

The Platform

for

Human Resource Development for TB

**Five years exchange of global
experience**

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List of Abbreviations

CDR	Case Detection Rate
DOTS	Directly Observed Treatment Short Course
DR Congo	Democratic Republic of Congo
EPQI	Evidence based Participatory Quality Improvement
HR	Human Resource
HRD	Human Resource Development
HRH	Human Resources for Health
JCRC	Joint Clinical Research Centre (Uganda)
LHS	Local Health System
LTI	Leprosy TB Inspector
MDG	Millennium Development Goal
MDR-TB	Multiple Drug Resistant Tuberculosis
MJAP	Mulago Mbarara Teaching Hospitals' Joint AIDS Program
NGO	Non-Governmental Organization
NTCP	National Tuberculosis Control Program
NTP	National Tuberculosis Program
NUMAT	Northern Uganda Malaria, AIDS & Tuberculosis Program
PIF	Performance Improvement Framework
PPM	Public Private Mix
RSA	Republic of South Africa
SEARO	South-East Asia Regional Office
SWAp	Sector wide Approach
TA	Technical Assistance
TBC	Tuberculosis Control
TB CAP	Tuberculosis Control Assistance Program
TBCTA	Tuberculosis Coalition of Technical Assistance
TFT	Task Force Training
XDR-TB	Extreme Drug Resistant Tuberculosis

Introduction

Within the context of the USAID funded TB CAP project which ran from 2005-2010, four annual Human Resource Development (HRD) platforms were organized to advocate for Human Resource Development in TB control and to draw attention to its challenges.

However, even before TB CAP started in 2005, the foundation for the HRD platforms had already been established by the Tuberculosis Coalition for Technical Assistance (TBCTA); TBCTA formed a Task Force Training (TFT) comprising HRD and training experts from TBCTA partner organizations. This TFT pioneered the concept of HRD in TB control and developed and published several training modules and guidelines. The TFT evolved into an HRD Working Group in which all TBCTA partners participated. This HRD Working Group subsequently organized and facilitated the TB CAP HRD platforms.

Participants from the Platform were staff working in National TB Programs, HRD experts from TBCTA, staff working in collaborative TB/HIV activities and partners from global, regional and country organizations involved in Human Resources for Health. Communication apart from the platform meetings was maintained through an e-Portal for HRD which is still used , providing ongoing support to individuals and groups of professionals.

Although the experiences from the platforms form a rich resource that is already documented in proceedings of individual meetings, this publication intends to bring into focus seven main lessons learned from the total four years of HRD platform experience.

List lessons here:

The first lesson highlights training as the main HRD effort. It is effective and much more training remains required. However, it is also recognized that training solitarily is not enough; therefore the second lesson learned is devoted to supervision and quality improvement.

It is shown that even the best trained and supervised staff cannot produce quality unless there is financial, material and moral backing. This forms the third lesson, which shows the importance of political and administrative support.

TB control personnel often perform under difficult circumstances. It is important to create opportunities for their professional growth and establish forums where they can exchange experiences (lesson learned nr 4). Such forums have helped to stimulate “thinking outside the box”, trying innovative solutions such as task shifting and engaging ex-patients acting as health workers (lesson learned 5).

Planning Human Resource Development for TB control has been strongly promoted throughout the entire platform period. All the foregoing has a much better chance if it is well planned (lesson learned 6). However, no plan will succeed unless there is wide support. For that reason, the final lesson learned (7) is about partnership and wide involvement among all stakeholders, in general key conditions for success.

In the final conclusions, the report summarizes in what different ways staff competence and availability can be improved and how this contributes to program performance.

