Human Resources for Health (HRH) Indicator Compendium

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For questions or comments, please contact Sara Pacqué-Margolis or Crystal Ng.

INTRODUCTION

Methodology

This compendium provides a list of published indicators on human resources for health (HRH) organized according to the results framework of the Capacity*Plus* project. The objective of this compendium is to provide a tool for HRH systems strengthening practitioners interested in monitoring HRH projects and programs.

In order to provide a valuable set of measurement tools, indicators from multiple sources were evaluated based on the widely-referenced criteria for data quality: accuracy, reliability, completeness, precision, timeliness, and integrity[1]. Each indicator relates to a specific desired output or outcome, can be quantified, is associated with an overall program result of the Capacity*Plus* project, can be realistically achieved with appropriate resources and support, and can be measured over a designated period of time. While far more extensive lists of indicators are available, many of these indicators in some of these lists do not meet these criteria and consequently compromise their usefulness for monitoring HRH results.

The Pan American Health Organization (PAHO)'s "Handbook for measurement and monitoring: Indicators of the regional goals for human resources for health. A shared commitment" and the World Health Organization (WHO)'s "Handbook on monitoring and evaluation of human resources for health" served as the primary resources for this compendium due to the level of detail and thoroughness provided by these sources. The PAHO and WHO indicators were supplemented with additional indicators specific to the Capacity*Plus* result areas. While many indicators were drawn from sources related specifically to the monitoring of HRH, some indicators were also drawn from non-HRH-specific sources, as appropriate.

Data source limitations

Many indicators require data sources that are currently not available in countries where HRH investments are being made. Examples include indicators based on data derived from population or facility surveys or functioning human resources information systems (HRIS). Lack of access to high-quality data represents a major barrier to the monitoring and evaluation of a wide range of health systems strengthening outputs and outcomes. Despite these limitations, this compendium is offered as a user-friendly and practical resource for HRH practitioners to select high-quality indicators that provide valid measurement of results directly related to their HRH investments.

Thematic gaps

While measurements such as worker productivity and retention are more readily quantified, measurements pertaining to management and partnership remain difficult to define. As a result, indicators for global leadership, HRH policy and planning, and to some extent workforce

[1] MEASURE Evaluation. 2007. Data quality assurance tool for program-level indicators. http://www.cpc.unc.edu/measure/publications/pdf/ms-07-19.pdf

development are less available than indicators for performance support. Indicators are particularly lacking for the following Capacity*Plus* result areas: human resources policy, human resources management systems, and continuing professional development (CPD).

Document structure

This document contains an indicator compendium table followed by two appendices. The indicator compendium table provides the name, description, method of calculation, and source for each indicator organized according to the Capacity*Plus* results framework. Appendix A provides information on the documents from which the indicators are drawn. The compendium may be used to obtain further information on data sources or measurement limitations, and appendix B provides additional tools that accompanied indicators in their original documents.

INDICATOR COMPENDIUM TABLES

Global Leadership

Indicator	Description/Definition	Method of Calculation	Source
Partnerships			
Relations with government entities	Organization has relations with government entities, for coordinated implementation and/or advocacy for policy change.	See table in appendix B	2
Relations with technical agencies	Organization has relations with technical agencies (e.g., UN agencies, large nongovernmental organizations, local universities, others that offer technical assistance) and knows where it can get technical assistance when needed.	See table in appendix B	2
Relations with other nongovern-mental implementers	Organization has relations with other implementers in the area, so that it can complement its programming competencies with those of other agencies.	See table in appendix B	2
Relations with potential donors	Organization maintains relations with a diverse set of potential donors and keeps them informed of its work, so that it can efficiently take advantage of funding opportunities as they arise.	See table in appendix B	2
Leadership			
Leadership development	There is a systematic process for developing and choosing new leaders on a periodic basis.	See table in appendix B	2
Leadership development program established for managers at all levels (hospital or administrative unit)	A leadership development program that prepares leaders at all levels has been institutionalized. There is a clear leadership transition policy and plan to implement it.	Yes/no	7
Accountability of leadership	There is a systematic process so that decisions are made in a way that all staff are aware of them and understand.	See table in appendix B	2

