

Proceedings of the HRD/TB platform meeting

# Together we can achieve



28 & 29 May 2008, The Hague  
The Netherlands

**TB|CTA**  
The Tuberculosis Coalition  
for Technical Assistance



**USAID**  
FROM THE AMERICAN PEOPLE



**TOGETHER WE CAN ACHIEVE**



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## Table of Contents

Acknowledgments	iv
List of Abbreviations	v
1. Introduction	1
2. Health Systems Context	3
2.1 Primary Health Care, Now More than Ever	3
3. TB Control Context	6
3.1 The Global TB situation	6
3.2 DOTS and Stop-TB Strategy	6
3.3 Challenges in DOTS, Stop TB implementation in countries	8
3.4 Ways countries manage these challenges	10
4. The Human Resource Context	12
4.1 The human resources for health crisis	12
4.2 Recent global initiatives in response to the HRH crisis	13
4.3 Human Resource Development for TB Control	14
4.4 Common obstacles to Human Resource Development for TB Control	14
5. HRD solutions and initiatives from countries	16
5.1 Decentralization of training and monitoring meetings in Bangladesh	16
5.2 Community DOTS in DR Congo	17
5.3 TB control in prisons in Cambodia	18
5.4 Training of Leprosy TB Inspectors in smear microscopy in The Gambia	19
5.5 Deployment of microscopists in Lesotho and Zambia	20
5.6 Training Plan for Health Care Workers in Thailand	21
5.7 Guidelines for pediatric TB control in Haiti	21
5.8 Participatory Quality Improvement in Mexico	22
5.9 A District Rapid Appraisal Tool for TB in South Africa	24
5.10 Assessment of laboratory training needs in Vietnam	24
5.11 Introduction of a TB HR Supervision tool in Kenya	25
5.12 Training on Management of Drug-Resistant TB in the Philippines	25
5.13 Providing standardized training materials for CHWs in Rwanda	26
5.14 Planning for NTLP training in Tanzania	27
5.15 An HRD Inventory for the National TB Program in Malawi	27
5.16 A joint effort for building Human Resource Capacity in Uganda	29
5.17 Country support for HR Development by WHO / SEARO	30
6. Discussion	32
7. Further support requirements	36
8. Recommendations	38
References	40

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## List of Abbreviations

ACSM	Advocacy Communication Social Mobilization
ART	Anti Retroviral Treatment
CBO	Community Based Organization
CDC	Center for Disease Control and Prevention
CDR	Case Detection Rate
CENAT	National Centre for Tuberculosis and Leprosy Control
CHW	Community Health Worker
DOTS	Directly Observed Treatment Short Course
DTLC	District TB Leprosy Coordinator
DTO	District TB Officers
EQA	External Quality Assurance
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GHWA	Global Health Workforce Alliance
HRD	Human Resource Development
HRH	Human Resources for Health
HRM	Human Resource Management
HW	Health Worker
JATA	Japan Anti Tuberculosis Association
KNCV	Royal Dutch Tuberculosis Foundation
LGU	Local Government Units
LTI	Leprosy TB Inspector
MDG	Millennium Development Goal
MDR TB	Multi Drug Resistant Tuberculosis
MIS	Management Information System
MJAP	Mulago Mbarara Teaching Hospitals' Joint AIDS Program
MOH	Ministry of Health
MOST	Management & Organizational Sustainability Tool
MSH	Management Sciences for Health
NTP	National Tuberculosis Program
NUMAT	Northern Uganda Malaria AIDS & Tuberculosis Program
PIH	Partners in Health
PMU	Project Management Unit
PPM	Private Public Mix
PTLC	Provincial TB Leprosy Coordinator
SARA	Support for Analysis and Research in Africa
SDCP	Select Disease Control Program
SEARO	South-East Asia Regional Office
SNRL	Supra National Reference Laboratory
STI	Sexually Transmitted Infection
TB CAP	Tuberculosis Control Assistance Program
TBCTA	Tuberculosis Coalition for Technical Assistance
TDFI	Tropical Disease Foundation Inc.
TFT	Task Force Training
TLCU	TB/Leprosy Central Unit
TMIH	Tropical Medicine and International Health
USAID	United States Agency for International Development
WHO	World Health Organization
WHR	World Health Report



# 1. Introduction

The Tuberculosis Coalition for Technical Assistance (TBCTA) is a unique coalition of the major international organizations in TB control. TBCTA has provided a unique resource for USAID, through which it has been able to increase its involvement in global TB control while learning through collaboration with experienced and well-respected international TB experts and key organizations.

The “TB Control Assistance Program” (TB CAP, 2006 - 2010) builds and expands upon the work of TBCTA. It continues supporting the areas of political commitment, DOTS strengthening and expansion, and capacity building. However, a key distinction is a larger emphasis on increasing TB/HIV integrated approaches, increasing the involvement of new partners at the country level (especially the private sector), and improving drug management systems. Most important for this publication, TB CAP emphasizes building human, institutional, and financial capacity for DOTS implementation that can be sustained beyond the life of the project.

TB CAP operates within the Strategic Framework of the USAID Bureau of Global Health Strategic objective to achieve “Decreased morbidity and mortality by increasing case detection and treatment success of pulmonary TB patients in USAID priority countries”. Specific objectives, referred to in the terms of this Strategic Framework as Intermediate Results (IR) are:

1. Increased Political Commitment for DOTS
2. Strengthened and Expanded DOTS programs
3. Increased public and private sector DOTS participation and collaboration
4. Increased and strengthened TB and HIV/AIDS coordinated activities
5. Improved human and institutional capacity.

Insufficient human resource capacity (Intermediate Result 5) has increasingly been recognized as a key constraint and barrier toward scaling up DOTS and implementing the “Stop TB Strategy” and the “Global Plan to Stop TB”.

An earlier human resource for TB development working group of TBCTA<sup>2</sup> has henceforth, under TB CAP, evolved to become an HRD/TB Platform with participation, not only of USAID/TB CAP target countries from all parts of the world, but also reaching out to include expertise on human resource development, health systems and HIV/AIDS. The purpose of the first platform meeting was to identify the main issues and challenges in HRD and the actions needed at country level for scaling up TB control.

The second HRD/TB platform meeting took place in The Hague, the Netherlands, on 28-29 May 2008 with participants from 30 countries. The meeting supplied provisional information regarding important advances in TB control, the first global forum of the global Health Workforce Alliance and health systems requirements. Country reports highlighted common human resource problems. National TB program managers/HIV managers and advisors, all over the world are struggling with HR problems including how to plan for HR. Additionally, there are issues of quality and quantity of health/laboratory staff; several other issues were revealed which will be addressed in the following pages. Special breakout sessions provided discussions on topics

<sup>2</sup> Also referred to as Task Force Training (TFT)

of special concern including Task shifting feasibility for TB control programs, HRD and TB infection control, Staff performance and retention, Development of HRD strategic plans, implications of HR performance in TB/HIV collaboration and health systems strengthening.

The main emphasis and strength of the platform meeting was the richness of initiatives and innovative solutions related by countries. Each country has its specific problems, but also its own unique solutions, or at least its own ways of coping with those problems. There are no definitive blue prints, but rather methodologies and experiences providing a basis from which to learn from one another and exchange ideas.

In view of this wealth of valuable contributions a resolution was passed to capture the experiences in a special publication to be used as a resource for future reference and for triggering innovative solutions for those who are unable to attend the platform meetings.

This booklet is the result of the above resolution. The beginning chapter (Chapter-2) describes health systems in the context of the renewed interest in Primary Health Care. Chapter-3 indicates the global context of TB control and provides a brief overview of the common challenges of implementing DOTS and Stop TB strategies with emphasis on staffing and training. Chapter-4 portrays the human resource for health crisis and takes stock of where we are with human resource development for TB control, while also identifying common obstacles. The main body of this publication is Chapter-5, which relates a number of unique initiatives and innovations by participating countries. Some methodologies are small and modest, others large and ambitious, but all form a rich resource of experience. Chapter-6 discusses the experiences in the context of the Global Health Workforce Framework. Finally, Chapter-7 summarizes the type of further support that is required while Chapter-8 lists twenty (20) recommendations emanating from the platform meeting.

It is our aspiration that this collection of cases will serve as a source of inspiration for all who struggle to develop the human resource capacity for TB control.

## 2. Health Systems Context

### 2.1 Primary Health Care, Now More than Ever

A health system has been defined (WHR 2000) as consisting of all the people and actions whose primary purpose is to improve health. Four vital functions of a health system include Service provision, Resource generation (including human resource development), Financing, and Stewardship: the role of oversight and development of vision.

The World Health Report 2008 notes that, if left to their own devices, health systems do not gravitate naturally towards the goal of health for all as articulated in the Declaration of Alma Ata in 1978. Worrisome trends show disproportional focus on a narrow offer of specialized curative care, a 'command-and-control' approach to disease control and too much tolerance for the flourishing of unregulated commercialization of health.

