV/AIDS

Cognizant Technical Officers/Technical Advisors

Tony Boni, Management Sciences for Health(MSH)/Rational Pharmaceutical Management (RPM)
Dennis Carroll, Infectious Disease Specialist, Office of Health, Infectious Disease and Nutrition
Elizabeth Fox, BASICS II
Jim Griffin, JHPIEGO/Training in Reproductive Health (TRH)
Jim Heiby, University Research Co., LLC (URC)/QAWD
Karen Kavanaugh, Abt Associates/PHR*plus*
Debbie Kosko, PRIME II
Maureen Norton, CATALYST
Jessica Pollak, EngenderHealth
Marne Sommers, MSH/RPM
Susan Wright, MSH/Management and Leadership Program

Country Coordinators

Celeste Carr, South Africa
Frances Davidson, Senegal
Robert Emrey, Chief, Health Systems Division; Country Coordinator, Egypt
Joyce Holfeld, Nigeria
Gerry Jennings, Uganda
Pam Mandel, Ukraine
Nancy McCharen, Senegal
Mark Rilling, Indonesia
Elizabeth Schoenecker, Cambodia
Barbara Seligman, Bangladesh
Patricia Stephenson, Zambia
Wyman Stone, Malawi
Dana Vogel, Chief, Service Delivery Improvement Division; Country Coordinator, Kenya

Missions

Ali Abdelmegeid, Egypt
Felix Awantang, Senegal
John Crowley, South Africa
Robert Cunnane, Uganda
Jeannie Friedmann, Bangladesh
Nancy Godfrey, Ukraine

Cheryl Kamin, Malawi
Monica Kerrigan, Indonesia
Mike Strong, Kenya
Mark White, Cambodia

Cooperating Agency Representatives

Lynn Bakamjian, EngenderHealth
Mona Byrkit, PRIME II
Joseph Dwyer, MSH/Management and Leadership Program
Barbara Felling, JSI/DELIVER
Kama Garrison, JHPIEGO/TRH
Dan Kraushaar, BASICS II
Ron McCarick, JHPIEGO/TRH
Edgar Necocchea, JHPIEGO/TRH
David Nicholas, URC/QAWD
Mary O'Neil, MSH/Management and Leadership Program
Nancy Pielemeier, Abt Associates/PHR*plus*
Cathy Solter, Pathfinder International/CATALYST

APPENDIX C

**HCD SURVEY RESULTS
USAID COUNTRY COORDINATOR AND MISSION RESPONSES**

HCD SURVEY RESULTS
USAID COUNTRY COORDINATOR AND MISSION RESPONSES

Table C1
How Would You Characterize Trends in Per Capita Availability of Health Service Providers in Your Host Country by Geographic Area Over the Past Decade?

Respondent/Area	Greatly Deteriorated	Declined Somewhat	Remained Same	Improved	Greatly Improved	Response Total
Country Coordinator						
Urban	0	33%	17%	33%	17%	6
Rural	17%	33%	33%	17%	0	6
National	0	50%	33%	0	17%	6
USAID Mission						
Urban	22%	22%	11%	33%	11%	9
Rural	44%	22%	0	33%	0	9
National	33%	33%	0	33%	0	9

Table C2
How Would You Characterize Trends in Per Capita Availability of Health Service Providers in Your Host Country by Program Element Over the Past Decade?

Respondent/Program Element	Greatly Deteriorated	Declined Somewhat	Remained Same	Improved	Greatly Improved	Response Total
Country Coordinator						
FP	0	40%	40%	20%	0	5
Other RH	0	20%	40%	40%	0	5
HIV/AIDS	0	20%	0	80%	0	5
MCH	20%	20%	20%	40%	0	5
ID*	0	40%	0	60%	0	5
Nutrition	20%	20%	20%	40%	0	5
USAID Mission						
FP	22%	22%	44%	11%	0	9
Other RH	11%	22%	33%	33%	0	9
HIV/AIDS	22%	11%	33%	33%	0	9
MCH	22%	44%	0	22%	11%	9
ID	22%	44%	0	33%	0	9
Nutrition	33%	22%	11%	33%	0	9

*Infectious Disease

Table C3
Has the Impact of HIV/AIDS Increased the Need to Train More Service Providers in Your Country?

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

Table C4
Has Your Country Asked for Assistance in Addressing Future HCD Needs in Health Service Delivery?

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

Table C5
In Your Country, Are There HCD Strategies in Place that Allocate Resources for Health Service Providers?

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

Table C5a
If Yes, Do Specific Strategies Exist for Meeting Future Needs in the Following Health Program Areas?

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

Table C5b
If No, Has There Been Interest in Developing HCD Strategies for Service Delivery?

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

Table C6
Does Your Country Have Specific Policies and Programs that Address the Following HCD Components?

Respondent/Component	Yes	No	Don't Know	Response Total
Country Coordinator				
Supply System for Health	80%	20%	0	5
Performance Management	40%	0	60%	5
Personnel Administration	60%	20%	20%	5
Education/Training of Service Providers	80%	20%	0	5
Integration of HR and Health System	40%	20%	40%	5
USAID Mission				
Supply System for Health	38%	38%	24%	9
Performance Management	38%	50%	12%	9
Personnel Administration	86%	14%	0	9
Education/Training of Service Providers	75%	25%	0	9
Integration of HR and Health System	38%	12%	50%	9

Table C7
Does the USAID Mission in Your Country Currently Have a Strategy for Addressing Future Health Service Delivery HCD Needs?