Lesson learned nr. 1:

Training is key and part of a package

<p>Why does it matter?</p> <p>Training is a key aspect of Human Resource Development for TB control. Health workers at different levels of the health system need to have the skills, knowledge and attitudes to successfully implement and sustain comprehensive TB prevention, care and control services based on the Stop TB Strategy. Especially where there is a gap in knowledge and skills competence based training is key for success. Training is also necessary to introduce new interventions such as the management of M/XDR-TB and in TB/HIV co-infection. In addition to TB technical issues, training should in addition address development of leadership, improvement of management, to prepare staff for supervisory and mentoring roles.</p>	<p>What we can do</p> <p>Training should be part of a comprehensive package of building and maintaining human capacity; make sure workers are motivated, committed and have the necessary supplies, equipment and an appropriate work environment combined with good management support. One of the strategies in an HRD strategic plan for TB control can be dedicated to organizing on-going in-service training (clinical, laboratory and management) for all health workers involved in implementing the Stop TB Strategy. The details can be worked out in a per country training plan, covering training conducted at all levels and for all categories of staff. A system of accreditation can be helpful for the standardization and quality improvement of training.</p>
<p>Lessons learned</p> <p>Training should be responsive to adult learning needs; make sure that learners can:</p> <ul style="list-style-type: none">• Take responsibility for their own learning based on their own needs• Participate actively rather than passively in their learning process• Share their experiences, learning from each other, and the trainer learning from the learners in a safe and comfortable environment• Experience mutual trust and respect, and feel accepted as members in a group where new ideas, attitudes and behavior are the norm <p>Training courses and curricula should be competence based with emphasis on performance standards and performance assessment tools. When integrating courses in pre-service curricula early consultation with experts from the education sector is a must.</p> <p>Capacity building and subsequent international training activities of two Regional Training Centres, the National TB & Leprosy Training Center, Zaria, Nigeria and Gadjah Mada University Faculty of Medicine, Jogjakarta Indonesia have played an important role in the total training effort.</p>	

Case study: Decentralization of training in Bangladesh

The Bangladesh team envisioned that staff at different levels of the health system should have the skills, knowledge and attitude, in other words the competence necessary to successfully implement and sustain TB Control activities including the implementation of new and revised strategies and tools.

The team developed a short term plan including urgent training of DOTS health providers and laboratory staff in expanded DOTS activities, DOTS-Plus, HIV-TB and PPM. It was planned to review and develop training courses and training modules with standardized content. The short term plan also catered for staff supervision, using NGO and partners' support for training and technical assistance as well as functioning technical working group meetings on a continuous basis.

Some specific solutions were already implemented through a high quality and sustainable partnership tackling HRD issues. Training was decentralized whilst HR capacity was created. Master trainers are now in place; it reportedly worked. Quarterly monitoring meetings further increased staff motivation for both government and NGOs. Opportunities were further created for learning and growing through fellowships, higher level training and the accreditation of training.

Partners included the HR Team of the National TB Control Program and HR Teams at all levels including NGOs. Technical assistance was provided by TB CAP.

The efforts resulted in a firmly committed HRD team whilst sustainable and qualitative affiliation was also established with NGOs. HRD assessment was done on the basis of performance by the service providers identified during supervisory visits. Communication improved, which resulted in Government and NGOs identifying and listing staff turn-over and handing the lists to NTP, which subsequently made an effort for inclusion of new staff on the ongoing courses.

Although decentralizing training is not a long-term solution to the staff turn-over problem, it is a step in the right direction and has improved the HR situation.

Lesson learned nr. 2:

Beyond training: supervision and quality improvement

<p>Why it matters</p> <p>Training is essential; however, it is not enough. Much more is required to improve performance and to sustain results in real life situations.</p> <p>Regular supervision as a follow-up to training is essential. It should be of a supportive type, providing an opportunity for learning by doing. In that way the health worker will not feel threatened and will feel free to share problems and ask questions. Supportive supervision is welcomed and it stimulates better performance. Mentoring is another way of improving performance by providing guidance on the job; it consists of assigning a senior, or more experienced worker to provide regular guidance to a less experienced or recently appointed one.</p> <p>Quality improvement initiatives finally stimulate health workers to take personal responsibility for the enhancement of program performance in their own hands</p>	<p>What we can do</p> <p>Development, introduction and utilization of supervision and appraisal tools is one way of providing follow-up and adding to training. Several countries are an example: South Africa introduced a District Rapid Appraisal Tool, Pakistan developed a Performance Appraisal Tool for evaluation of district's performance of TB control. Kenya devised a tool that identified staff availability for TB diagnosis and treatment.</p> <p>In addition to providing tools, supervisors also need to be trained on how to supervise.</p> <p>Performance Improvement Framework (PIF) as propagated by Regional Centre for Quality of Health Care, Kampala Uganda goes a lot further. Its use includes defining your desired performance, implementing interventions, and finally evaluating if you succeed up your standard. An important aspect of PIF is creating networks of practitioners or "collaboratives".</p>
<p>Lessons learned</p> <p>Supportive supervision in South Africa improved TB control outcome indicator. It was found that staff learned more in a friendly and non-threatening environment and that supportive supervision increases staff motivation, whilst self- assessment reinforces and improves learning. On-site learning was found more effective than classroom learning. The Pakistan team also found that appraisal should be participatory and supportive.</p> <p>Facilitative supervision does require many supportive mechanisms. In particular adequate resources which enable people to effectively perform (Malawi) and proper work organization.(Kenya)</p> <p>PIF achieved improvement of TB indicators in Uganda, Tanzania and Kenya. Countries must be allowed to set targets which they feel they can achieve. Leadership is critical and managers and decision makers must be constantly engaged especially as staff turnover is high. Countries must further be encouraged to document and present what they do. It is</p>	

very motivating for implementers to be given the chance to attend meetings and to present their work. Recognizing performance and celebrating small successes increases motivation.

Case study: Participatory quality improvement in local health systems for TB control in Mexico

Mexico has the ambition to be a leader program to obtain a “Mexico Free of TB”. However, the present situation shows that there is still a long way to go. A quality improvement project used Evidence based Participatory Quality Improvement (EPQI) as a method involving teams of health workers.

Health workers (managers and operative personnel) were empowered to improve the quality of a Local Health System for TB control in a participatory manner, using different quality tools for data analysis and decision making. Each team included 35 – 45 health workers: physicians, nurses, chemistry, social workers, managers, supervisors and those responsible for TB, HIV and drug management.

All levels were engaged including National Program of TB, state level staff, local health system, health centers to the level of promoters

The activity resulted in action plans for:

- promotion including detection of bad cough in the waiting room,
- 100% of contact investigation during first 5 months of the action plan,
- An educational program for patients and contacts at home,
- Quality improvement of medical records,
- Increasing of social mobilization and health workers working as a team.

It was learnt that data analysis for decision making is better with active participation of health workers. Empowerment of the basic work team, team work and involvement of leaderships form the base of successful projects. Supervision and coaching by the instructor and local leaders is necessary at least every 2 weeks. Finally, even a good project requires at least 6 months before showing improved results.

Benefits included commitment of health workers and integration as a team and quality improvement of district health services in public health problems. In addition local leaders felt empowered and felt proud of their job. The results were clear: case detection in Tapachula improved significantly and the cure rate increased from 35 to 91%.

The high staff turnover however forms a challenge while some leaders, lacking public health training (Chief of District Health Services) showed a lack of involvement.

In total 651 health workers from 16 out of 40 priority local health systems (LHS) had gone through the process at the time of the 2010 platform meeting. Whilst the achievement is impressive, it also shows how much more needs to be done, considering that there are 245 LHS in the Country and TB CAP has come to an end.

To help sustain and replicate the process, a Guideline of Participatory Quality Improvement to TB Control (Spanish) was developed. It has been translated to English; therefore the wider community may benefit.

Lesson learned nr. 3:

Political and administrative support

<p>Why it matters</p> <p>Political and administrative support is of immense importance. Where it exists the morale of program staff is boosted and plans will be given priority. Government and development partners will be motivated to allocate financial material and human resources. Political support generates goodwill with the public and facilitates advocacy for TB control.</p> <p>HRD for TB control relies on political will and administrative support from central and local levels including Local Governments, or non public health orientated medical administrators in the health system.</p>	<p>What we can do?</p> <p>Leadership development is important and should be given even more emphasis in the future.</p> <p>Advocacy (Policy influencing) is yet another way to strengthen political support. For instance, Lesotho seeks to advocate for TB to be a priority among politicians, so that more attention is given to HRD in TB. The NTCP in South Africa is advocating for review of TB posts in the provinces. Thailand attempts to convince policy makers to prioritize TB control. Mexico focuses the attention of addressing TB on high burden districts. The Philippines advised using international opportunities to strengthen TB initiatives requiring high demand for HR. DR Congo advocates for health budget increases by working side by side with the National Medical Council and National Medical Trade Union.</p>
<p>Lessons learned</p> <p>There is an element of luck; where political or administrative support existed, it was identified as an important factor for success; the case study below speaks of “a golden time for TB control”, on the other hand, lack of political support, low priority allocated to TB control, and was also a frequently mentioned challenge.</p> <p>Strong advocacy and leadership development can change the balance. More efforts are required to build leadership for change.</p>	

Case study: Mr. and Ms. TB - A project initiative by the Permanent Secretary in Thailand

The need was identified to motivate staff for achievement of TB control and to designate persons responsible for TB at provincial level and large hospitals and to enhance supervision, monitoring, evaluation and motivation.

The Permanent Secretary of the Ministry of Health was at the centre of an initiative, reported in the 2009 platform, whereby throughout the nation the Vice Provincial Public Health Medical Doctor at Provincial Level and the Vice Hospital Director or Senior Hospital Doctor were designated to enhance TB control activities at all levels within provinces, to motivate health care workers relevant to TB control and to manage information for action.

The initiative became known as the “Mr. and Ms. TB Project”.

It is expected that this specific assignment of responsibilities will put Quality DOTS in place with management of information for action which is relevant to TB and achievement of 85/70 targets.

It will remain challenging to increase the success rate to achieve Millennium Development Goals target and to reduce the rate of increase of MDR-TB.

However, since this initiative, the NTP team reported: “We’ve haven’t had such strong commitment like this since 1979.” This is the golden period of TB Control in Thailand.

Lesson learned nr. 4:

Creating opportunities for professional growth

<p>Why it matters</p> <p>It is of utmost importance to attract and maintain health workers for TB control and HIV, both fields which are perceived as risky and therefore unpopular. Health workers should not only be retained in the service, they should remain competent and highly committed to dealing with new challenges.</p> <p>Providing opportunities for further learning and exchanging experiences is extremely motivating, which is important in retaining health workers in the service and in enhancing their commitment to a challenging tasks in difficult working environments.</p>	<p>What we can do</p> <p>Quarterly monitoring meetings at national or regional level were highly appreciated. Joint review missions whereby outside experts and local NTP staff worked together to assess and solve problems were also ranked as highly supportive.</p> <p>Opportunities for professional growth and international learning experience are also important motivators. The platform meetings themselves were an important opportunity for growth and development as well as participation in the e-Portal for HRD.</p>
<p>Lessons learned</p> <p>Evaluation / feedback received from the platform confirmed the motivating effect of meeting and forging links with peers in a relaxed environment. Exchanging experiences among people from different countries and backgrounds was highly appreciated and recognized as an important factor which enhanced learning and the acceptance of new ideas related to human resource development.</p> <p>SEARO noted the high level of motivation of the TB HRD Teams in its region as a factor contributing to the successes in developing HRD capacity. In the 2009 meeting it was reported that regional advocacy and support contributed to several benefits at country level:</p> <ul style="list-style-type: none">• Quarterly monitoring meetings increased staff motivation for both government and NGOs• High quality and sustainable partnerships helped tackling HRD issues• Joint review missions in countries improved health staff performances <p>Creating opportunities to learn and grow through fellowships, higher training and accreditation of training.</p>	

Case study: Country support for HR Development by WHO/SEARO

The WHO / SEARO team shared as vision for human resource for TB development to reach and sustain a situation whereby staff at different levels of health system have the competence to successfully implement and sustain TB Control activities including the implementation of new and revised strategies and tools. The goal is to have competent staff/personnel of TB control (based on their job description/task) available, in the right number, at the right place and the right time, with the necessary support system to motivate staff, enabling the achievement of the NTP goals.