Among common short-comings of health care delivery mentioned in the 2008 report, "fragmented and fragmenting care" seems to be of particular relevance to TB control:

*"The excessive specialization of health-care providers and the narrow focus of many disease control programs discourage a holistic approach to the individuals and families they deal with and do not appreciate the need for continuity in care."*

The necessary reorientation of health systems, the report argues, "has to be based on sound scientific evidence and on rational management of uncertainty, but should also integrate what people expect of health and health care for themselves, their families and their society. This requires delicate trade-offs and negotiation with multiple stakeholders that imply a stark departure from the linear, top-down models of the past. Thus PHC reforms today are neither primarily defined by the component elements they address, nor merely by the choice of disease control interventions to be scaled up, but by the social dynamics that define the role of the health system in society."

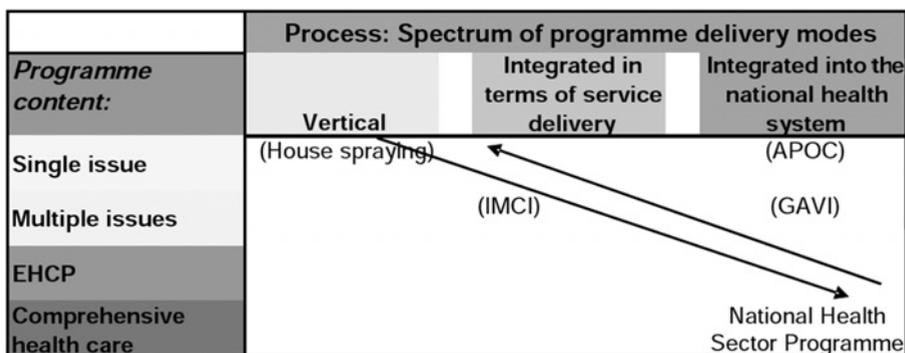
#### **The report proposes PHC reforms in four interlinking groups:**

- Universal Coverage reforms moving toward universal access and social health protection
- Service delivery reforms re-organizing health services as primary care around people's needs and expectations
- Public policy reforms integrating public health actions with primary care and by pursuing healthy public policies across sectors
- Leadership reforms replacing command-and-control approaches on the one hand and laissez-faire disengagement of the state on the other hand, by a leadership style appropriate for the complexity of contemporary health systems.

It can be concluded that there is a challenge for TB control to respond to these proposals; however, it is also noted that "Disease-specific and health-system approaches are not necessarily

in conflict, but can be mutually supportive". It is recognizable that "Many of the barriers to improved service delivery are common across a range of health programs and can best be addressed by common strategies". Andy Haynes: 'Contribution of health systems to disease control' (TMIH editorial, Nov 2007) and the question is whether each national program should develop its own IEC strategy and materials, conduct its own training courses and planning workshops, conduct its own supervision, use its own incentives schemes, and deploy separate supply, maintenance, monitoring, evaluation and reporting systems. Should disease control programs continue competing for infrastructure and staff time?

The issue of integration/non-integration is not necessarily a choice between all and nothing; there is a spectrum of program delivery modes (See graph below).



Advantages and disadvantages of integrating programs into general health systems need to be considered:

**Advantages of integration:**

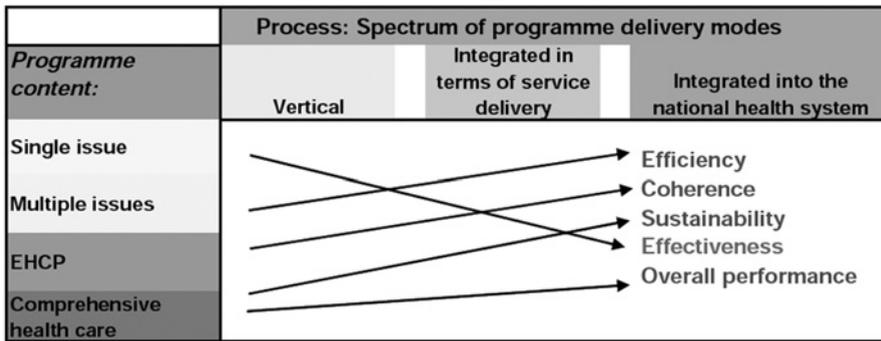
- Easier for clients
- Rational priority setting & planning
- Efficient use of resources
- Scope for inter-sectoral activities

**Disadvantages of integration:**

- Requires multifunctional PHC workers
- Lower quality?
- Less effective?
- Less donor interest
- Monitoring more difficult

There is however a tradeoff between effectiveness of the single issue vertical disease control program approach and the advantages of integration. The challenge is to keep progress with case detection and cure rates on track while integrating. Whether this will be possible depends strongly on the strength of the prevailing health system. Integration of a priority disease program should therefore only be recommended if it does not jeopardize fragile gains.

The following picture demonstrates the tradeoff.



In conclusion it is put forward that TB programs having multiple linkages to other disease control programs while sharing intervention strategies would be beneficial to all.



## 3. TB Control Context

### 3.1 The Global TB situation

TB is the single largest cause of death from a curable and preventable infectious disease. The greatest absolute number of cases is found in Asia and the greatest per capita prevalence is found in Africa. The emergence of multi drug-resistant tuberculosis (MDR-TB), extensively drug-resistant tuberculosis (XDR-TB) and TB/HIV co-infection are worrying trends.

HIV has direct impact on the epidemiology of TB through reactivation of TB infection acquired before HIV infection and by rapid progression of TB infection acquired after HIV infection. Transmission to the population not infected with HIV constitutes indirect impact. Treatment is complicated due to the difficulty of co-management of TB and AIDS primarily because of the drug interactions between anti-TB and ART. Therefore, any investment in ART scale-up by HIV policy makers also needs to give due attention to TB prevention, diagnosis and treatment.

### 3.2 DOTS and Stop-TB Strategy

DOTS began through the leadership of organizations such as the Union and KNCV in the 1980s. DOTS is now the WHO-recommended TB control strategy. DOTS has now evolved into the Stop TB Strategy launched in 2006 by the Stop TB partnership with the following 6 components:

- 1 PURSUE HIGH-QUALITY DOTS EXPANSION AND ENHANCEMENT**
  - a. Political commitment with increased and sustained financing
  - b. Case detection through quality-assured bacteriology
  - c. Standardized treatment with supervision and patient support
  - d. An effective drug supply and management system
  - e. Monitoring and evaluation system, and impact measurement
- 2 ADDRESS TB/HIV, MDR-TB AND OTHER CHALLENGES**
  - Implement collaborative TB/HIV activities
  - Prevent and control multidrug-resistant TB
  - Address prisoners, refugees and other high-risk groups and special situations
- 3 CONTRIBUTE TO HEALTH SYSTEM STRENGTHENING**
  - Actively participate in efforts to improve system-wide policy, human resources, financing, management, service delivery, and information systems
  - Share innovations that strengthen systems, including the Practical Approach to Lung Health (PAL)
  - Adapt innovations from other fields
- 4 ENGAGE ALL CARE PROVIDERS**
  - Public-Public, and Public-Private Mix (PPM) approaches
  - International Standards for TB Care (ISTC)
- 5 EMPOWER PEOPLE WITH TB, AND COMMUNITIES**
  - Advocacy, communication and social mobilization
  - Community participation in TB care
  - Patients' Charter for Tuberculosis Care
- 6 ENABLE AND PROMOTE RESEARCH**
  - Programme-based operational research
  - Research to develop new diagnostics, drugs and vaccines

The Stop TB Strategy considers that public health services need to enhance their capacity to implement high quality DOTS, and emphasizes community involvement in TB care and a patient-centered approach. The Stop TB Strategy also emphasizes collaboration and synergy among the public, private and voluntary sectors. It considers the need for new partnerships and approaches, based on the increasing impact of HIV on the incidence of TB, particularly in sub-Saharan Africa. The DOTS TB control strategy also highlights the need to deal with drug-resistant forms of TB in the former Soviet Union and other areas of the world. Sustaining effective TB control programs now means integrating them into primary health care and adapting them to ongoing reforms occurring within health sectors across the globe (WHO 2006).

Globally the treatment success rate Stop TB target of 85% has been reached, but there remain great inter-regional and inter-country differences.

Case detection (smear+) is also increasing but remains short of the target of 70%. Case detection in Africa has reached 46%; in Europe and Eastern Mediterranean detection has reached 52%.

MDG Goal 6 includes halting and beginning to reverse the incidence of TB by 2015. TB prevalence and mortality are falling, but need to decrease at a faster pace to reach targets. Incidence rates are stable and/or decreasing slowly.

The new challenges for effective TB control present increased demands for highly competent human resources. In particular, national TB programs face a lack of competence to implement the Stop TB strategy, including TB/HIV and MDR-TB control, shortage of staff, inappropriate or inadequate training, insufficient access to information and knowledge resources, low morale and motivation due to feeble policies and practices for human resource development (HRD). The quality of performance often is affected by unsafe conditions in the workplace, lack of supportive supervision, lack of integration of services with the private sector and high attrition of health workers.

Therefore, human resource development has been getting new attention and priority within the overall planning for Stop TB interventions at the national level and the continued development and strengthening of the strategic planning of HRD within the NTP is crucial. The International Standards for TB Control (ISTC) that are now widely supported and available will also contribute to the focus upon and strengthening of HR.