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

Table C8
Does the USAID Mission in Your Country Currently Have a Strategy for Addressing Future Health Service Delivery HCD Needs?

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

Table C9**Which HCD Components Are Being Addressed in Your Projects at the Present Time?**

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

Table C10**Could Your Projects Be Doing More To Strengthen Service Delivery HCD at This Time?**

Respondent	Yes	No	Response Total
Country Coordinator	100%	0	5
USAID Mission	100%	0	9

Table C11**Should USAID Give Greater Emphasis to Service Provider HCD in the Future?**

Respondent	Yes	No	Response Total
Country Coordinator	100%	0	5
USAID Mission	100%	0	9

Table C12**In Which Sector Has Your Support for Service Provider HCD Been Most Concentrated Over the Past Five Years?**

Respondent	Public Sector	Private Sector	NGOs	Response Total
Country Coordinator	100%	0	0	5
USAID Mission	56%	0	44%	9

Table C13
What Priority Has Been Given to Each Type of Service Provider in Your Country's Training Efforts?

Respondent/ Service Provider Type	High Priority	Medium Priority	Low Priority	Response Total
Country Coordinator				
Doctors	0	100%	0	5
Nurse-midwives	80%	0	20%	5
Traditional Nurse-midwives	25%	50%	25%	4
Paramedics	0	50%	50%	4
Community Workers	0	75%	25%	4
Traditional Healers	0	25%	75%	4
USAID Mission				
Doctors	62%	25%	12%	8
Nurse-midwives	33%	67%	25%	9
Traditional Nurse-midwives	25%	0	75%	8
Paramedics	33%	33%	33%	9
Community Workers	12%	62%	25%	8
Traditional Healers	0	25%	75%	8

Table C14
Has the Effectiveness of This Training Been Systematically Evaluated?

Respondent	Yes	No	Response Total
Country Coordinator	40%	60%	5
USAID Mission	33%	67%	9

Table C14a
If Yes, How Would You Rate the Effectiveness of This Training in Strengthening the Capacity to Deliver Services in Your Country?

Respondent	Highly Effective	Moderately Effective	Not Very Effective	Cannot Be Determined	Response Total
Country Coordinator	0	100%	0	0	2
USAID Mission	25%	50%	0	25%	4

Table C15
Are Other Donors in Your Country Making Contributions to HCD for Service Providers?

Respondent	Yes	No	Don't Know	Response Total
Country Coordinator	60%	0	40%	5
USAID Mission	100%	0	0	9

Table C16
Is There Donor Coordination on HCD Issues in Your Country?

Respondent	Yes	No	Don't Know	Response Total
Country Coordinator	20%	40%	40%	5
USAID Mission	56%	22%	22%	9

Table C17
In Your Country, How Would You Rank Each Health Program Element in Terms of Future Demands on Service Delivery HCD?

Respondent/ Program Element	High Demand	Moderate Demand	Low Demand	No Demand	Response Total
Country Coordinator					
FP	40%	20%	40%	0	5
Other RH	60%	20%	20%	0	5
HIV/AIDS	60%	40%	0	0	5
MCH	100%	0	0	0	5
ID	100%	0	0	0	5
Nutrition	60%	20%	0	20%	5
USAID Mission					
FP	56%	33%	11%	0	9
Other RH	67%	33%	0	0	9
HIV/AIDS	78%	22%	0	0	9
MCH	67%	33%	0	0	9
ID	44%	56%	0	0	9
Nutrition	44%	33%	22%	0	0

Table C18
What Type of Health Worker Should Receive Priority Attention in Future Service Delivery HCD Efforts in Your Country?

Respondent/ Health Worker Type	High Priority	Medium Priority	Low Priority	Response Total
Country Coordinator				
Doctors	17%	67%	17%	6
Nurse-midwives	83%	17%	0	6
Traditional Nurse-midwives	50%	50%	0	4
Paramedics	40%	20%	40%	5
Community Workers	60%	40%	0	5
Traditional Healers	25%	50%	25%	4
USAID Mission				
Doctors	56%	44%	0	9
Nurse-midwives	100%	0	0	9
Traditional Nurse-midwives	33%	33%	33%	9
Paramedics	44%	44%	11%	9
Community Workers	67%	22%	11%	9
Traditional Healers	12%	38%	50%	8

Table C19
How Would You Rank the Importance of the Following Common HCD Service Provider Imbalances in Your Country?