Indicator	Description/Definition	Method of Calculation	Source
Participation in decision-making	Everyone in organization feels that they have been sufficiently consulted and their concerns addressed for important decisions.	See table in appendix B	2
Work group commitment	The work group is committed to the organization's mission and to continuous learning, improvement, and innovation.	Yes/no	3
Leadership focus	The work group has identified priority challenges and selected actions that address barriers to achieving results.	Yes/no	3
Contextual understanding	The work group can provide valid and relevant evidence about the nature of its internal and external environments, quality and extent of its performance, and resources available on best practices, and can identify challenges within and facing the team.	Yes/no	3
Alignment and mobilization	Work group responsibilities and resources are internally aligned and work group goals are externally aligned in order to address selected challenges and meet stated objectives.	Yes/no	3

Health Workforce Policy, Planning, and Management

Indicator	Description/Definition	Method of Calculation	Source
Basic HRH Indicators			
Stock (and density) of HRH	Total no. of health human resources (relative to the population).	Total no. of health workers in a given country/(Total population of the same country)	6
Skills mix	Distribution of HRH by occupation, specialization, or other skill-related characteristic.	No. of physicians, nurses, and midwives (or other categories of health service providers)/Total no. of health workers	6
Geographical distribution	Rural to urban distribution of HRH.	Density of human resources for rural areas of the country (total physicians, nurses, and midwives per 10,000 population)/Density of human resources for urban areas of the country (total physicians, nurses, and midwives per 10,000 population)	4
Age distribution	Distribution of HRH by age group.	No. of health workers of a given age group/ Total no. of health workers	6

Indicator	Description/Definition	Method of Calculation	Source
Gender distribution	Distribution of HRH by sex.	No. of female (or male) health workers/ Total no. of health workers	6
Institutional sector	Distribution of health workers by sector of activity.	No. of health workers employed in the public (versus private or nongovernmental) sector/Total no. of health workers	6
% of primary health care physicians	No. of primary health care physicians as a percentage of the total no. of physicians.	Total no. of primary care physicians x 100/ Total no. of licensed physicians in the country	4
Policy			
Level of development of an HRH unit	At least two key informants (and the best results will be obtained by involving three key informants) should classify the characteristics of the unit of human resources for health from the checklist provided.	See table in appendix B	4
HRH self-sufficiency policy	Existence of self-sufficiency policy. Self-sufficiency in HRH emphasizes strategic investment in country infrastructure development to enhance its overall capacity to achieve a more optimal, stable, and appropriately distributed health workforce through more effective recruitment and retention policies and programs.	Yes/no	4
% of health jobs covered by health and safety policies	Health and safety policies for health workers include any measures that are provided to ensure the quality and safety of the health services workplace, such as up-to-date and repaired equipment, clean environments, structurally safe work areas, the provision of safety training, health insurance coverage, and the provision of health care services.	Total no. of jobs in the health sector covered by health and safety measures x 100/Total no. of jobs in the health sector	4
Human Resources Management/Planning			
National HRH planning and management strategy	National HRH strategy developed, including a set of SMART indicators and targets, and with costed (budgeted) prioritized workplan for implementation and monitoring at the national and subnational levels.	Yes/no	6
HRH expenditure, total and per capita	HRH expenditure, total, per capita, and as a proportion of total expenditure on health (in national currency units, in US dollars, and in international dollars).	Total HRH expenditure/Total population or total expenditure on health	6
HRH expenditure by category	Breakdown of HRH expenditure by place of work (hospitals, ambulatory centers, public health offices), sector (public, private for-profit, private not-for-profit), employment status (regular employees, self-employed workers), occupational function (health service providers [direct patient care], health system management and support personnel).		6
Management budget	% of budget allocated to human resources management (HRM) or human resources development (HRD) annually.	Budget allocated to HRM or HRD/Total budget	5