### 3.3 Challenges in DOTS, Stop TB implementation in countries

The following overviews are based on country team contributions during the platform meeting.

The TB disease burden as such forms a challenge with increasing numbers of TB cases, MDR-TB, MDR-XDR TB and high TB/HIV co-infection rates. Country teams must deal with children suffering with TB, smear negative and extra-pulmonary TB and, additionally, the presence of high-risk populations such as prison inmates. Furthermore, TB has a negative economic impact.

Despite some encouraging trends, achieving agreed targets is not easy. Case detection and treatment success rates are still well below global targets in many countries. Ethiopia has a case detection rate (CDR) of 32%, well below the 70% target. Tanzania also reports low case detection. Sustaining the quality of DOTS implementation is a challenge in the Philippines, Indonesia and SEARO. Case holding of category II patients is sub-optimal in Indonesia and SEARO in general. Mexico also purports that approaching the cure rate goal is a challenge.

Thus, as many programs and staff are already stretched to their limits, scaling-up of comprehensive DOTS services seems a daunting task.

The call for building partnerships is demanding; limited engagement and participation of hospitals is a problem in the Philippines, while insufficient involvement of the private sector is mentioned in DR Congo. SEARO notes a considerable number of cases managed within the private sector mentioning the assurance of quality care as a major issue.

HRH issues also feature high among the challenges; shortage and high turn over of skilled human resources are mentioned for instance by Lesotho, Tanzania, Uganda, Haiti, Ethiopia and Nigeria, with poor retention of health professionals mainly in the rural and poor areas of Dr Congo. Shortages of laboratory staff in particular are mentioned repeatedly. Other shortages occur particularly at rural decentralized and/or health center level. DR Congo cites that health workers are overburdened on one hand, but poorly (or not at all) rewarded on the other hand. The need to train staff is also mentioned as a challenge; increasing training and number of staff for management of drug-resistant TB in the HRD plan is seen as a challenge by RSA, and the need to orient all frontline HWS to handle patients with both TB and HIV is mentioned by Uganda.

Laboratory services are singled out among the stated challenges: Cambodia mentions the difficulty of maintaining service quality including laboratory services; Ethiopia has a weak EQA and laboratory network and hence low capacity for MDR TB surveillance and diagnosis; Nigeria also mentions low laboratory coverage (694 of 2000 needed); weak laboratory networks are also referred to by Haiti, Tanzania and SEARO. SEARO has specified: "laboratory networks necessary to diagnose and follow up patients are weak in most settings" and "Limited technical support for programs exists, especially in the areas of laboratory diagnosis, surveillance, ACSM, and newer interventions – MDR-TB and TB-HIV".

Management issues are also listed among the hurdles to be overcome; drug management, supervision, monitoring and strategic information are demanding in Bangladesh, while Kenya struggles with workload and work organization, career development policy and practice and measures to enhance sustainable staff motivation. Weak human resource management is mentioned by both Dr Congo and Nigeria, the latter also specifying logistics and supplies and ACSM. Lesotho notes the absence of infection control measures in hospitals while Indonesia sees the need for access, quality, accountability, and transparency of TB services.

Weak health systems and poor health infrastructure are reported by Ghana, while ongoing health care reform and decentralization are challenging in Georgia and Indonesia. Poor access to health

services is reported by Haiti while DR Congo talks of inaccessibility for patients due to geographical and natural constraints and inadequate distribution of health centers throughout the country and war and permanent insecurity in 3 provinces. Ethiopia reports low community health seeking behavior whereas Thailand takes on community engagement in TB control through social mobilization as a challenge. SEARO notes that there has been little experience with large-scale integrated community-based management of MDR-TB and TB-HIV.

Getting accurate data for reporting TB/HIV collaborative activities has been attempted but is not an easy process within South Africa.

General poverty, inadequate funding, low budgets allocated to health sector and lack of resources to maintain/sustain existing DOTS facilities/services are final difficulties reported by Ghana, Cambodia and DR Congo.

In summary, challenges include a shortage of and/or a high turn-over rate of skilled human resources, many of whom are overburdened and thereby difficult to retain, with laboratory staff being a category of particular concern. There is a great need for training. However, the challenge is not training alone but includes solving management problems (drugs supply) and taking infection control measures which are very important for people who are working with TB and finally, achieving community participation, while often working within poor general health systems.

### 3.4 Ways countries manage these challenges

Better focus and scaling-up, are both a challenge and also a way out. Tanzania and Haiti profess a desire to strengthen intensified TB case finding, especially in certain target populations; Thailand, and Indonesia wish to pursue quality DOTS expansion and enhancement; and the Philippines will proceed with a programmatic approach of DOTS implementation amongst high-risk populations. Cambodia, Indonesia and SEARO, in general, intend to expand interventions to tackle TB/HIV, MDR-TB, childhood TB, extra-pulmonary TB, and SM-TB. Lesotho has plans to establish an infection control department and the Philippines are forging appropriate policies for DOTS implementation in hospitals (e.g. referral system for in- and out-patients). Cambodia is expanding community DOTS, PPM-DOTS whilst SEARO is addressing "difficult areas", i.e., interventions in cross-border areas, among at risk populations. Ethiopia, meanwhile, is strengthening ACSM and Bangladesh has managed to achieve accreditation of NTRL with SNRL.

Several countries are strengthening laboratory services. For instance, Cambodia is strengthening the TB laboratory network, while Nigeria attempts to establish and maintain the HR capacity of national and zonal level laboratories. Ethiopia, Haiti, Bangladesh and SEARO in general are putting emphasis on ensuring quality assured laboratory networks for microscopy, culture and drug susceptibility testing in order to diagnose and treat all forms of TB.

Building partnership is a frequently mentioned strategy for coping with the challenges. Bangladesh, Thailand, Haiti, Uganda and Lesotho are strengthening collaborative TB/HIV activities.

Involvement of the private sector is another frequently mentioned approach, reported from Nigeria, DR Congo, Mexico, Bangladesh and SEARO in general, while other countries are shown to be in the process of strengthening a partnership with various stakeholders, related programs and sectors and/or involving all health care providers. Involvement of civilian society and community is mentioned by Bangladesh, Indonesia and SEARO, while Georgia and DR Congo have advocated for TB control and for increasing the national part of the budget allocated to the health sector.

Information strengthening and research are yet another approach. PATH in Kenya plans research on workloads, the Philippines perform periodic prevalence and mortality studies, and SEARO is improving surveillance for accurately measuring trends of TB, HIV-TB and drug-resistant TB. South Africa has revised TB data collection tools to facilitate collection and reporting on TB/HIV collaborative activities while Mexico is consolidating the national information system to become a unique platform.

Resources mobilization (GFATM, government, others sources) are yet another way of trying to cope, either specifically to mobilize funds for MDR-XDR TB (Lesotho) or to manage TB effectively at all levels of health care delivery (Ghana). Georgia mentions the need to modify national and international financial resources to implement the above-mentioned plans, while Thailand declares the intention of specifically seeking additional funding from GF round 8 to fill the gap. Ghana has further made a case for poverty alleviation in general.

Planning, in particular planning for human resource development as such, is seen as a way of better coping, having been mentioned by Bangladesh, Georgia, South Africa and Tanzania. Indonesia meanwhile, seeks to strengthen policy and fostering local ownership of the TB control program.

Management solutions are mentioned by Cambodia, Kenya and Nigeria, stressing capacity building and staff motivation, work organization in relation to workloads, incorporation of career development in strategic plans and availing of appropriate tools (Mexico). Ghana, Indonesia and SEARO mention a need to begin strengthening health systems, either by improving or expanding physical infrastructure or by strengthening practices such as in-service training, supervision and better conditions of service that would motivate staff in public/private sectors, to provide quality preventive and curative services for comprehensive TB control.

Good supervision is seen as important. Kenya, Nigeria, Thailand and the Philippines are performing intensive supervision in combination with monitoring and evaluation, and/or by establishing clear policies with regular supervision and supports from NTP to the private sector.

HRH-related coping mechanisms are finally among the most frequently mentioned; the ingenious solutions related by country teams form the core of this booklet. Before coming to these solutions, the next chapter will introduce the human resource situation.



## 4. The Human Resource Context

### 4.1 The human resources for health crisis

A study of the Support for Analysis and Research in Africa (SARA) project (2003) already found that many countries face scarcities within almost all cadres of health workers. Personnel management systems in Africa are highly centralized and weak, and human resource planning and management has not been given the importance it deserves. New structures, practices, and technologies are imposing a heavy strain on an already fragile human resource base in the health sector. Meanwhile, the scope of professional practice has been too rigid and too inflexible. Many government health workers are ill-motivated and attrition has reached critical rates while some health workers have resorted to counter productive behavior. Even though many medical and technical positions are vacant, scarce medical personnel are often misused for managerial tasks. Finally, the study has found that donor resources devoted to training and HR development have been poorly coordinated and have not addressed the underlying cause of poor staff motivation.