Respondent/Imbalance	Greatly Important	Moderately Important	Low Importance	Not Important	Response Total
Country Coordinator					
Ratio of New Entrants to Total Provider Stock Too Low	0	33%	33%	33%	3
Ratio of Specialists to Generalists Too High	33%	33%	33%	0	3
Ratio of Doctors to Nurses Too High	33%	33%	33%	0	3
Ratio of Nurses to Auxiliary Nurse-midwives Too High	0	33%	67%	0	3
Ratio of Urban to Rural Providers Too High	25%	25%	50%	0	4
Ratio Emigrant to Retained Providers Too High	0	33%	33%	33%	3
USAID Mission					
Ratio of New Entrants to Total Provider Stock Too Low	38%	25%	25%	12%	8
Ratio of Specialists to Generalists Too High	12%	12%	62%	12%	8
Ratio of Doctors to Nurses Too High	25%	38%	25%	12%	8
Ratio of Nurses to Auxiliary Nurse-midwives Too High	25%	38%	25%	12%	8
Ratio of Urban to Rural Providers Too High	62%	25%	12%	0	8
Ratio of Emigrant to Retained Providers Too High	12%	0	25%	62%	8

Table C20
How Would You Rank the Importance of the Following Service Delivery HCD Issues in Your Country?

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

Table C21

In Your Opinion, What is the Likelihood (Probability) That USAID Resources and Technical Assistance Could Be Effective in Changing Policies and Practices in the Following HCD Areas Given Your Host Country Political, Regulatory, and Legal Environments?

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

APPENDIX D

**HCD SURVEY RESULTS
USAID CTO AND CA REPRESENTATIVE RESPONSES**

HCD SURVEY RESULTS
USAID CTO AND CA REPRESENTATIVE RESPONSES

Table D1
How Would You Characterize Trends in Per Capita Availability of Health Service Providers in Your Countries by Geographic Area Over the Past Decade?

Respondent/Area	Greatly Deteriorated	Declined Somewhat	Remained Same	Improved	Greatly Improved	Response Total
USAID CTO						
Urban	25%	50%	25%	0	0	4
Rural	50%	25%	0	25%	0	4
National	25%	50%	0	25%	0	4
CA						
Urban	22%	22%	11%	44%	0	9
Rural	33%	22%	33%	11%	0	9
National	22%	22%	22%	33%	0	9

Table D2
How Would You Characterize Trends in Per Capita Availability of Health Service Providers by Program Element in the Countries Where Your Organization (CA) Has Been Working Over the Past Decade?

Respondent/Program Element	Greatly Deteriorated	Declined Somewhat	Remained Same	Improved	Greatly Improved	Response Total
USAID CTO						
FP	50%	0	50%	0	0	4
Other RH	50%	25%	25%	0	0	4
HIV/AIDS	25%	25%	0	50%	0	4
MCH	25%	25%	25%	25%	0	4
ID*	25%	25%	25%	25%	0	4
Nutrition	33%	67%	0	0	0	3
CA						
FP	0	62%	25%	12%	0	8
Other RH	0	50%	12%	38%	0	8
HIV/AIDS	12%	12%	12%	62%	0	8
MCH	11%	22%	44%	22%	0	9
ID	11%	22%	22%	44%	0	9
Nutrition	11%	44%	33%	11%	0	9

*Infectious Disease

Table D3
Has the Impact of HIV/AIDS Increased the Need To Train More Service Providers in Your Countries?

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

Table D4
Have Your Countries Asked for Assistance in Addressing Future HCD Needs in Health Service Delivery?

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

Table D5
In Your Host Countries, Are There HCD Strategies in Place That Allocate Resources for Health Service Providers?

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

Table D5a
If Yes, Do Specific Strategies Exist for Meeting Future Needs in the Following Health Program Areas?

Respondent/ Program Area	Yes	No	Don't Know	Response Total
USAID CTO				
FP	100%	0	0	2
Other RH	50%	0	50%	2
HIV/AIDS	50%	0	50%	2
MCH	50%	0	50%	2
ID	0	0	100%	2
Nutrition	0	0	100%	2
CA				
FP	33%	33%	33%	3
Other RH	33%	0	67%	3
HIV/AIDS	100%	0	0	3
MCH	67%	0	33%	3
ID	33%	0	67%	3
Nutrition	0	0	100%	3

Table D5b
If No, Has There Been Interest in Developing HCD Strategies for Service Delivery?

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

Table D6
Do Your Countries Have Specific Policies and Programs That Address the Following HCD Components?

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

Table D7
Do the USAID Missions in Your Countries Currently Have Strategies for Addressing Future Health Service Delivery HCD Needs?

Respondent	Yes	No	Response Total
USAID CTO	60%	40%	5
CA	67%	33%	9

Table D8
Are Your CA Projects Currently Incorporating HCD for Service Providers as Part of Their Overall Objectives?

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

Table D9
Which HCD Components Are Being Addressed in Your Projects at the Present Time?

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

Table D10
Could Your Projects Be Doing More To Strengthen Service Delivery HCD at This Time?

Respondent	Yes	No	Response Total
USAID CTO	100%	0	4
CA	89%	11%	9

Table D11
Should USAID Give Greater Emphasis to Service Provider HCD in the Future?

Respondent	Yes	No	Response Total
USAID CTO	80%	20%	5
CA	89%	11%	9

Table D12
In Which Sector Has Your Organization's (CA's) Support for Service Provider HCD Been Most Concentrated Over the Past Five Years?

Respondent	Public Sector	Private Sector	NGOs	Response Total
USAID CTO	100%	0	0	5
CA	89%	0	11%	9

Table D13
What Priority Has Been Given to Each Type of Service Provider in Your Organization's (CA's) Training Efforts?