However, the region faces a number of staffing difficulties, for instance HRD information systems in the public sector are not yet established in most countries in the region. In most countries information exists neither on trained staff nor on staff requirements. HRD capacity (management, supervision and trainers) is in short supply at national and district levels. The number of district supervisors is in particular inadequate. Staff numbers are further negatively affected by zero growth policy in the face of high staff turnover. Paradoxically, in view of the shortages, there is also a high probability of staff underutilization.

The training effort is also compromised since no criteria for selection of staff for training exist, with exception of India, Indonesia, Myanmar and Nepal. There is little or no follow-up of trained staff or activities in Bangladesh, Nepal and Thailand. There is no monitoring and evaluation of training programs. Pre-service training is not in accordance with NTP guidelines with the exception of India and Indonesia.

To stand up to these challenges, WHO/SEARO is supporting countries in the development of HR plans and decentralizing training, developing HR capacity and building up a critical mass of master trainers in countries. WHO/SEARO advocates for quarterly monitoring meetings for increasing staff motivation for both government and NGOs while promoting high quality and sustainable partnerships for tackling HRD issues in countries. Joint review missions in countries were instated to improve health staff performances. WHO/SEARO are finally supporting countries in creating opportunities to learn and grow through fellowships, higher training, and accreditation of training.

In this work the TB Unit of WHO/SEARO is working in close collaboration with the HR Teams of the National TB Control Programs with technical assistance from TB CAP.

As a result, HR capacity has been developed. Thanks to firm commitments of HRD teams working at NTPs HRD plans and decentralized training programs have been developed. Staff motivation increased and health staff performance improved. Opportunities have also been created for learning and professional growth.

Lesson learned nr. 5:

Thinking outside the box

<p>Why it matters</p> <p>In view of the challenges faced by TB programs, e.g. the need for new competencies on the one hand and the various constraints such as lack of personnel and finances on the other, standard solutions are no longer sufficient. Training remains important, but can it be combined with HIV training and be shared among partners to become more efficient? More personnel is usually needed, but there are restrictions to recruitment; we need to think more widely and beyond the borders of the conventional TB program to address such situations. Innovative thinking is also necessary to fit donor funding priorities.</p>	<p>What we can do</p> <p>In The Gambia the inadequate number of laboratory assistants was a constraint to achieving the desired aim of 100% smear microscopy. It was therefore decided to revise the roles and job responsibilities of Leprosy TB inspectors and to train them to perform smear microscopy thus buying time until sufficient numbers of laboratory assistants had been trained.</p> <p>In Lesotho and Zambia the shortage of laboratory personnel was tackled by recruiting personnel on contract, giving them a 5-week training course and subsequently deploying them as microscopists.</p> <p>Tanzania and DR Congo (see case study below), gained experience deploying ex-TB patients in TB control.</p>
<p>Lessons learned</p> <p>It is crucial to be proactive and to show initiative, which requires leadership; Mozambique was pioneer in DOTS in 1984 and working with Volunteers for Community Based DOTS, while using “brigadas móveis” (mobile brigades) in prevention.</p> <p>In The Gambia as a result, of training Leprosy/TB inspectors (LTI) in smear microscopy, numbers of new smear microscopic centres increased from 6 to 22 (1990-2007), while newly trained lab assistant are now gradually taking over smear microscopy from LTIs. It was learned that specialized staff can be used to achieve high coverage of smear microscopy within a short period of time; a remarkable example of task shifting.</p> <p>Recruiting and training microscopists was a different approach which also worked</p> <p>Task shifting involving community members has not only been possible, but has had demonstrable positive effect for instance on the treatment success rate.</p> <p>There are however limitations; using microscopists requires a good quality control system, relying on community members requires close collaboration with well trained health workers.</p>	

Case study: Community DOTS in DR Congo

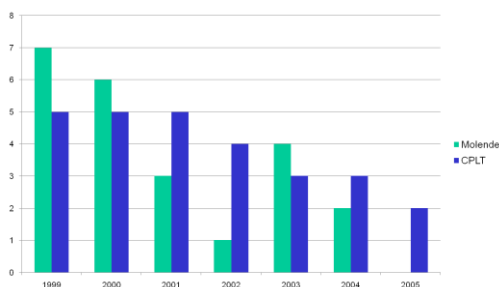
In DR Congo health workers are overburdened and poorly motivated, in addition, health centers are not equally distributed throughout the country. Many people are not able to get precise information about TB because they cannot attend health centers, in addition, patients are often not correctly followed up, which leads to treatment defaulting.