According to WHO (WHR 2006) estimates, there are currently 57 countries with a workforce density below a threshold necessary to achieve high coverage of essential interventions required for meeting the health-related Millennium Development Goals (MDGs). The great majority of these countries are in Africa, the region with the highest TB prevalence per capita as well as the highest HIV burden. The remaining countries with critical HRH shortage are mainly, although not exclusively in South East Asia, the region with highest TB prevalence in terms of absolute numbers and also, next to Africa, the highest HIV burden in absolute numbers. Paradoxically, these health workforce insufficiencies often coexist in a country with large numbers of unemployed health professionals. In many countries, the skills of limited yet expensive professionals are not well matched to the local profile of health needs. Critical skills in public health and health policy and management are often in deficit. Many workers face daunting working environments, poverty-level wages, unresponsive management, insufficient social recognition and weak career development. Almost all countries suffer from mal-distribution characterized by urban concentration and rural deficits, but these imbalances are perhaps most disturbing from a regional perspective. The exodus of skilled professionals in the midst of so much unmet health need in Africa places this region at the epicenter of the global health workforce crisis (WHR 2006).

Up-scaling of activities to meet Millennium Development and Poverty Reduction Goals has enormous human resource implications. The aggregate expectations of Select Disease Control Programs (SDCP), on Human Resources for Health are often unrealistically high and not sustainable (Petit/Mshana, 2003). In addition these expectations are commonly narrow in outlook and too uninformed, first about the background of these human resources and second about the health systems and the stage in their development in which they are operating. Solutions require that SDCP objectives are pursued in a comprehensive coordinated way by preparing and contributing to the planning, development, maintenance, deployment and management of a health workforce that is geared toward delivering evidence-based integrated

essential health care packages. Pre- and in-service training programs and the development of learning materials should be similarly integrated. These efforts should support and strengthen national health care systems rather than compete with them.

## 4.2 Recent global initiatives in response to the HRH crisis

### **Global Health Workforce Alliance (GHWA)**

The GHWA is a partnership organization formed in 2006. It includes national governments, civil society, finance institutions, workers, international agencies, academic institutions and professional associations and is hosted by WHO. The alliance has been formed to identify and implement solutions to health workforce problems through the work of six task forces. The first Global Health Workforce Alliance Forum took place in Kampala, March 2–7, 2008, resulting in the Kampala Declaration which calls upon the following: provision of proper stewardship, leadership and management, coherent support to formulate comprehensive strategies and plans, determination of appropriate health workforce skill mix, assurance of adequate incentives and an enabling and safe working environment, with GHWA monitor progress.

### **Addis Ababa declaration on Task shifting**

An International Conference on Task Shifting took place in Addis Ababa in January 2008. Task shifting was defined as “A process of delegation whereby tasks are moved, where appropriate, to less specialized health workers”. Task shifting was recommended since it

- Constitutes more efficient use of available human resources
- Expands the resource pool, creates local jobs and new opportunities
- Increases levels of responsibility throughout workforce and creates job satisfaction
- Builds bridges between communities and health facilities
- Can reduce costs in some circumstances

The declaration was made in recognition of the global human resource constraints in view of the Millennium Development Goals to reduce child mortality, improve maternal health and combat HIV and AIDS, malaria and other diseases.

The following section shows to what extent participating TB control country teams have experienced and dealt with the human resource for health crisis.

## 4.3 Human Resource Development for TB Control

During the HRD/TB Platform (May 2008) participant country teams shared their visions for human resource development for TB control. The vision as expressed by Ghana being concise on the one hand, yet containing all the elements, the “common denominator” as follows:

*A health system comprising of public and private sectors, with adequate staff, the relevant competence and improved health systems to manage TB at all levels in the society*

However, realizing their visions for human resource development for TB control has not and will not be easy for countries. Progress has been made, as will become clear on the following pages, but there are great obstacles to be overcome.

#### 4.4 Common obstacles to Human Resource Development for TB Control

In accordance with the findings in the WHR 2006 and other mentioned references, many countries participating in the platform meeting mentioned that there are still staff shortages, either in general, showing unfavorable health worker per population ratios, or with relation to specific activities such as TB/HIV collaborative activities (Haiti). Imbalances in distribution between urban and rural areas has also been mentioned as well as the fact that existing staff often has inadequate skills or that the skills mix among various categories of health workers is inadequate. Attracting staff to work in TB services, their retention and motivation with or without incentives is not easy. Achieving a required critical mass among categories of health workers is difficult. In addition to these staffing problems, some countries noted misconceptions concerning human resource development; for instance sometimes HRD is seen as training only (DR Congo), while Kenya reported an “ad hoc approach to HRD”. Inadequate information, lack of tools to monitor staff attrition and turn over, and keeping track of staff competencies hampers human resource development for TB control. DR Congo for example, testified that HRD data is not systematically reported on an annual basis and HRD needs are not really assessed. There are leadership, management and supervision problems. Uganda finds it challenging to sustain political commitment of local governments. Nigeria faces delayed implementation of activities after training and does not have effective coordination of human resources for health including weak and ineffective supervisory structures at all levels and lack of clear job descriptions. Countries also face low outputs from the health training institutions while it is, moreover, taxing to regularly update and train health workers to match new evidence and developments.

The following chapter relates how countries have been coping with their human resource TB problems and adapting to stand up to the challenges.



## 5. HRD solutions and initiatives from countries

Case Studies covering: issues, solutions, partnership, results and lessons learned

### 5.1 Decentralization of training and monitoring meetings in Bangladesh

The Bangladesh team envisions 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. There is a concept to review and develop training courses and training modules with standardized content. The short term plan also caters 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 specified solutions have already been implemented through a high quality and sustainable partnership tackling HRD issues. Training has been decentralized while HR capacity has been created. Master trainers are now in place; it is reportedly working. Quarterly monitoring meetings further increase staff motivation for both government and NGOs. Opportunities are further created for learning and growing through fellowships, higher level training, and accreditation of training.

Partners include the HR Team of the National TB Control Program and HR Teams at all levels including NGOs. Technical assistance is provided by WHO, KNCV and TB CAP.

The efforts have resulted in a firmly committed HRD team while sustainable and qualitative affiliation has been established with NGOs. HRD assessment is done on the basis of performance by the service providers identified during supervisory visits. Communication has improved, which has resulted in Government and NGOs identifying and listing staff turn-over and handing the lists to NTP, who subsequently have made an effort for inclusion of new staff on the ongoing courses. Although this is not a long-term solution to the staff turn-over problem, it is a step in the right direction.

For the long term, a plan exists that incorporates establishing a database on staff requirements and training needs and establishing incentive packages to increase staff motivation. It is further planned to set up systems for monitoring and evaluation of training activities and developing a group of master trainers involving partners with a mechanism for updating their quality on a continual basis

In conclusion, a concerted effort of learning and acting has improved the HR situation, but an enormous amount of work still remains to be done to sustain the results.

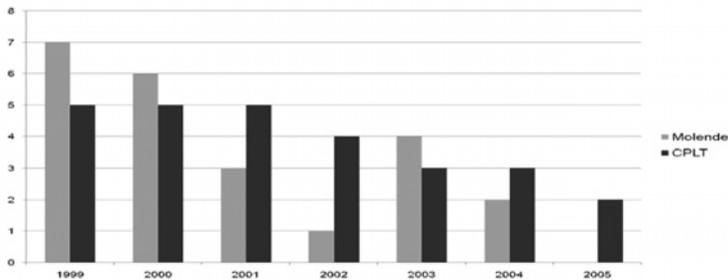
## 5.2 Community DOTS in DR Congo

In DR Congo health workers are overburdened and poorly motivated, and additionally, health centers are not equally distributed throughout the country. Because they are not able to attend health centers many people are not able to get precise information about TB. In addition, patients are often not correctly followed-up, which leads to default of treatment.

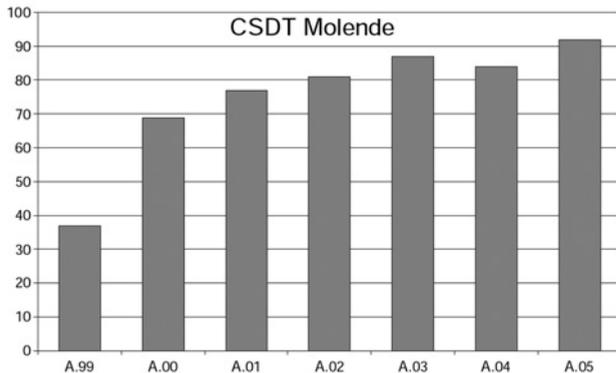
As a unique initiative, former patients have constituted an association to help health workers to follow TB patients until they are cured. They provide health education to patients and their families, visit patients at home, and even bring patients their TB medications.

This exceptional partnership includes former patients, other trained members of the community and health workers. As a result, some health centers with low treatment success rate have improved their performance as shown in the example of Molende in the following two graphs:

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



**Evolution of treatment success Rate in Molende from 1999 to 2005**



This experience clearly shows that involvement of the community in the struggle against tuberculosis through former patients' association(s) contributes to the improvement of TB patient's care. Often former patients are in a better position than health care workers to empathize with new patients and to explain their own feelings over contracting tuberculosis, relating how they participated and behaved with their own cure of the disease. Ex-patients can assist health workers, while incentives such as weekly meetings, supervision, training, and bicycles help sustaining community members' work. Although the above approach is successful, it should be noted that community members do not and should not replace health workers.