Respondent/ Service Provider Type	High Priority	Medium Priority	Low Priority	Response Total
USAID CTO				
Doctors	20%	20%	60%	5
Nurse-midwives	0	20%	80%	5
Traditional Nurse-midwives	80%	20%	0	5
Paramedics	60%	20%	20%	5
Community Workers	100%	0	0	5
Traditional Healers	100%	0	0	5
CA				
Doctors	33%	44%	22%	9
Nurse-midwives	78%	11%	11%	9
Traditional Nurse-midwives	22%	22%	56%	9
Paramedics	11%	44%	44%	9
Community Workers	33%	33%	33%	9
Traditional Healers	0	11%	89%	9

Table D14
Has the Effectiveness of This Training Been Systematically Evaluated?

Respondent	Yes	No	Response Total
USAID CTO	80%	20%	5
CA	33%	67%	9

Table D14a
If Yes, How Would You Rate the Effectiveness of This Training in Strengthening the Capacity to Deliver Services in Your Countries?

Respondent	Highly Effective	Moderately Effective	Not Very Effective	Cannot Be Determined	Response Total
USAID CTO	25%	75%	0	0	4
CA	100%	0	0	0	9

Table D15
Are Other Donors in Your Countries Making Contributions to HCD for Service Providers?

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

Table D16
Is There Donor Coordination on HCD Issues in Your Countries?

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

Table D17
In Your Countries, How Would You Rank Each Health Program Element in Terms of Future Demands on Service Delivery HCD?

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

Table D18
What Type of Health Worker Should Receive Priority Attention in Future Service Delivery HCD Efforts in Your Countries?

Respondent/ Health Worker Type	High Priority	Medium Priority	Low Priority	Response Total
USAID CTO				
Doctors	40%	40%	20%	5
Nurse-midwives	100%	0	0	5
Traditional Nurse-midwives	20%	60%	20%	5
Paramedics	60%	40%	0	5
Community Workers	60%	40%	0	5
Traditional Healers	0	20%	80%	5
CA				
Doctors	33%	56%	11%	9
Nurse-midwives	100%	0	0	9
Traditional Nurse-midwives	56%	33%	11%	9
Paramedics	56%	44%	0	9
Community Workers	89%	11%	0	9
Traditional Healers	22%	56%	22%	9

Table D19
How Would You Rank the Importance of the Following Common HCD Service Provider Imbalances in Your Countries?

Respondent/Imbalance	Greatly Important	Moderately Important	Low Importance	Not Important	Response Total
USAID CTO					
Ratio of New Entrants to Total Provider Stock Too Low	20%	80%	0	0	5
Ratio of Specialists to Generalists Too High	0	60%	40%	0	5
Ratio of Doctors to Nurses Too High	20%	40%	0	40%	5
Ratio of Nurses to Auxiliary Nurse-midwives Too High	0	50%	25%	25%	5
Ratio of Urban to Rural Providers Too High	80%	20%	0	0	5
Ratio of Emigrant to Retained Providers Too High	25%	0	75%	0	4
CA					
Ratio of New Entrants to Total Provider Stock Too Low	43%	29%	29%	0	7
Ratio of Specialists to Generalists Too High	25%	50%	25%	0	8
Ratio of Doctors to Nurses Too High	50%	25%	25%	0	8
Ratio of Nurses to Auxiliary Nurse-midwives Too High	14%	43%	43%	0	7
Ratio of Urban to Rural Providers Too High	62%	38%	0	0	8
Ratio of Emigrant to Retained Providers Too High	14%	43%	14%	29%	7

Table D20
How Would You Rank the Importance of the Following Service Delivery HCD Issues in Your Countries?

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

Table D21

In Your Opinion, What is the Likelihood (Probability) That USAID Resources and Technical Assistance Could be Effective in Changing Policies and Practices in the Following HCD Areas Given Your Host Country Political, Regulatory, and Legal Environments?

Respondent/HCD Area	High Probability	Moderate Probability	Low Probability	Response Total
USAID CTO				
Staff Recruitment	0	0	100%	5
Staff Deployment	0	60%	40%	5
Career Development	0	100%	0	5
Staff Retention	0	40%	60%	5
Staff Appraisal	40%	60%	0	5
Time/Attendance Reporting	20%	20%	60%	5
Employee Incentives	20%	40%	40%	5
Service Conditions	0	80%	20%	5
Terms of Employment	0	40%	60%	5
Preservice Training	80%	20%	0	5
Inservice Training	60%	40%	0	5
Certification/Accreditation	60%	40%	0	5
Civil Service Reform	0	20%	80%	5
Workload Planning	40%	40%	20%	5
Training HR Specialists	40%	40%	20%	5
CA				
Staff Recruitment	22%	44%	33%	9
Staff Deployment	33%	22%	44%	9
Career Development	11%	67%	22%	9
Staff Retention	0	89%	11%	9
Staff Appraisal	33%	56%	11%	9
Time/Attendance Reporting	11%	56%	33%	9
Employee Incentives	11%	56%	33%	9
Conditions of Service	0	44%	56%	9
Terms of Employment	0	56%	44%	9
Preservice Training	56%	33%	11%	9
Inservice Training	56%	33%	11%	9
Certification/Accreditation	67%	11%	22%	9
Civil Service Reform	0	56%	44%	9
Workload Planning	33%	56%	11%	9
Training HR Specialists	50%	38%	12%	9

APPENDIX E

**OPEN-ENDED RESPONSES TO SURVEY QUESTION 18a:
WHAT ARE IMPORTANT HCD INITIATIVES TO CONSIDER
IMPLEMENTING?**

**OPEN-ENDED RESPONSES TO SURVEY QUESTION 18a:
WHAT ARE IMPORTANT HCD INITIATIVES TO CONSIDER
IMPLEMENTING?**

What Would Be Important HCD Initiatives to Consider Implementing in Your Country?