As a unique initiative, former patients have constituted an association to help health workers to follow TB patients until they are cured. They provide health education to patients and their families, visit patients at home, even bringing them drugs.

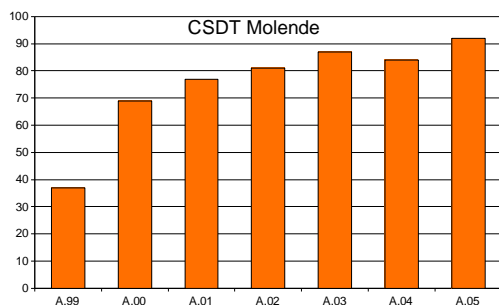
This exceptional partnership includes former patients, other trained members of the community and health workers.

As a result, some health centres with a low treatment success rate have improved their performance as shown in the example of Molende in the following two graphs:

2. Evolution of default rate of TB patients in Molende from 1999 to 2005



1. Evolution of treatment success Rate in Molende from 1999 to 2005



The experience clearly shows that involvement of the community in the struggle against tuberculosis through the former patients' association, contributes to the improvement of TB patient's care. Former patients explain better to new patients than health workers what they have felt when they got the disease and how they had to behave in order to be

cured. Ex-patients can also assist health workers, while incentives such as weekly meetings, supervision, training and bicycles help to sustain community members' work. N.B. Although the above approach is successful, it should also be mentioned that community members do not replace health workers.

Lesson learned nr. 6:

Planning for Human Resources

<p>Why it matters</p> <p>The health workforce is the most critical resource for the Stop-TB strategy and the health sector as a whole. Unfortunately human resources for health are in many cases in critically short supply. The technical interventions exist, but in order to implement them human resources are required:</p> <ul style="list-style-type: none">➤ the right numbers of people,➤ in the right place,➤ at the right time,➤ with the right skills,➤ with the right motivation and attitudes,➤ at the right cost,➤ doing the right work. <p>The purpose of strategic planning for developing the human resources for health is to approach this ideal for implementation of the Stop-TB Strategy, in harmony with the overall HR for Health strategic plan of the country. The planning process in itself will assist in forging partnerships and building political support.</p>	<p>What we can do</p> <p>Have a HRD plan, if necessary, use technical assistance to develop it as done by several countries.</p> <p>The handbook “Planning the Development of Human Resources for Health for Implementation of the Stop TB Strategy” can also be used to develop these plans.</p> <p>As recommended in the handbook, first create sufficient interest and support buying in for the HRH strategic plan with NTP management, the MOH and all other relevant stakeholders. Next, establish leadership for HRH strategic planning process; decide who should take the lead and who should do what. Set up an HRH strategic plan working group giving attention to tasks and responsibilities, number and profile of members as well as the required time investment.</p>
<p>Lessons learned</p> <p>Strategic planning is possible: in 2010 Indonesia, Southern Sudan, Malawi, South Africa, Uganda, Nigeria, Vietnam, Botswana and Mexico have HRD strategic plans based on global guidelines while others are in the process of development and finalizing the strategic HRD plans like Dr Congo, Mozambique, Namibia, Zambia, Cambodia, Ethiopia, Ghana, Afghanistan, Botswana, Kenya. Pakistan and Zimbabwe.</p>	

Case study: Malawi National Tuberculosis Control Program Human Resources Strategic Plan 2009-2011

In 2002 the National Tuberculosis Program Malawi introduced the concept of Human Resource Development into the management of the Tuberculosis Control Program. NTP representatives attended the 2 African HRD Task Force Training (TFT) workshops and assigned a HRD focal point in 2003. In 2004 the first working document (2004/5), supplementary to the 5 year Plan of Works of the NTP was developed and implemented. Promising results are in place through the impact of the structured training policy. Training material for Health Centre and District level has been updated and shaped into modules. Within the last three years 60 % of the health staff involved in TB control has been trained. Quality Assurance systems are piloted and introduced country-wide. An excellent start for the new HR Strategy to built on.