Indicator	Description/Definition	Method of Calculation	Source
CPD budget planning	Existence of budgetary provision for in-service/continuing education training.	Yes/no	1
Staff requirement planning	Existence of institutional models for projecting, monitoring, and evaluating staffing requirements.	Yes/no	1
% of health services and program managers certified in health management	Health services and program managers are understood to be any professional that has been chosen to lead health institutions. Specific requirements for public health and management competencies, including ethics training, require certification in public health and management whether through a university course or in-service training. The contents of these courses develop public health and management competencies, and greater comprehension of ethical principles necessary for the effective performance of those management functions.	No. of managers with health management courses x 100/Total no. of managers leading health units and programs See follow-up questions in appendix B	4
Development of primary health care teams	Each of the questions on primary health care service delivery will be awarded between 0 and 10 points depending on level of country team development and the range of services provided. The scores for each question will be totaled to provide an overall country indicator.	See table in appendix B	4
Strategy for handling labor conflicts	Effective negotiation mechanisms and legislation to prevent, mitigate, or resolve labor conflicts and ensure essential services if they happen. Essential services are defined as those critical, nonelective health care services whose provision is required to save or sustain human life.	Essential services legislation currently exists: yes/no Formal negotiation mechanisms currently exist: yes/no	4
Foreign credential recognition	Existence of mechanisms for foreign health professionals credential recognition.	Yes/no	4
Human Resources Information Systems (HRIS)			
Existence of an HRIS advisory body	Regular meetings and consultations among national and international stakeholders in health, development, and information management to steer and monitor implementation of the HRH information and monitoring system.	Yes/no	6
National HRIS coordinating mechanism	Existence of a national coordinating mechanism with a dedicated unit with sufficient resources (human, financial, and technical) to develop, implement, and monitor the information system.	Yes/no	6
HRIS used for HRH decision-making	Contents of the HRH information system used to inform decision-making among health authorities at the national and subnational levels on a regular basis (e.g., annual planning and management review).	Yes/no	6
Timeliness of the HRH information and monitoring system	National HRH information and monitoring system populated with data at the subnational and national levels on a regular basis (e.g., quarterly/annually).	Yes/no	6

Indicator	Description/Definition	Method of Calculation	Source
Validation of the HRH information and monitoring system	Comprehensive review of all available HRH data sources conducted and used to update and calibrate the national HRH information and monitoring system on a regular basis (e.g., biennially/quinquennially).	Yes/no	6
Consistency of the HRH information and monitoring system	All indicators and data within the HRH information and monitoring system use a common set of definitions and classifications allowing for consistent comparisons over time, across sources, and at the international level.	Yes/no	6
Disaggregation of data	All relevant indicators and data within the HRH information and monitoring system can be disaggregated by cadre, gender, geographical area, sector, or other characteristics.	Yes/no	6

Health Workforce Development

Indicator	Description/Definition	Method of Calculation	Source
Preservice Education			
% of secondary school graduates	No. of students graduating from secondary school, e.g., expressed as % of all children of secondary schooling age.		6
Application rate, per cadre	No. of applicants per seat* available, per cadre (over a given period). *Also termed "training place"		6, 5
Applicants accepted (no. and %), per cadre	No. and % of applicants accepted for health education training programs, per cadre.	No. of applicants accepted into a specific education program to become a health worker/No. of applicants to a specific education program to become a health worker	6, 5
% of health schools accredited	Schools of clinical health sciences and, specifically, public health accredited by a recognized accreditation body.	No. of accredited schools of clinical health sciences or schools of public health x 100/Total no. of schools of clinical health sciences or schools of public health	4
% of training programs that match or surpass position requirements	Current % of training programs for the designated professional groups (nurses, nursing auxiliaries, health technicians, and community health workers) that match or surpass the stated requirements for current employment positions.	Total no. of training programs that match or surpass requirements x 100/ Total no. of training programs for the designated health professions	4