Respondent/Country	Response
Country Coordinator	
Indonesia	Owing to the country's push to decentralize the delivery of health services, strengthen technical and system capabilities at the regency (kabupaten) level.
	Address issues pertaining to the quality of care and encourage more effective administration/management of the service delivery system.
Kenya	Promote incentives for RH service providers, better supervision, and efficient workload planning (Kenya has lots of staff who do not always have a lot to do).
South Africa	Recruit and train more nurses. Also consider introducing financial incentives for community health workers.
USAID Mission	
Bangladesh	More pre and inservice training for skill development. Also place greater emphasis on performance management for community-based service providers.
Cambodia	Institute salary incentives based on performance (government rather than donor driven) and identify and reward achievements among health providers.
	Cost-recovery initiatives are needed to better fund health services and generate higher staff salaries and working conditions.
Egypt	Update medical and nursing school curriculums to be more competency-based and oriented toward evidence-based clinical practice.
	Strengthen the teaching and training capabilities of university faculties and MOHP trainers.
	Develop and update information technology (IT) applications used by students and professionals in medical and nursing schools.
Malawi	Support local institutions to increase capacity (e.g., by supporting lecturer/tutor training).
	Undertake studies of HR needs (e.g., through situation analysis) and develop specific HR policies and interventions.
Senegal	Provide more training in health program planning and system analysis, training in monitoring/evaluation, and specific technical skills.
Uganda	Focus initially on improving inservice and preservice training—we will need to use inefficient vertical training programs until the training system improves.
	Incentives and performance monitoring are critical but cannot be addressed effectively through a health sector program. This is a civil service policy issue.
Ukraine	Civil service reform is most critical, along with reducing the number of physicians trained, increasing the number of nurses and support staff.
	Greater emphasis needs to be given to primary health care rather than specialized curative services.
	The health system needs to be rationalized, patients need to pay for services, and health providers need to be paid.
	Health facilities need to be appropriate to need (with some hospitals closed), and pharmaceuticals need to be procured and paid for.
Zambia	Greater support to preservice training and established training institutions instead of the current focus on disease specific inservice training.
	Technical support to human resources management, including recruitment and retention.
	Participating with national governments in establishing incentive schemes for health workers, such as home ownership and transportation/loan schemes.

What Would Be Important HCD Initiatives to Consider Implementing in the Countries Where Your Organization (CA) is Working?

Respondent	Response
USAID CTO	Work with decentralized health regions to improve HCD for all facility-based clinical health care.
	Go beyond pre and inservice training and incorporate more management, supervision, and deployment issues in technical assistance work.
Cooperating Agencies	Better staff recruitment and deployment systems are needed. Encourage motivation and incentive strategies that enhance performance and staff retention.
	More work in health manpower planning and the identification of future skill sets is needed.
	Better protect human capital in the health sector, especially in settings with elevated HIV/AIDS prevalence and high-risk occupations.
	Promote quality assurance by giving greater attention to accreditation, certification, and licensing of service providers.
	Improve preservice curricula so that inservice training is eventually needed less.
	Give greater attention to the in-country distribution of staff (in many cases distribution is the problem, not absolute numbers of staff trained).
	Improve service outreach (again, numbers may not be the greatest HR problem) by increasing staff abilities to do outreach.
	USAID's commitment to inservice training needs to be continued while providing more HR management training for supervisors.
	Try out performance appraisal and remuneration systems for improved performance (e.g., performance contracting).
	Much more work is needed on evaluation and operations research to determine the effectiveness of different HCD approaches.
	Greater utilization of on-the-job training and distance learning methods should be promoted in future HCD work.
	Much HCD work is done outside the ministries of health. We should be working more with ministries of finance (for education funding), ministries of education (for nursing and medical education) and ministries of labor (for remuneration, incentive structures, deployment, and production policies).
	We need to work with various ministries and the private sector in dealing with licensing, tax incentives, drug dispensing, importation regulations, and so on.
	USAID projects do HCD work all the time, but there is no place where this experience is captured and reviewed to see what we know and assess new ideas. As a result we are spending millions of dollars on training, supervision courses, etc., without knowing what others are doing and without rigorous analysis of whether it is working. HCD is a critical priority but we do not do it well, we do not coordinate our work, we do not systematically evaluate it, and we do not share experiences (e.g., best and worst practices).
	Donor projects tend to focus on the production of health workers, supervision training, and the quality of work done by providers (mainly in the public sector). The real issues in HCD are distribution of health manpower within a country, motivation of workers to perform primarily related to salary and benefits, and drug and supply logistics so that workers have the materials they need to actually perform the work the systems ask of them. We generally do not consider these areas as HCD issues, but they are.
We are all looking for quick fixes/successes. HCD is a long-term but critical thing and it affects everything we do. It is high time we do something, but the probability of doing anything that will have an impact on the short term is low. We should do something, but do not expect quick changes.	