The NTP HR Strategy Plan 2008-2011 is in line with the MOH HRD Strategy Plan 2007-2011 and is part of the new overall 5 year NTP Strategy Plan (2007-2011). The NTP HR Strategy Plan covers the components of systemic capacity building and the concept of “Managing for Performance” (Joint learning Initiative project). These two concepts by practical approach initiate HR and HRD planning, take into consideration the need for number & mix of workers, their deployment and support systems, their motivation and competency and the tools needed to be able to perform.

The NTP HR Strategy takes into consideration the HR situation within the National Health System of Malawi, the performance of the NTP and the global TB strategies.

The HR related National Health System issues are several and include HR shortages, SWAp implementation and the Millennium Development Goals.

The “HRH crisis” in Malawi with staff levels below critical level is by far the most challenging issue.

The following strategies have been put in place in the HRD Plan to facilitate HRD issues for TB Program:

1. Strengthen the Central Unit to facilitate and lead the implementation of the STOP TB strategy
2. Participate in and contribute to overall health workforce planning and policy development in Malawi
3. Improve access to TB control services by involving communities in health promotion activities, case-finding, DOTS, and patient support (task-shifting)
4. Strengthen collaboration with private healthcare providers in STOP TB activities (case detection, diagnosis, treatment)
5. Regularly monitor and supervise health and laboratory workers’ performance in implementing the STOP TB strategy
6. Organize regular in-service training (clinical, laboratory and managerial) for all health workers involved in the implementation of the STOP TB strategy.

7. Strengthen pre-service training for doctors, nurses, laboratory technicians and other health workers involved in the implementation of the STOP TB strategy

Lesson Learned nr. 7:

Partnership is a condition for success

<p>Why it matters</p> <p>Partnership is cross-cutting, since it was a crucial element in all the above lessons learned. It is important for training as mentioned in the case studies from Bangladesh and Uganda. Supervision depends on it, while systematic approaches toward quality improvement include the formation of ‘collaboratives’; the Participatory Quality Improvement initiative in Mexico, involved people from health facility, local health system and state level; TB control in prisons in Cambodia involved the Ministry of Health, the Ministry of interior affairs, prison health staff and NGO. TBCTA itself was a partnership. The platform meetings brought TB and HIV program staff, as well as personnel from HR departments together in partnership. The theme of the second platform meeting “Together we can achieve” applies to the whole HRD for TB Platform initiative.</p>	<p>What we can do</p> <p>Two forms of partnership have been outstanding, contributing to the successes in many countries:</p> <ul style="list-style-type: none">• Partnership between the national TB programmes and the various HRD Departments for instance in Tanzania, and Zambia• Partnership between TB and HIV programs, occurred in virtually all countries, ranging from a National TB/HIV Coordination Committee in Bangladesh to occasional joint training events in Cambodia. <p>The strengthening of these links was also apparent in the representation in successive platform meetings. Involvement of the private and NGO sector has also been crucial in increasing the coverage of DOTS and other elements of the Stop TB strategy, for instance, the programme in the Philippines collaborates with local experts, private and NGOs taking into account complementarity of tasks.</p>
<p>Lessons learned</p> <ul style="list-style-type: none">• Forging partnerships is possible and highly rewarding and it is probably the most important lesson learned.• Opportunities for forging partnerships arise around joint planning and training activities such as the development and subsequent use of standard training materials.• However, the forging of partnerships is not always easy. It was challenging in one country to get an HRD department on board, in another, health systems directors without public health training were reportedly not very supportive.• Having a focal HR person for TB in place is important to deal with such issues.	

Case study: A joint effort for building Human Resource Capacity in Uganda

In Uganda a high association exists between TB and HIV. National Data from September 2007 show that 60% of the TB patients are also HIV positive. There was a need identified to orient all frontline HWS to handle patients with both TB and HIV.