### 5.3 TB control in prisons in Cambodia

The Cambodia team has a vision for Human Resource for TB Development to have sufficient numbers of motivated TB health workers with right skills and fair distribution at all levels. However, TB control in Cambodia faces many problems, with TB control in prisons specifically posing a challenge:

- There are no measures or policies for infectious control in prisons. Consequently, there are no standards for TB case finding and contact investigation. TB cases are detected through passive case finding only.
- Referral for smear negative TB suspects is not in place due to lack of funds to transport prisoners to hospital(s) for x-ray examination.
- The DOT watcher is not a health staff worker nor is he/she trained as such.
- There is no consistency of supervision by OPD health staff OD or province and the referral slip is not used when a TB prisoner is released.

To respond to the above mentioned challenges, TB control in prisons has been given special attention with an outline of solutions included in a focused plan.

A memorandum of understanding was reached between CENAT of the Ministry of Health and the Prison Department of the Ministry of Interior Affairs. Under this agreement refresher training has been provided for prison health staff. Supervision and review will henceforward include prison health staff. Prison clinics will use all NTP forms for recording and reporting while NTP referral slips will be used to refer released patients for treatment continuation. NTP provides TB IEC materials to prisons with TB education also being provided for general prisoners.

The partnership in this venture includes CENAT of the Ministry of Health and the Prison Department of the Ministry of Interior Affairs, prison health staff and NGOs.

Although it is too early to assess the outcome of the present initiative, previous collaboration between CENAT/MOH and prisons with active cases has shown a finding in two prisons that resulted in 45 active TB cases found among 1275 prisoners. All 45 active TB cases were treated. CENAT further provided DOTs training to health staff in 24 prisons in the country.

## 5.4 Training of Leprosy TB Inspectors in smear microscopy in The Gambia

In The Gambia the inadequate number of laboratory assistants is a constraint to achieving the desired aim of 100% smear microscopy.

It has therefore been decided to revise the roles and job responsibilities of Leprosy TB inspectors and to train them to perform smear microscopy to buy time until sufficient numbers of laboratory assistants have been trained.

Financial assistance has been obtained to organize training that is highly practical and hands-on instruction on the conduct of sputum smear examination. Meanwhile, funding has also been used for the yearly training of new lab assistants.

The initiative involves the collaboration of the Directorate of State of Health and Social Welfare, the Medical Research Council, KNCV, and the National Reference Laboratory; funds have been obtained from GFATM.

Subsequently roles and job responsibilities of Leprosy Inspectors (LTI) have been revised to incorporate smear microscopy and all LTIs have been trained accordingly; simultaneously, 10 laboratory assistants are to be trained yearly under GFATM from 2006-2010.

As a result, the numbers of new smear microscopic centers have increased from 6 to 22 (1990-2007), while newly trained lab assistants are now gradually taking over smear microscopy from LTIs.

In conclusion it has been shown that specialized staff (LTIs) can be used to achieve high coverage of smear microscopy within a short period of time; a remarkable example of task shifting.

## 5.5 Deployment of microscopists in Lesotho and Zambia

The long-term vision in Lesotho is to have adequate and skilled human resources for TB control at all levels. However, the immediate concern is the poor human resource capacity for laboratory services resulting in long turn-around time for smear microscopy in all laboratories.

A scheme has been devised for improving turn-around time for smear microscopy by implementing the recruitment and training of 30 microscopists under the Global Fund plan of round 6, phase 1. All 30 microscopists have been trained on smear microscopy using standard operational procedures. Two to three microscopists have subsequently been placed in each laboratory.

The national tuberculosis program and the laboratory have been key role players in this activity together with the Global Fund Coordinating Unit.

As a result, the turn-around time for smear microscopy has improved from one week to 2-4 hours in some laboratories. It has been learned that some of the human resource problems can be solved once funds are available. Team work has been found to be important for the success of any program.

In Zambia staff shortages have been identified in North Western and Luapula provinces. Subsequently, consultations have been held with other partners supporting supplementary laboratory staff called microscopists (CDC and Zambart) and TB CAP have re-programmed APA1-2 funds to support staff salaries for 15 microscopists.

Permission has been obtained from MOH to employ microscopists under TB CAP and advertisements have been developed with input from national reference laboratory- Chest Diseases Laboratory staff and reviewed by the NTP.

Interviews have been carried out in respective districts where applicants were identified and fifteen candidates have been employed and trained for five weeks with MOH approved curriculum.

The initiative has addressed HRD needs and candidates have resources from the local community in the two provinces, are supervised by health facility administrators and shall have regular technical supervision by trained laboratory personnel through EQA support. Because of their good credits in high school they can be trained further to become skilled laboratory personnel.

## 5.6 Training Plan for Health Care Workers in Thailand

Thailand's vision is to have an adequate, competent and motivated workforce for TB control at all levels. The aim is that all health personnel working in TB control are to be well-trained, motivated and willing to work for TB patients.

As one step toward achieving this aim, a workshop on HRD for TB control was organized from 7-8 May 2008, to develop a plan for revision of specific curricula and training materials for each health care worker.

The work involved national TB control program experts, national TB control Program coordinators, regional TB coordinators and the Bureau of TB officers.

The workshop resulted in an HRD Action Plan for 2009 stipulating requirements for module and learning materials for each of the health care worker categories including post training evaluation.

It was further evident that policy makers at all levels should prioritize TB control and enhance budget and resource allocations accordingly.

## 5.7 Guidelines for pediatric TB control in Haiti

The vision for human resource in the field of TB development in Haiti is that private and public health systems having adequate staffing with relevant professional competencies and with the needed support systems to motivate staff to use their competencies to provide quality preventive and curative services for comprehensive TB care to the entire population.

The very low rate of detection of TB in children and the lack of a knowledge base regarding TB in children has been identified as a key issue to be solved. One consideration to realize this resolve is to develop guidelines for pediatric TB control and to provide training in TB pediatric case control, in the use of the Mantoux test and by the tracking of child patients who have a smear positive TB.

Training involved all health care workers involved in TB care including general physicians, nurses and auxiliary-nurses, and bacilloscopists.

The training program reportedly resulted in a notable improvement in the motivation of HCW for a better care of children and helped to increase the number of cases of detection of TB in children. Thus, it can be expected to lead to a decreased morbidity and mortality rate that has thus subsequently occurred due to TB in children.

It was learned that continuous training is an essential component of a TB program. Health care workers are motivated to upgrade their competency through training. It is, however, necessary to create a monitoring system to keep track of performance after training.

## 5.8 Participatory Quality Improvement in Mexico

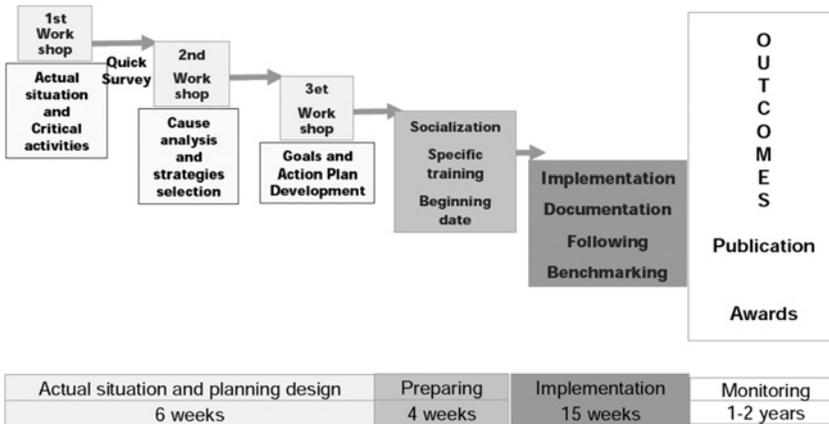
Mexico has the ambition to be a leader in instituting a program by which to obtain a "Mexico Free of TB". This ideal requires establishment of practices oriented to population health improvement with equal opportunities and without gender or social category distinction. Moving toward this ideal calls for the development of necessary technical skills in health care workers; additionally there needs to be a development of management and organization abilities with attention aimed towards quality and recognition of quality performance.

However, the present situation shows that there is still a long way to go. In thirteen out of thirty-two states there are more than 100 cases of TB per year; only 11% – 20% of these cases that include the symptoms of a bad cough are properly examined; and contact investigation is only done in between 8% – 27% of these cases. Laboratory results are commonly delayed by 2 to 3 weeks and drug administration can be delayed as long as 2 weeks to 3 months. Information on clinical records is missing. The cure rate is currently less than 60%.

A quality improvement project implemented Evidence based Participatory Quality Improvement (EPQI) as a method that involved teams of health workers totaling 312 health workers from 8 states. The process is shown in the next figure.

Participatory Quality Improvement on Local Health Systems to decrease TB.