APPENDIX F

**HUMAN CAPACITY DEVELOPMENT NEEDS AND ACTIONABLE
PRIORITIES REPORTED BY USAID FIELD MISSIONS**

HUMAN CAPACITY DEVELOPMENT NEEDS AND ACTIONABLE PRIORITIES REPORTED BY USAID FIELD MISSIONS

Table F1

How Would You Characterize Trends in Per Capita Availability of Health Service Providers in Your Host Country by Geographic Area Over the Past Decade?

Geographic Area	Greatly Deteriorated	Declined Somewhat	Remained Same	Improved	Greatly Improved	Response Total
Urban	Malawi Zambia	Kenya Senegal	Uganda	Bangladesh Cambodia Ukraine	Egypt	9
Rural	Malawi Senegal Uganda Zambia	Kenya Ukraine		Bangladesh Cambodia Egypt		9
National	Malawi Uganda Zambia	Kenya Senegal Ukraine		Bangladesh Cambodia Egypt		9

Table F2

How Would You Rank the Importance of the Following Common HCD Service Provider Imbalances in Your Country?

Provider Imbalance	Greatly Important	Moderately Important	Low Importance	Not Important	Response Total
Ratio of New Entrants to Total Provider Stock Too Low	Malawi Senegal Zambia	Bangladesh Cambodia	Uganda Ukraine	Egypt	8
Ratio of Specialists to Generalists Too High	Ukraine	Senegal	Bangladesh Cambodia Egypt	Malawi Uganda Zambia	8
Ratio of Doctors to Nurses Too High	Egypt Zambia	Bangladesh Senegal Ukraine	Cambodia	Malawi Uganda	8
Ratio of Nurses to Auxiliary Nurse-midwives Too High	Bangladesh Zambia	Cambodia Senegal Uganda	Ukraine	Egypt Malawi	8
Ratio of Urban to Rural Providers Too High	Bangladesh Egypt Senegal Uganda Zambia	Malawi Ukraine	Cambodia		8
Ratio of Emigrant to Retained Providers Too High	Zambia		Uganda Ukraine	Bangladesh Cambodia Egypt Malawi Senegal	8

Table F3
Which HCD Components Are Being Addressed in Your Projects at the Present Time?

HCD Component	Yes	No	Don't Know	Response Total
Supply System for Health	Bangladesh Cambodia Egypt Malawi	Kenya Senegal Uganda Zambia	Ukraine	9
Performance Management	Bangladesh Cambodia Egypt Senegal Ukraine Zambia	Kenya Uganda Malawi		9
Personnel Administration	Egypt Senegal Malawi Ukraine	Bangladesh Cambodia Kenya Uganda Zambia		9
Education/Training of Service Providers	Bangladesh Cambodia Egypt Kenya Malawi Senegal Uganda Ukraine Zambia			9
Integration of HR and Health System	Bangladesh Egypt Malawi Zambia	Cambodia Kenya Uganda Ukraine	Senegal	9

Table F4
How Would You Rank the Importance of the Following Service Delivery HCD Issues in Your Country?

Service Delivery Issue	High Priority	Medium Priority	Low Priority	Response Total
Staff Recruitment	Bangladesh Malawi Senegal Zambia	Cambodia Egypt Kenya	Uganda Ukraine	9
Staff Deployment	Cambodia Egypt Kenya Senegal Zambia	Bangladesh Malawi Uganda	Ukraine	9
Career Development	Bangladesh Cambodia Malawi Senegal Zambia	Egypt Kenya Uganda Ukraine		9
Staff Retention	Bangladesh Cambodia Egypt Malawi Senegal Zambia	Kenya	Uganda Ukraine	9
Staff Appraisal	Bangladesh Egypt Malawi Senegal Uganda Zambia	Cambodia Kenya Ukraine		9
Time/Attendance Reporting	Bangladesh Cambodia Egypt Senegal Zambia	Malawi	Uganda Ukraine	8
Employee Incentives	Cambodia Malawi Senegal Uganda Zambia	Bangladesh Egypt Ukraine		8
Service Conditions	Cambodia Egypt Malawi Senegal Uganda Ukraine Zambia	Bangladesh		8
Terms of Employment	Cambodia Malawi Senegal Uganda Ukraine Zambia	Bangladesh Egypt		8
(Continued on following page)				

Service Delivery Issue	High Priority	Medium Priority	Low Priority	Response Total
Preservice Training	Bangladesh Cambodia Egypt Malawi Senegal Uganda Ukraine Zambia	Kenya		9
Inservice Training	Bangladesh Cambodia Egypt Malawi Uganda Ukraine Zambia	Kenya Senegal		9
Certification/Accreditation	Bangladesh Cambodia Egypt Kenya Senegal Uganda Ukraine	Malawi Zambia		9
Civil Service Reform	Cambodia Kenya Uganda Zambia	Bangladesh Malawi Senegal Ukraine	Egypt	9
Workload Planning	Bangladesh Cambodia Malawi Zambia	Egypt Senegal Ukraine	Uganda	8
Training HR Specialists	Bangladesh Cambodia Zambia	Egypt Malawi Uganda	Senegal Ukraine	8

Table F5
What is the Likelihood (Probability) That USAID Resources and Technical Assistance
Could Be Effective in Changing Policies and Practices in the Following HCD Areas Given
Your Host Country Political, Regulatory, and Legal Environments?