Indicator	Description/Definition	Method of Calculation	Source
% of courses on priority diseases	Proportion of courses devoted to country priority diseases.	No. of courses devoted to country priority diseases/Total no. of courses	5
Training strategy addresses community health needs	Schools of clinical health sciences will have reoriented their education toward primary health care and community health needs and adopted interprofessional training strategies.	Yes/no on scale of 0-3 for each item below, for a total score of 0-15: Training (for physicians, nurses, and midwives) is not centered on biomedical model Inclusion of primary health care contents in the curriculum Inclusion of primary health care practices in the curriculum (e.g., through clinical experience in community or primary health care centers) Existence of interprofessional training strategies in the schools of clinical health sciences Existence of financial support for interprofessional training	4
Training place capacity, per cadre and health education institution	No. of education and training places per cadre and health education institution.		6
Student:faculty ratio, per cadre and health education institution	No. of students per (full-time) qualified instructor, per cadre and health education institution.		6, 1
Instructor attrition rate, per cadre and health education institution	Attrition (turnover) rate among instructors, per cadre and health education institution (over a given period).		6

Indicator	Description/Definition	Method of Calculation	Source
Student attrition rate, per cadre and health education institution	Attrition (drop-out) rate per student cohort, per cadre and health education institution (over a given period).	No. of medical students that enrolled in year t x 100/No. of medical students that graduated in year t+ no. of years in career x	6, 4
Annual no. of graduates, per cadre and health education institution	No. of students graduating each year, per cadre and health education institution.		6
Licensure of nationally trained health workers (no. and %)	No. and % of new nationally trained health workers granted professional certification/licensure, per cadre.		6
Licensure of internationally trained (foreign-trained) health workers (no. and %)	No. and % of new internationally trained (foreign-trained) health workers granted professional certification/licensure, per cadre.		6
Establishment of global code of practice and international recruitment ethical norms (country level)	A global code of practice refers to an international agreement on ways and means to ethically recruit and manage skilled health workers. The code focuses on three broad themes: protecting individual migrant workers from unscrupulous recruiters and employers; ensuring that individuals are properly prepared for and supported by their places of employment; and ensuring that flows of migrant health workers do not unduly disrupt the health services of the source countries. Ethical norms refers to formal standards to guide countries in the international recruitment of health workers, based on the principles of transparency, fairness, and mutuality of benefit with respect to source countries, destination countries, institutions, recruiting agencies, and migrant health workers.	Yes/no: Has adopted a global code of practice—yes: 50% or no: 0% Has established ethical norms for international recruitment—yes: 50% or no: 0%. Total score is 0% to 100%	4
Workforce generation ratio	Ratio of entry to the health workforce.	No. of graduates of health professions education institutions in the last year/Total no. of health workers	6
In-Service Systems			
% of facility staff who received in-service training, by cadre and type of training	Percentage of facility staff receiving in-service training during a reference period (e.g., annually), by cadre and type of training.	No. of facility staff receiving in-service training/Total staff	6
Continuing Professional Development			
% of facility staff participating in	Percentage of facility staff receiving in-service training/continuing education annually (also measured by	No. of facility staff receiving in-service	1

Indicator	Description/Definition	Method of Calculation	Source
CPD, by cadre	days of training per staff member annually), by cadre.	training/Total staff	