## ***Work Plan for each team work***



The exercise involved a great variety of practitioners including physicians, nurses, laboratory technicians, supervisors, epidemiologists, social workers and those responsible for the TB program. All levels of organizations were engaged including the National Program of TB, state level staff, local health system, and 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 the first 5 months of the action plan
- an educational program for patients and contacts at home
- quality improvement of medical records
- the increasing of social mobilization and health workers working as a team.

An example is the increased case detection in Tapachula. The cure rate increased from 35% to 91%.

It was learned 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.

## 5.9 A District Rapid Appraisal Tool for TB in South Africa

South Africa introduced a District Rapid Appraisal Tool to increase capacity of PHC Supervisors to monitor TB program performance. The tool assists staff to identify their own challenges with TB management and to devise their own interventions to address those challenges. The approach reinforces training and is also meant to increase the staff motivation in TB program management.

The enterprise included District TB coordinators, PHC supervisors, facility staff working in TB and members of the Provincial TB Program.

The Platform Meeting was informed of improvement in TB program management and better staff motivation to monitor their performance in TB management. It showed that staff learns better in a friendly and non-threatening environment. Last but not least; there was an improvement in TB outcome indicators.

It was learned that supportive supervision increases staff motivation, while self- assessment reinforces and improves learning. On-site training was found to be more effective than classroom learning.

## 5.10 Assessment of laboratory training needs in Vietnam

Vietnam is facing a lack of laboratory technicians in districts and an insufficient number of skilled staff at provincial level. Moreover, there is a high turn-over rate of trained staff. Additional problems result from the delay in allocation of funds under the health sector reform as well as a lack of updated training materials which hinders the training effort.

In response to these challenges, Vietnam performed a training needs assessment for laboratory staff and has developed a plan for human resource development 2006-2010. A laboratory technical manual was also designed. Subsequently, training funds have also been allocated to provinces.

Partners in this set of activities include members of the NTP steering committee, senior staff in NRL in Hanoi, 8 regional laboratories upgraded to regional reference centers (Culture and supervision), and provincial technicians of 64 provinces/districts in lowland areas and big cities.

As a consequence of the effort, the development plan has been approved by MOH and funds have been allocated for laboratory development and availability for training. The laboratory manual has been integrated into the comprehensive manual of the NTP and 'training of trainers' at provincial level has been implemented.

## 5.11 Introduction of a TB HR Supervision tool in Kenya

The Kenyan team's vision for human resource for TB development is to provide a sufficient number of health workers who have the skills, knowledge and attitudes necessary to successfully implement and sustain comprehensive TB control services.

In pursuing this vision Kenya has developed a TB HR Supervision tool that looks at staffing, tasks and job descriptions, work load assessment, working environment, staff motivation, competency levels, training and training needs and finally supervision.

Provincial and district TB and Leprosy Coordinators have collaborated in this venture with clinical officers, nurses, laboratory technologists, and laboratory technicians.

Application of the tool has identified staff availability for TB diagnosis and treatment but has found that task descriptions differ from the reality, thereby, requiring the implementation of job descriptions. Different organization of work was noted in various facilities. It was further revealed that there is a difference between real workloads and perceived workloads.

Among the main lessons learned was the importance of the effects of work organization and the relationship between work organization and workloads.

## 5.12 Training on Management of Drug-Resistant TB in the Philippines

The HRD vision of the Philippine team is to contribute to the attainment of the goals of the NTP through human resource development and management.

Achievement of the vision is hampered by the limited technical and managerial capacities of health workers on PMDT and the difficulty of transferring the technology from project to program. There is further a high demand for additional human resources to implement PMDT.

As a contribution to strengthening the technical capacity of health workers, training modules on the Programmatic Management of Drug-Resistant TB (PMDT) have been developed.

Development of the modules has involved NTP staff at central and regional levels, local government units, implementers, local and international experts including TDFI and WHO, private MDs, and DOTS Unit Heads.

The endeavor has resulted in collaboration of key partners, both public and private sectors, and the development of policies, guidelines and standards with technical support from international and local experts. Access has been opened for opportunities for financial assistance and the actual development of the training modules has been achieved.

This experience has taught those involved how to optimize international opportunities and local

expertise. It has been found that public and private sectors can work as partners, but policies, guidelines and standards need to be developed to direct the stakeholders. Finally, it has been established that a complex job such as PMDT requires thorough task analysis of human resources.

### 5.13 Providing standardized training materials for CHWs in Rwanda

“Accompangateurs” (Community Health Workers) in Rwanda provide home-based care and psychosocial support to patients in treatment. They act as a link between the patient and health center but also carry out active case finding and educate the community on a variety of health topics.

Partners in Health (PIH) have developed standardized training materials for CHWs (low-literate, adults) across PIH sites to help increase quality and impact. The materials are designed to provide CHWs with the necessary knowledge, skills and attitudes to do their work within the communities. The materials can also be used to further disseminate the PIH model for community-based health care.

The training team from PIH Boston has collaborated with key CHW program staff across sites. Focus groups with CHWs have been used to determine preferred methods and content while clinical teams have given written technical comments. Low-literacy specialists have been involved in curriculum development, while graphic designers, illustrators, editors, translators and printers have participated in the production of the first pilot version of a set of materials. Skills-training includes care and treatment for HIV/AIDS, TB and STIs, while attitudes are also given attention to create a sense of solidarity and support with the poor/vulnerable in the community. A pilot version is available in hard copy and online.

Subsequently, 77 nurses and social workers have been instructed as trainers and 78 CHWs have been trained with the pilot version. A preliminary evaluation has revealed that content and participatory approaches are very well received. The Ministry of Health is now considering validating the program of study as a national curriculum.

In conclusion, the need to allocate adequate human and financial resources has been reconfirmed. It is important to have a dedicated training team in place, and necessary though difficult to ensure that the training is not isolated, but linked to program work. Suppositions made during development of the training materials need regular review and re-affirmation.

### 5.14 Planning for NTLP training in Tanzania

Tanzania’s vision for Human Resource for TB Development is to mobilize sufficient, highly motivated and skilled staff for TB control.

However, program training previously has been uncoordinated and lacking clearly set priority areas. It has therefore been resolved to perform proper planning for NTLP training in Tanzania.

The planning process has been spearheaded by the TB/Leprosy Central Unit (TLCU) linking with the Ministry of Health and Social Welfare's Human Resource Department, NGOs, National AIDS Control Program, WHO, academia, research institutes, regional and districts' staff, the Central TB Reference Laboratory (CTRL) and Kibong'oto TB hospital.

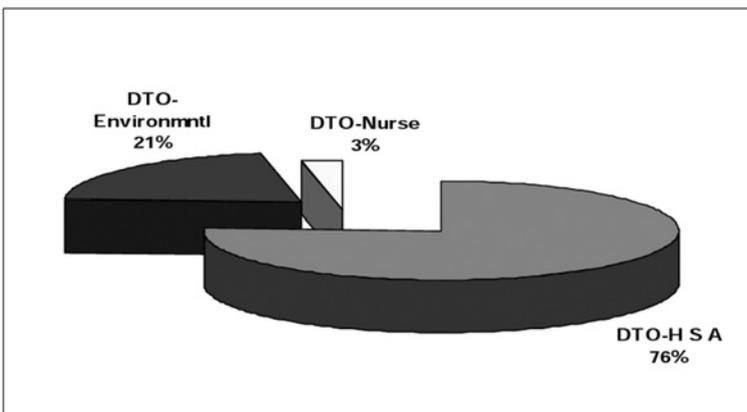
As a result priority areas are now decided and a draft program training schedule has been produced. A few courses have already been undertaken: PPM, TB/HIV case management, MDR-TB case and program management. An HRD expert has been hired through CIDA-KNCV support and supervision has been revived after recruiting a few more technical staff at central unit. It has been realized that by involving others the impossible will become possible.

### 5.15 An HRD Inventory for the National TB Program in Malawi

With relation to HRH for TB development Malawi wishes to reach and sustain a situation whereby staff at varying levels of the health system have the skills, knowledge and attitudes, in other words, the competence to successfully put into practice and sustain TB control activities including the implementation of new and revised strategies.

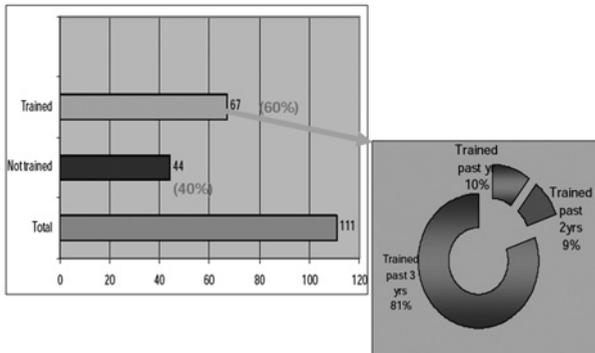
In order to determine a baseline, the Malawi National TB Program embarked on determining the exact workforce for District TB Officers (DTO) available for TB Control activities at implementation level. An inventory was undertaken in the 27 districts in Malawi on all currently serving TB Officers.