HCD Area	High Probability	Moderate Probability	Low Probability	Response Total
Staff Recruitment	Malawi	Cambodia Zambia	Bangladesh Egypt Kenya Senegal Uganda Ukraine	9
Staff Deployment	Cambodia Malawi Zambia	Egypt	Bangladesh Kenya Senegal Uganda Ukraine	9
Career Development	Bangladesh Cambodia Malawi	Egypt Senegal Ukraine Zambia	Kenya Uganda	9
Staff Retention	Zambia	Cambodia Malawi	Bangladesh Egypt Kenya Senegal Uganda Ukraine	9
Staff Appraisal		Bangladesh Egypt Malawi Ukraine Zambia	Cambodia Kenya Senegal Uganda	9
Time/Attendance Reporting		Bangladesh Cambodia	Egypt Kenya Malawi Senegal Uganda Ukraine Zambia	9
Employee Incentives		Cambodia Senegal Ukraine	Bangladesh Egypt Kenya Malawi Uganda Zambia	9
Service Conditions	Malawi	Bangladesh Cambodia Egypt Ukraine	Kenya Senegal Uganda Zambia	9
Terms of Employment		Bangladesh Malawi Ukraine	Cambodia Egypt Kenya Senegal Uganda Zambia	9
(Continued on following page)				

HCD Area	High Probability	Moderate Probability	Low Probability	Response Total
Preservice Training	Cambodia Egypt Malawi Uganda Ukraine Zambia	Bangladesh Kenya	Senegal	9
Inservice Training	Cambodia Egypt Malawi Uganda Ukraine Zambia	Bangladesh Kenya Senegal		9
Certification/Accreditation	Bangladesh Cambodia Ukraine Zambia	Egypt Kenya Malawi Senegal Uganda		9
Civil Service Reform		Bangladesh Malawi Ukraine	Cambodia Egypt Kenya Senegal Uganda Zambia	9
Workload Planning	Bangladesh	Cambodia Egypt Malawi Uganda Zambia	Kenya Senegal Ukraine	9
Training HR Specialists	Bangladesh Cambodia Uganda Zambia	Egypt	Kenya Malawi Senegal Ukraine	9

APPENDIX G

**HUMAN CAPACITY DEVELOPMENT NEEDS AND ACTIONABLE
PRIORITIES REPORTED BY COOPERATING AGENCIES**

HUMAN CAPACITY DEVELOPMENT NEEDS AND ACTIONABLE PRIORITIES REPORTED BY COOPERATING AGENCIES

Table G1

How Would You Characterize Trends in Per Capita Availability of Health Service Providers in the Countries Where Your Organization Works Over the Past Decade?

Location	Greatly Deteriorated	Declined Somewhat	Remained Same	Improved	Greatly Improved	Response Total
Urban	MSH	Pathfinder URC	BASICS II	JSI JHPIEGO PHR <i>plus</i> PRIME II		8
Rural	MSH Pathfinder	JSI URC	BASICS II JHPIEGO PRIME II	PHR <i>plus</i>		8
National	MSH	Pathfinder URC	BASICS II JSI	JHPIEGO PHR <i>plus</i> PRIME II		8

Table G2

How Would You Rank the Importance of the Following Common HCD Service Provider Imbalances in the Countries Where Your Organization is Working?

Service Provider Imbalance	Greatly Important	Moderately Important	Low Importance	Not Important	Response Total
Ratio of New Entrants to Total Provider Stock Too Low	BASICS II MSH URC	Pathfinder JHPIEGO	PRIME II		6
Ratio of Specialists to Generalists Too High	BASICS II JHPIEGO	Pathfinder MSH PRIME II	PHR <i>plus</i> URC		7
Ratio of Doctors to Nurses Too High	BASICS II JHPIEGO Pathfinder	MSH PHR <i>plus</i>	PRIME II URC		7
Ratio of Nurses to Auxiliary Nurse-midwives Too High	JHPIEGO	MSH URC	BASICS II Pathfinder PRIME II		6
Ratio of Urban to Rural Providers Too High	BASICS II JHPIEGO MSH Pathfinder	PHR <i>plus</i> PRIME II URC			7
Ratio of Emigrant to Retained Providers Too High	JHPIEGO	Pathfinder PRIME II	MSH	BASICS II URC	6

Table G3
Which HCD Components Are Being Addressed in Your Projects at the Present Time?