Health Workforce Performance Support

Indicator	Description/Definition	Method of Calculation	Source
Retention			
Health worker geographic retention	Percentage of health workers whose current primary health care practice setting is the same geographic location as their own community. "Their own community" is defined as the geographic location (city/town and country) that the primary health worker identifies as his or her place of birth.	Total no. of primary health care workers practicing in their own community x 100/Total no. of primary health care workers currently employed in the country	4
Staff satisfaction	Staff feel satisfied and well treated by the organization.	See table in appendix B	2
% of health service employment positions without social protection	Social protection from precarious, unprotected employment for health service providers differs from country to country, but is considered to include—at a minimum—health insurance, pension, and sick leave/maternity leave.	Total no. of health service employment positions in the country that are without social protection/Total no. of health employment positions in the country	4
Workforce loss ratio	Ratio of exits from the health workforce (can be subdivided based on data available for cadre, reason for leaving, etc.).	No. of health workers who left the active labor force in the last year/Total no. of health workers	6
Productivity			
Labor force activity rate	Proportion of HRH currently active in the labor force (over a given period).	No. of persons with health-related skills active in the labor force/Total no. of persons of working age with health-related skills	6
Employment/ unemployment rate	Proportion of HRH currently employed (or unemployed) (over a given period).	No. of persons with health-related skills currently employed (or unemployed)/Total no. of persons with health-related skills active in the labor force	6
Provider productivity	Relative no. of specific tasks performed among health workers.	Specific tasks performed over a given period (e.g., ambulatory visits, immunizations, surgeries) by a given	6

Indicator	Description/Definition	Method of Calculation	Source
		health service provider/Total no. of specific tasks performed over the same period among all health service providers	
Absenteeism	Days of absenteeism among health workers.	No. of days of employee absences over a given period in the health workplace/ Total no. of scheduled working days among employees over the same period in the same place	6
	Average no. of hours worked per week per HRH category.	Hours worked/1 week	5
Dual employment	Proportion of HRH currently employed at more than one location.	No. of health workers currently employed at more than one location/Total no. of health workers	6

Appendix A: Reference Documents

	Document Name	Source Organization	Source Link
1	Development of regional HRH indicators and monitoring template	Asian Action Alliance for Human Resources for Health Development	http://aaahrh.org/documents/draft_monitoring.pdf
2	Organizational capacity and viability assessment tool (OCVAT)	Child Survival Technical Support Plus (CSTS+) Project	http://mchipngo.net/lib/components/Documents/MCP/Annexes/3_OCVAT_3.xls
3	Menu of indicators on management and leadership capacity development	Management Sciences for Health	http://erc.msh.org/toolkit/toolkitfiles/file/LM_Indicator_Menu_Not_Prgm_Specific_20072.pdf
4	Handbook for measurement and monitoring: Indicators of the regional goals for human resources for health. A shared commitment.	Pan American Health Organization	http://new.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=10910&Itemid=
5	Assessing financing, education, management and policy context for strategic planning of human resources for health	World Health Organization	http://www.who.int/hrh/tools/assessing_financing.pdf
6	Handbook on monitoring and evaluation of human resources for health	World Health Organization	http://whqlibdoc.who.int/publications/2009/9789241547703_eng.pdf
7	Tools for planning and developing human resources for HIV/AIDS and other health services	Management Sciences for Health and World Health Organization	http://www.who.int/hrh/tools/tools_planning_hr_hiv-aids.pdf