It was found that 21% of DTOs are environmental health staff, 3% are nurses and 76% are HSA, a relatively low level cadre (see next graph).



Of the 111 TB Officers discovered during the exercise, 40% were untrained. Of the 60% trained staff, 10% were trained during the past year and 9% two years ago. The greater majority (81%) were trained three or more years ago (see next graph).

## Training Status of TB Officers



The inventory revealed that 15 out of the 28 districts will need more DTOs. It was also found that Malawi uses the lower cadre of HSA predominantly in its TB control activities. The information concerning the training status indicates a need for conducting refresher courses for most of the serving TB Officers in Malawi.

In conclusion, evidence-based decision making is crucial for effectiveness in TB Control.

### 5.16 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 shows that 60% of the TB patients are also HIV positive. A need has been identified for orienting all frontline HWS to handle patients with both TB and HIV.

It has also been realized that multiple partners have been working in the fields of HIV/AIDS, TB and TB/HIV. These partners include WHO, TB CAP, NUMAT-USAID, MJAP collaboration, UPHOLD-USAID and JCRC. Coordination has been a challenge.

A joint effort has been 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 is training 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, with 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.

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

It has been learned that coordination of partners is a challenge which needs to be addressed a priori (project versus program). This experience builds a case for having standardized training materials; the modules have been a tremendous help. Notably, there is need for refresher sessions in view of high staff turn over rate, however, the modalities of providing further training need to be thoroughly considered and planned. TOTs are required to build sustainable training capacity in districts, central, regional and DHO offices and at larger Health facility level.

There is further need for appropriate IEC materials to reach out to the public and the community.

## 5.17 Country support for HR Development by WHO/SEARO

The WHO/SEARO team share a vision for human resource for TB development to reach and sustain a situation whereby staff at different levels of the 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 correct numbers, at the right places and at the right times, with the necessary support system to motivate staff to enable the achievement of the NTP goal.

However, the region faces a number of staffing difficulties, e.g., HRD information systems in the public sector are not yet established in most of the countries in the region. In many countries information does not exist on trained staff and/or on staff requirements. HRD capacity (management, supervision and trainers) is in short supply at national and district levels. The number of district supervisors is particularly 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 further compromised since no criteria for selection of staff for training exists, with the 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 the training program(s). Pre-service training is often not in accordance with NTP guidelines with the exceptions of India and Indonesia.

To stand up to these challenges, WHO/SEARO is supporting countries in 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 have been instituted to improve health staff performances. Finally, WHO/SEARO are supporting countries in creating opportunities to learn and grow through fellowships, higher training, and accreditation of training.

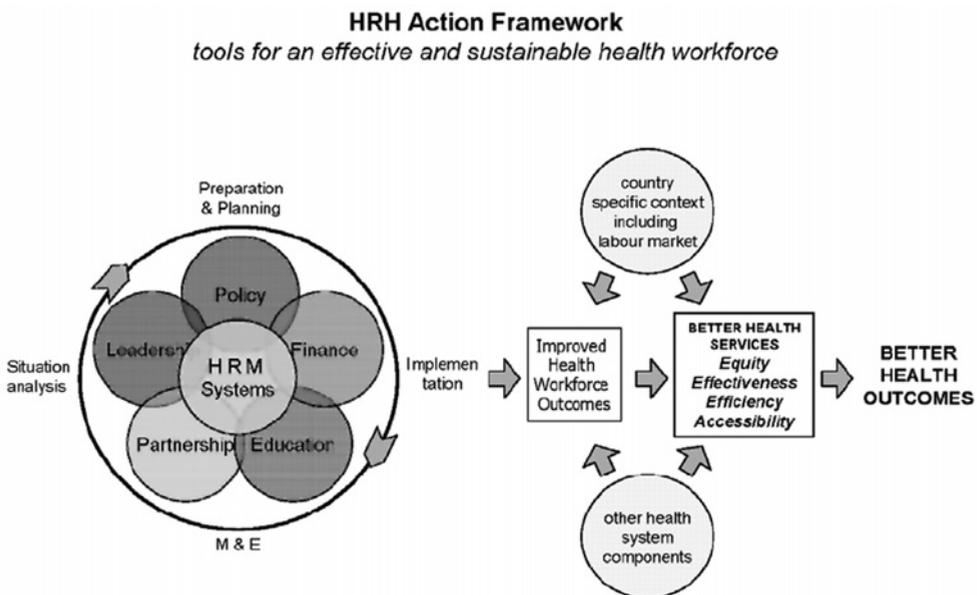
For this work of the TB Unit CDS, WHO/SEARO is in close collaboration with HR Teams of the National TB Control Programs and receiving technical assistance from TB CAP.

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 has increased and health staff performance has improved. Opportunities have been created for learning and growing.

It has been learned that the firm commitments of HRD Teams have been crucial, although more still needs to be accomplished. It has been important to forge sustainable and qualitative partnership with NGOs. The training task remains immense with continued medical education, workshops, orientations, external training, etc., being required.

## 6. Discussion

Human Resource Development is about having the right number of people; with the right skills, in the right places, at the right times, with right attitudes/commitment, doing the right work, at the right cost, with the right productivity. (Petit, 2006). Key starting points for action identified for governments and donors in the USAID-SARA Paper (February 2003) includes adoption of a “systems approach” to diagnose HR problems and a recommendation to improve the HR information base and to conduct country case assessment to identify critical gaps. Other suggestions call for a reduction of the rigid professional practice barriers to enable health workers to take on additional functions, and to review the relevance of training programs while experimenting with alternative training methods. Contracting services and management to private partners is encouraged as a way of adopting more flexible employment and provider arrangements. The HRH Action Framework advocated by the Health Workforce Alliance brings the various elements of the human resources for health system together:



As is to be expected, the great majority of solutions brought forward by countries have been related to training (represented by the “Education” circle in the framework). Bangladesh has decentralized training by creating a pool of master trainers and providing fellowships, higher training, accreditation of training; Cambodia has enhanced capacity through technical assistance and training, improving pre-service training to produce sufficient quantity of general health workers. Ethiopia has embarked on massive TB training for general health workers and laboratory personnel and has incorporated TB in the pre-service curriculum. Georgia has engaged in the training of staff and the construction of a new training center, expected to be completed in 2009. Ghana sees regular in-service training, regular promotions and better conditions of service as

ways of motivating all categories of staff for TB management. Training, career development through training, and continuing medical education are mentioned as possible answers by Haiti, Kenya, Mexico, Indonesia and Nigeria. Thailand has revised specific curricula and training materials for each of the health care worker categories, and South Africa has established training committees. The Gambia has trained Cuban doctors in the diagnosis of smear-negative, extra-pulmonary, and pediatric TB through KNCV TA as a short term solution; at the same time they have implemented the training of more Gambian Medical Doctors by school of medicine UTG, and ten (10) laboratory assistants are to be trained annually for the long term. Nigeria has instituted capacity building establishing and/or strengthening program management teams at the state and local government levels, organizing capacity building programs for the health care service providers. SEARO has also seen capacity building in countries as one of its main tasks.

Next to training, good supervision (HRM) is an absolute requirement. For instance, Bangladesh did an HRD assessment identified during supervisory visits by the service providers. Kenya practices continuous supervision by PTLCs and DTLCs and Mexico deploys a strategy of supervision and continuous advising in all attention levels (local to national level).

Better work organization (HRM) has been put forward as a way to address the obstacles in a number of ways: Georgia aims at full utilization of the new NTP building; Mozambique sees Health Centers as the backbone for delivering Health Services; Kenya has work re-organization in relation to workload in the pipeline; Ghana is balancing distribution of trained health staff to all regions/districts/sub-districts for effective management of TB; and South Africa has designated sub-district TB Coordinators in some areas.

Provision of incentives (HRM, finance) is also mentioned as a way of overcoming the obstacles; Cambodia has increased government salaries; supplementary salary for TB workers at province, district and health facility will be realized through GFATM. DR Congo, Haiti, Kenya and the Philippines have discussed performance or non-performance linked incentives and motivating schemes for staff retention.

The need to recruit and retain health workers (HRM) has been repeatedly expressed. The Ministry of Health of Cambodia has endeavored to improve recruitment and retention processes, recruiting more capable and qualified TB health workers (NTP/MoH) and sharing the burden. Ethiopia has designed a motivation and retention scheme and Kenya intends to work out career development in its strategic plan. In Kenya, GFATM has released money to employ 88 laboratory technicians; South Africa has employed full-time District TB Coordinators for all provinces. Tanzania recently hired an HRD expert and introduced an accelerated hiring plan while Thailand has managed to include more health personnel in TB control. The Gambia has utilized the GFATM to create the position of TB clinician at central level while PPM and second M&E staff positions are planned for GFATM round 9 proposal applications in October 2008.