HCD Component	Yes	No	Don't Know	Response Total
Supply System for Health	JHPIEGO PHR <i>plus</i> URC	BASICS II MSH PRIME II	JSI	7
Performance Management	JHPIEGO JSI PRIME II URC	BASICS II MSH PHR <i>plus</i>		7
Personnel Administration	PRIME II URC	BASICS II JHPIEGO MSH PHR <i>plus</i>	JSI	7
Education/Training of Service Providers	JHPIEGO JSI MSH PHR <i>plus</i> PRIME II URC	BASICS II		7
Integration of HR and Health System	JHPIEGO URC	BASICS II MSH PHR <i>plus</i> PRIME II	JSI	7

Table G4
How Would You Rank the Importance of the Following Service Delivery HCD Issues in the Countries Where Your Organization Works?

HCD Issue	High Priority	Medium Priority	Low Priority	Response Total
Staff Recruitment	JHPIEGO JSI MSH	BASICS II Pathfinder PRIME II	PHR <i>plus</i> URC	8
Staff Deployment	BASICS II JHPIEGO MSH Pathfinder PRIME II URC	JSI PHR <i>plus</i>		8
Career Development	BASICS II JHPIEGO MSH PHR <i>plus</i> PRIME II URC	JSI Pathfinder		8
Staff Retention	JHPIEGO JSI MSH Pathfinder PRIME II URC	PHR <i>plus</i> BASICS II		8
(Continued on following page)				

HCD Issue	High Priority	Medium Priority	Low Priority	Response Total
Staff Appraisal	JSI MSH PHR <i>plus</i> PRIME II URC	BASICS II JHPIEGO	Pathfinder	8
Time/Attendance Reporting	MSH PHR <i>plus</i> URC	JHPIEGO JSI PRIME II	BASICS II Pathfinder	8
Employee Incentives	BASICS II JHPIEGO JSI MSH PHR <i>plus</i> PRIME II URC	Pathfinder		8
Service Conditions	BASICS II JHPIEGO MSH URC	JSI PHR <i>plus</i> PRIME II	Pathfinder	8
Terms of Employment	BASICS II JHPIEGO MSH URC	JSI Pathfinder PHR <i>plus</i> PRIME II		8
Preservice Training	BASICS II JHPIEGO JSI MSH Pathfinder PHR <i>plus</i> URC	PRIME II		8
Inservice Training	BASICS II JHPIEGO JSI MSH Pathfinder PHR <i>plus</i> URC	PRIME II		8
Certification/ Accreditation	JHPIEGO JSI Pathfinder PHR <i>plus</i>	MSH PRIME II URC	BASICS II	8
Civil Service Reform	JHPIEGO MSH Pathfinder PHR <i>plus</i> URC	JSI PRIME II	BASICS II	8
Workload Planning	JHPIEGO MSH Pathfinder PHR <i>plus</i> PRIME II URC	JSI	BASICS II	8
Training HR Specialists	JSI MSH PHR <i>plus</i> URC	JHPIEGO Pathfinder PRIME II	BASICS II	8

Table G5
What is the Likelihood (Probability) That USAID Resources and Technical Assistance
Could be Effective in Changing Policies and Practices in the Following HCD Areas Given
Indigenous Political, Regulatory, and Legal Environments?

HCD Area	High Probability	Moderate Probability	Low Probability	Response Total
Staff Recruitment	PRIME II	JHPIEGO JSI MSH URC	BASICS II Pathfinder PHR <i>plus</i>	8
Staff Deployment	JHPIEGO PRIME II	MSH URC	BASICS II JSI Pathfinder PHR <i>plus</i>	8
Career Development	PRIME II	JHPIEGO JSI Pathfinder PHR <i>plus</i> URC	BASICS II MSH	8
Staff Retention		JHPIEGO JSI MSH Pathfinder PHR <i>plus</i> PRIME II URC	BASICS II	8
Staff Appraisal	Pathfinder PRIME II URC	JHPIEGO MSH PHR <i>plus</i> JSI	BASICS II	8
Time/Attendance Reporting	URC	JHPIEGO MSH PHR <i>plus</i> PRIME II	BASICS II JSI Pathfinder	8
Employee Incentives	JHPIEGO	JSI PHR <i>plus</i> PRIME II URC	BASICS II MSH Pathfinder	8
Service Conditions		JHPIEGO PHR <i>plus</i> PRIME II	BASICS II JSI MSH Pathfinder URC	8
Terms of Employment		JHPIEGO JSI PRIME II URC	BASICS II MSH Pathfinder PHR <i>plus</i>	8
Preservice Training	JHPIEGO JSI MSH Pathfinder	PHR <i>plus</i> PRIME II URC	BASICS II	8
(Continued on following page)				

HCD Area	High Probability	Moderate Probability	Low Probability	Response Total
Inservice Training	JHPIEGO MSH JSI URC	Pathfinder PHR <i>plus</i> PRIME II	BASICS II	8
Certification/ Accreditation	JHPIEGO JSI Pathfinder PHR <i>plus</i> URC	PRIME II	BASICS II MSH	8
Civil Service Reform		JHPIEGO JSI PRIME II URC	BASICS II MSH Pathfinder PHR <i>plus</i>	8
Workload Planning	PRIME II JHPIEGO JSI	MSH Pathfinder PHR <i>plus</i> URC	BASICS II	8
Training HR Specialists	JHPIEGO JSI MSH URC	Pathfinder PHR <i>plus</i> PRIME II	BASICS II	8

APPENDIX H

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