Appendix B: Measurement Tools

Quick Links

Global Leadership

Partnerships

Leadership

Health Workforce Policy, Planning, and Management

Policy

Human Resources Management/Planning

Health Workforce Development

Health Workforce Performance Support

Retention

Global Leadership

Measurement Tool						
MIN. No attainment	1. Informal activity only	2. Start of formal activity	3. Some/fair progress	4. Good progress	5. Excellent progress	MAX. Complete attainment
Partnerships						
Indicator: Relations with government entities						
Organization has no meetings or relations with government agencies, in particular the Ministry of Health. There is little or no knowledge of relevant government policies or service plans.	Organization has some knowledge of relevant government health policies and plans. Managers sometimes informally discuss these matters and how the organization should work within these parameters, but there have been no discussions with the relevant government entities.	Organization has knowledge of relevant government health policies and plans. Managers discuss these matters and how the organization should work within these parameters. Once in the last two years someone has met with a relevant government entity to discuss plans and/or policies.	Organization met at least once in the last two years with national government for advocacy and information exchange and/or meets but not regularly with local Ministry of Health to exchange information.	Organization meets but not regularly with national Ministry of Health for information exchange and advocacy and/or meets at least twice a year with local Ministry of Health to coordinate actions.	Organization usually has regular meetings with relevant government agency and knowledge of its plans/policies. Also meets at least quarterly with local Ministry of Health officials to exchange information and/or jointly plan.	Organization has regular (at least twice a year) meetings with relevant government agency. Has detailed knowledge of its plans and policies. Has done joint planning and/or evidence-based advocacy with it at least once in last two years. Also meets at least quarterly with local Ministry of Health officials to exchange information and/or jointly plan.
Indicator: Relations with technical agencies						
Organization has no contacts or knowledge of the activities or competencies of technical agencies in the country.	Organization has some knowledge about technical competencies of some agencies, but it is not sure who it would contact if help was needed in a technical area such as	Organization has contact, but not on a regular basis, with technical agencies. Has some knowledge of where to find assistance on technical topics in which it needs help, but	Organization has contacts at technical agencies and technical staff attend events at least several times a year either for information exchange or training. Managers also	Organization has contacts at technical agencies and technical staff attends events at least several times a year either for information exchange or training. Managers also	Organization usually knows where it can turn to for outside assistance but no ongoing formal relationship with outside technical agencies (such as a local	Organization has ongoing relationship or partnership with at least one technical agency, preferably local (e.g., national university) for needed technical assistance. For

Measurement Tool						
MIN. No attainment	1. Informal activity only	2. Start of formal activity	3. Some/fair progress	4. Good progress	5. Excellent progress	MAX. Complete attainment
	doing a baseline survey.	either depends on an outside donor to make the contact or has experienced problems getting the required assistance more often than not.	are aware of the technical agencies. But there is either usually dependence on an outside donor for contact or there have been problems in acquiring needed quality assistance on their own.	are aware of the technical agencies. Organization shares responsibility for getting assistance with outside donors.	university or a UN agency).	any type of technical assistance (e.g., baseline study, research analysis, or training for specialized area), organization knows specific organizations and individuals it can consult.
Indicator: Relations with other nongovernmental implementers						
Organization works in isolation. There is no knowledge of the strategies or work of other organizations.	There is knowledge of other organizations' work and informal internal discussions, mainly when planning projects and with an eye not to duplicate services.	There is knowledge of other organizations' work and efforts not to duplicate programming. Additionally, there have been discussions at least once in the last two years with another organization about collaboration of some kind.	There is sometimes consultation with the management of other organizations in the area, especially in the planning stages. There may sometimes be joint activities.	When planning projects there is sometimes internal discussion as well as consultation with others to ensure no duplication, and there has been at least one instance in last two years of joint activities with another organization.	When planning projects there is always internal discussion as well as consultation with others to ensure no duplication, and activities are often done jointly with other organizations.	Has effective partnerships working together, sharing resources, or referring clients to other nongovern-mental, private, or community organizations.
Indicator: Relations with potential donors						
Organization has no contacts or knowledge of the plans or funding priorities of potential donors with activities in the country.	Organization has some knowledge of relevant contacts and/or plans of at least some key donor agencies, but no meetings or relations with	Organization has some knowledge of relevant contacts and/or plans of at least some key donor agencies, and has had at least one	Organization has contacts with some key donors. There is some planning for regular meetings with them, but for whatever reason these	Organization has contacts with some key donors. There is planning for regular meetings with them. These meetings occur but not as often as ideal	Organization has regular contact with most if not all prioritized donors. There is knowledge of these donors' plans. Organization also on the	Organization has prioritized current/potenti al donors and has regular contact with them (at least one formal meeting in last year with all prioritized