Information strengthening and research (M&E, Situation analysis) have been repeatedly mentioned as ways to address these obstacles. Georgia has planned research and analysis for determining needs of the staff for further development. Haiti has identified the HR gaps, both in

terms of numbers required and knowledge and skills. PATH in Kenya has planned research on workload while Indonesia has strengthened the MIS-HRD. Nigeria is developing a monitoring tool for all training initiatives. Information sharing and communication are important. Quarterly monitoring meetings have increased staff motivation for both government and NGOs in Bangladesh. This has been confirmed by SEARO as well. Actively listening to the concerns of health workers and giving active/positive feedback are key communication skills. Clearly explaining job responsibilities and terms of references has also been found to be essential. DR Congo has indicated the importance of consulting NTP staff before appointing supplementary new members.

Partnership, also an element in the framework, has been found to be of great help to surmounting hindrances to HR development: Bangladesh experiences the result that high quality and sustainable partnership can tackle HRD issues. Mexico is engaging in Medical and Nurses school alliances. The Philippines collaborates with local experts (private, NGOs) for technical support and complementation of tasks, coordinating with key offices and project partners for assistance on the development of the NTP HR plan. SEARO advocates for high quality and sustainable partnership of the type that tackles HRD issues in countries.

Planning, (another circle in the framework) and development of strategies have been put forward as means to tackle the difficulties; Tanzania and Nigeria have been engaged in developing and implementing HRD strategic plan and monitoring and evaluation plans respectively. Kenya has developed an HR strategy, while the Ministry of Health in Mozambique is finishing an HRD plan 2008-2015 with 3 scenarios according to availability of funds. The NTP leadership in DR Congo is advocating a HRD plan for approval by the Minister of Health.

Advocacy (policy influencing) is yet another method. Lesotho seeks to advocate for TB to be a priority among politicians, so that more attention is given to TB. NTCP South Africa is advocating for review of TB posts in the provinces. Thailand is attempting to convince policy makers to prioritize TB control. Mexico focuses its attention on addressing tuberculosis on high burden jurisdictions.

It is crucial to be proactive and to show initiative, which requires leadership; an example is Mozambique having been a pioneer in DOTS in 1984 and working with Volunteers for Community Based DOTS, using “brigadas móviles” (mobile brigades) as a means of prevention; and The Philippines having stressed the value of accessing international opportunities to strengthen TB initiatives requiring high demand for HR (e.g. Rolling Continuation Channel/RCC proposal). Raising funds (finances) remains essential. DR Congo advocates for health budget increase by working side by side with the National Medical Council and National Medical Trade Union. Lesotho is also mobilizing more funds for NTP from donors to improve human resource capacity and more position for NTP staff at district level to be included in Round 8 of the GFATM.

It appears, therefore, that consciously or sub-consciously, participants to the platform meeting have, together, covered all the core elements of the HRH Action Framework.



## 7. Further support requirements

Nevertheless, it is a mainstay that further support is required. The majority of requests relate to capacity building: Bangladesh desires support to improve skills and skills balances; Georgia needs support for development of HR at the NTP GEO; Indonesia has identified the need for advanced courses to build capacity; Nigeria is interested in leadership and management development programs and specifically indicates a wish to strengthen the capacity of NTBLTC Zaria with relation to HR matters; The Philippines need to strengthen technical capacity of field staff on data analysis; whilst Mexico would like to build sustainable capacity for implementing successful training models. Haiti on the other hand needs support for improving the working environment. SEARO is committed to supporting and assisting countries in particular with reference to TB control programs in the context of health systems strengthening.

Support is also required for training issues: Bangladesh need assistance with updating curricula and training methods, a continuing education program to reduce threat to service providers regarding increased burden to health systems/workload, and to reduce threat to service providers on risk of infection, disease and death as well as psychosocial threat and stigmatization. Bangladesh also sees the need for refresher courses and supervision in general. Training support is requested by Tanzania and Kenya, the latter specifically asking for training in data-base handling and training of an HR officer. South Africa needs training on mentoring skills for coordinators and supervisors. Continuing training of health service providers in all related programs is requested by Nigeria.

Technical assistance is another frequently mentioned type of required support. Ethiopia, Haiti, Indonesia, Lesotho, Tanzania and Thailand simply mention the need of technical assistance or support for human resource management and development. DR Congo specifies requiring technical assistance in implementing HRD at national level in order for it to be reproduced to lower levels (intermediary and peripheral levels). The Philippines need assistance for the development of a NTP HR plan linked with the long-term HR plan of the DOH. Mexico needs technical assistance to document and share successful experiences.

Bangladesh expresses a desire to be supported in its effort to increase staffing numbers and equitable distribution in the face of attrition and high turn over rates, the costs in terms of time and money, in an environment that lacks planning and management and a zero growth policy frustrating efforts to increase posts, with, in addition, migration and competing sectors on limited pool of HR while production training is inadequate and time consuming.

The need for financial support for HRD, e.g., from the GFATM was explicitly mentioned by Ethiopia, Haiti, Indonesia, Thailand, Lesotho and Bangladesh. SEARO definitively stated the need for long term funding for HSS and TB Control for the member countries.

The issue of support through partnership was raised by Bangladesh who stressed the need for sharing of responsibility and communication between health/program planners and colleges/universities. Linking all stakeholders (public, private), civil society, NGOs, CBOs, individuals and donors in the fight against TB has been stated as a required support by Ghana. Ghana also

mentioned formation of health worker advisory boards, reaching of common agreements by all stakeholders and co-ordination of donor groups as a type of support required for community mobilization. The Mexican team expressed a desire to incorporate other countries experiences with a rationale approach to Mexico's situation, the sharing of these experiences being a form of support.

Provisions of information and research were also identified. Nigeria cited a need for assistance with development of the HRD management information system. South Africa stated a need for help to develop skills for conducting research on training activities and Tanzania requested external monitoring of programs and projects.

Bangladesh would like to be supported by an advocacy for service recognition, not unlike the Philippine team which requires continuous advocacy support to LGUs to provide the needed manpower complement for NTP.

Regular conduct of monitoring, supervision, and evaluation, especially at field level, is required to sustain effort in the Philippines. Meanwhile, the need for tools to follow up on training is still on top of the agenda in South Africa.

In conclusion, TB programs around the world have shown how human resource development can be practiced: through training and education, leadership development and capacity building, recruitment, motivation, retention and work organization, seeking evidence through research, information strengthening, monitoring and evaluation and mobilization of funds, and advocacy at policy level. Last, but not least it has been shown how partnerships have helped to make the impossible possible.

## 8. Recommendations

From deliberations during the second platform meeting it is recommended that:

1. National TB programs should appoint a HRD focal person, either part- or full-time, whose task it is to deal with training and all other aspects of HRD for TB control, in the context of national HRH and health systems development;
2. National TB programs should make human resource development plans preferably integrated with HRD plans for HIV/AIDS and other priority disease control programs and in line with national HRD and health systems development policies, strategies and plans;
3. HRD plans and other means should be used as advocacy for more attention from national policy makers and development partners in order to mobilize and develop human and financial resources as well as technical assistance;
4. Special attention should be given to scaling-up the availability of staff with laboratory skills via recruitment, for training as well as task shifting;
5. Human resource development for TB should be well informed and should be guided by evidence from appropriate HR HMIS systems, training needs assessment and other research, based on a relevant research agenda;
6. Human resource development for TB should be regularly monitored and evaluated with feedback to workers provided through quarterly monitoring meetings or other appropriate means;
7. The training effort, although already considerable, should be intensified, decentralized and supported with funds, technical assistance and through regional training centers;
8. Appropriate curricula, learning materials and learning tools should be developed and shared in support of the training effort;
9. Staff should be recruited where critical shortages exist, if necessary on contract with the use of external funding;
10. Conventional as well as innovative methods should be used to make the existing health workforce more productive in terms of implementing the Stop TB strategy: such methods should include but not be limited to better work organization, task shifting, and involving (ex-) patients and community members;
11. Best use should be made of available (albeit scarce) human and other resources by focusing on priority and hitherto neglected patient groups such as prisons in-mates, TB in children, and people with multiple drug resistant TB;

12. Health workers for TB control should be motivated and remain committed to their work through measures such as quarterly monitoring meetings, participatory quality improvement (involving health workers in the evaluation of results), creating opportunities for further development, and other incentives;
13. Infection control and other aspects of health workforce prevention, treatment and care should be implemented with special consideration for the risks that TB workers are exposed to;
14. Tools and technologies should be created to assist health workers either during their training or while performing their job, preferable through a reduction of the workload;
15. Any existing training materials, tools, good practices should be widely shared and made accessible to anybody involved in TB;
16. Partnership should be strongly fostered between government and private sector, among programs, universities and training schools, among various implementation programs, TB and prisons, etc. Such partnership may include agreeing memoranda of understanding (MOU), sharing information, dialoging and dividing the work;
17. TB agencies/programs should examine critically how their activities affect the overall performance of national health systems and should show how to actively sustain health sector support systems.
18. HRD and HRM for TB control should ultimately be integrated into sector-wide efforts to develop and adequately manage human resources for health provided that Stop TB strategies can be adequately maintained.
19. Financial and technical assistance to HRD for TB should be scaled up still further; this scaling up should include the development of more consultants;
20. All concerned should show initiative, should dare to be innovative, and should be flexible and ready “to think outside the box”.

**“Together we can achieve”**

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