It was also realised that multiple partners had been working in the fields of HIV/AIDS, TB and TB/HIV. These partners included WHO, TB CAP, NUMAT-USAID, MJAP collaboration, UPHOLD-USAID and JCRC. Coordination was a challenge.

A joint effort was made for building human resource capacity to implement TB/HIV collaborative activities in Uganda, using a standardized Training Package consisting of 10 modules.

In the coordinated exercise WHO trained 13 districts (2006), whereas Uphold trained 28 districts while planning to train 28 more. TB CAP trained 12 districts with a view to reach 20 districts. TB CAP also trained 3 Regional Liaison Officers to coordinate training. NUMAT took care of 5 districts of the North (Apac, Lira, Pader, Kitgum and Gulu) while MJAP concentrated on Regional Hospitals (Mulago, Mbarara, Jinja, Hoima planning to expand to 11).

Partners in this unique venture included WHO, TB CAP, NUMAT, MJAP, the Joint Clinical Research Centre, the National TB and Leprosy Control Program, and the National Aids Control Program, all using the same standard training package.

As a result of this harmonized endeavor, well over 50% of districts were trained, whilst coverage of remaining districts and regional hospitals was on track. The monitoring and evaluation system was updated to capture TB/HIV collaborative activities routinely (Modified NTLF monitoring stationery- Unit TB register, District TB registers, Quarterly Report Forms and National Data Base). Training is a contribution toward improved quality of care for clients, and creating increased demand for HIV testing among TB clients. It is also a step in the direction of integrating TB/HIV collaborative activities into the general health service and is an example of improved coordination between partners.

Conclusion

Understanding of Human Resource Development has deepened and broadened among teams from participating countries. In addition, the opportunity for exchanging experiences, together with technical assistance, training and support, have resulted in concrete improvements such as the development of HRD strategic plans, appointment of HRD focal persons, writing of curricula and standard training materials as well as setting up of HRD for TB information systems.

The HRD platform experience has shown that staff competence can be improved in various ways. Training was and remains an important activity, especially if it addresses technical and managerial / leadership aspects and if it is based on assessed performance gaps and adult learners' needs. In order to achieve acceptable coverage of all health workers in need of training it is important that training is decentralized through training cascades and that multiple partners are involved. Combining training for TB and HIV has also proven possible and contributes to efficiency. Coordination of such multi-partner training effort is greatly enhanced through training plans and the use of agreed standard training curricula and learning materials. Updating of in-service and even more so, pre-service curricula requires linking with regulatory and professional bodies. The Regional Training institutes in Africa and Asia have played an important role in building capacity of mid and high level program managers in TB and TB/HIV programs.

Further to training, improving staff competence also requires supportive supervision, mentoring, sometimes technical assistance, and further depends on political support, leadership, management and work organization. Workers need the necessary tools and supplies and can be motivated through appropriate monetary and non-monetary incentives – among them training, quarterly monitoring meetings and joint reviews. Ultimately the aim should be to establish performance improvement frameworks including partnership arrangements known as “performance improvement collaboratives”.

Improved availability of staff has been achieved through context specific retention and motivations schemes, working with public and private partners, through contracting of staff, training and contracting of microscopists and shifting of tasks including involvement of community members including ex-patients. Political commitment has been important to get the necessary permissions and to approve budgets.

The various HRD activities have finally contributed to improved program performance. Case detection and treatment success rates improved through training and supervision, in Performance Improvement Framework (PIF) initiatives, and through involvement of community members and ex-patients. Task shifting with relation to sputum examination greatly improved accessibility and efficiency of laboratory services.

The overriding lesson learned is that involvement of partners and stakeholders is crucial; Engage the HR department of ministries of health, learn from other countries, know your local context to set priorities and finally, plan your work.

The platforms have greatly contributed to the learning of these lessons, creating the opportunity to learn from each other's innovative, non-standard solutions. Thinking outside the box and looking for innovative solutions remains important in a changing environment in TB. Appointing TB/HR focal persons with clear job descriptions at central level of the NTP's was advocated for and in many cases implemented.

The HRD platforms have resulted in stronger links between NTPs and Human Resource Development departments within Ministries of Health and have contributed to keeping HRD high on the agenda.