Measurement Tool						
MIN. No attainment	1. Informal activity only	2. Start of formal activity	3. Some/fair progress	4. Good progress	5. Excellent progress	MAX. Complete attainment
	them.	meeting or activity with them.	meetings seldom occur (no formal meetings in last year with any major donor).	(some donors with formal meetings in last year, but not others).	lookout for new donors. But still not completely systematic.	donors). There is knowledge of these donors' plans. Organization is also open to and on the lookout for any new donors.
Leadership						
Indicator: Leadership development						
There is no development of new leadership, and no change of leadership has occurred in the organization within the last five years.	There is a stable lower tier of leaders, but there is no plan for or clear path for advancement in the organization. There has been no change in leaders for at least five years.	There is a plan for development of leaders and/or some clear path for advancement within the organization. It is still recent (within the last year) and there has not been enough time to assess if it is effective.	The current leaders follow active steps to promote and advance new leaders, but there is not a regular change of leadership.	There is a formal process for changing leaders. It is usually but not always followed.	There are periodic elections for new leadership. There are rules limiting the consecutive no. of terms that one person can have. But within the last five years there has been at least one problem (e.g., rules not followed for timing of elections or transition of leadership).	There are periodic elections for new leadership. There are rules limiting the consecutive no. of terms that one person can have. Transitions have occurred and have always been smooth.
Indicator: Accountability of leadership						
There is no mechanism for widely circulating in a timely manner the important decisions made by leaders. There are no plans for instituting measures to change this situation.	Although there is no formal process for informing staff and volunteers of important decisions, important decisions are discussed informally and people generally feel informed	There is some process or forum in which important decisions can be discussed. This forum is occasionally used this way, but only occasionally.	Leaders sometimes report on tasks and bringing issues forward for discussion through appropriate and open forums (staff meetings, status reports, etc.). But more than half the	There are written guidelines/rules of accountability and transparency, governing how decisions taken should be discussed and disseminated. The rules are usually (but	There is a formal and regular (at least quarterly) process in which leaders discuss decisions taken. However, at least once in the last year, this process was not	There is a formal and regular (at least quarterly) process in which leaders discuss decisions taken. If the rules for discussion and dissemination are not followed there

Measurement Tool						
MIN. No attainment	1. Informal activity only	2. Start of formal activity	3. Some/fair progress	4. Good progress	5. Excellent progress	MAX. Complete attainment
	about them.		time the appropriate dissemination of decisions does not occur.	not always) followed.	properly followed and/or there is no process for corrective action to be taken if this process is not followed.	is some sort of corrective action taken.
Indicator: Participation in decision-making						
The top leader(s) make all important decisions on their own and without consulting others. They are not open to new ideas.	There is an informal process of consultation by top leadership for important decisions with a few trusted colleagues, and/or some delegation of important decision-making occurs. But this consultation or delegation is not systematic and occurs at the whim of the top leader.	Leaders make decisions in consultation with one or two other persons, but delegation of important decision-making does not occur.	Although there is a formal process of consultation and/or a formal structure for delegation of important decisions, this process is only followed about half the time.	There is a formal process of consultation but it is not always followed and/or there is a formal structure for delegation of important decisions. This process is followed about half the time.	There is a formal process of consultation but it is not always followed and/or there is a formal structure for delegation of important decisions. This process has usually but not always been followed in the last year.	A formal process for consultation and/or a formal delegation process is always followed.

Health Workforce Policy, Planning, and Management

Measurement Tool
Policy
Indicator: Level of development of an HRH unit
Characteristic 1. Hierarchy level in the ministerial organization: on behalf of the Ministry of Health, in advisory roles, or as a part of the leading team or part of the national direction levels. 2. Develop HRH policies for the whole organization. 3. Plan the no. and type of required human resources. 4. Strategic direction of the management of HRH, in-service training, and the approach toward problems and determinants. 5. Counts with an updated information system that includes an inventory of the HRH, no., type, location, and educational levels. 6. Utilizes negotiation for the intersectoral relationships with the education, employee, and union sectors.

Measurement Tool
Human Resources Management/Planning
Indicator: % of health services and program managers certified in health management
1. The Ministry of Public Health may have a registry of personnel that are employed in its units and programs, as well as of their training, which allows us to obtain the data that are required to build the indicator. 2. If this information is not available, perform interviews with key informants asking them the following questions: Do certification requirements in management exist for those that lead the health services and programs? Are there records of the volume of personnel with these training specifications? What level are these personnel from: national, regional, provincial, cantonal, or departmental? Does the state have a permanent training program in management for the directors?
Indicator: Development of primary health care teams
1. Is there a national program with respect to primary health care teams? (Yes–10 points or no–0 points) 2. If yes, what % of the country's total population is covered by the primary health care program teams? 3. Does the primary health care program utilize community networks? (Yes–10 points or no–0 points) 4. Does the program cover vulnerable populations? (Yes–10 points or no–0 points) 5. If yes, which of the following populations are covered by primary health care program teams? (One point each; maximum score 10 points) High-risk pregnant women / Cultural groups Ethnic groups / Impoverished Children / Handicapped Elderly / Language Religious groups / Mentally ill 6. Which professional groups are generally included in the primary health care teams? (Two points each; maximum score 10 points) Physicians / Community health workers Nurses / Nursing assistants Midwives 7. What broad competencies are currently required of the primary health care teams? (Two points each; maximum score 10 points) Diagnosis and management of acute and chronic conditions Antenatal and postnatal care Prevention of disease and disability Rehabilitation after illness Coordination of health care services for populations at high risk (e.g., children, mentally ill, elderly and the handicapped).

Health Workforce Development

No additional measurement tools

Health Workforce Performance Support

Measurement Tool						
MIN. No attainment	1. Informal activity only	2. Start of formal activity	3. Some/fair progress	4. Good progress	5. Excellent progress	MAX. Complete attainment
Retention						
Indicator: Staff satisfaction						
There is no system in place to determine if	Staff and/or volunteers have discussed the need for	There have been informal discussions among	There is a system in place for determining	There is a system in place for determining staff/volunteer	There is a system in place for determining staff/volunteer	There is a system in place for determining

Measurement Tool						
MIN. No attainment	1. Informal activity only	2. Start of formal activity	3. Some/fair progress	4. Good progress	5. Excellent progress	MAX. Complete attainment
staff/ volunteers are satisfied with work conditions. Such concerns are not discussed among managers.	getting information from staff and/or volunteers on work conditions and satisfaction but nothing has been done yet.	managers about the conditions of work for staff/volun-teers as problems or complaints have arisen. But there is no system for regularly collecting this information or acting upon it.	staff/ volunteer satisfaction (e.g., meetings in absence of their supervisors or other ways such as surveys or interviews). The informa-tion has been acted on at least once in the last three years.	satisfaction (e.g., meetings in absence of their supervisors or other ways such as surveys or interviews). The information is usually that there is satisfaction. When there is not, action is usually taken to improve.	satisfaction (e.g., meetings in absence of their supervisors or other ways such as surveys or interviews). There are still gaps in that there sometimes is low satisfaction and/or that results are not always followed up.	staff/volunteer satisfaction (e.g., meetings in absence of their supervisors or other ways such as surveys or interviews). The information is usually that there is satisfaction. When there is not, action is always taken to improve.

Capacity*Plus* is the USAID-funded global project uniquely focused on the health workforce needed to achieve the Millennium Development Goals. Placing health workers at the center of every effort, Capacity*Plus* helps countries achieve significant progress in addressing the health worker crisis while also having global impact through alliances with multilateral organizations.

The Capacity*Plus* Partnership

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