



# The Platform

TB Resource Development for TB  
Five years exchange of global experience

The Global Health Bureau, Office of Health, Infectious Disease and Nutrition (HIDN), US Agency for International Development, financially supports this document through TB CAP under the terms of Agreement No.GHS-A-00-05-00019-00.

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This report is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of TB CAP and do not necessarily reflect the views of USAID or the United States Government.



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The Tuberculosis Coalition  
for Technical Assistance



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## Acknowledgements

This publication was prepared by Dr. Peter Petit, an independent consultant and was coordinated by Ineke Huitema, HRD coordinator and Andrée Willemse, Project Officer of the Project Management Unit (PMU) of TB CAP at the KNCV Tuberculosis Foundation.

The author is grateful to all the participants of the HRD/TB platform meetings who have provided the foundation for this report. The report is based on participants country reports, discussions during break-out sessions, presentations and input during the meetings. The commitment, expertise and knowledge of the participants and facilitators have made it possible to develop this publication.

The author would also like to thank the working group on Human Resource Development of TB CAP: Jeff Glassroth<sup>2</sup>, Wanda Walton<sup>3</sup>, Ando Nobutaka<sup>4</sup>, Seraphine Kabanje<sup>5</sup>, Marleen Heus<sup>1</sup>, Mary O'Neil<sup>6</sup>, Jamshed Chhor<sup>7</sup>, Karin Bergström<sup>8</sup>, Asik Surya (Regional Member Asia), Mustapha Gidado (Regional Member Africa) as well as Maarten van Cleeff (PMU/TB CAP) for their valuable input and guidance during the platform meetings and the final review of this document. Tristan Bayly is thanked for the editing, layout and photos.

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## List of Abbreviations

CDR	Case Detection Rate
DOTS	Directly Observed Treatment Short Course
EPQI	Evidence based Participatory Quality Improvement
HCW	Health Care Worker
HR	Human Resource
HRD	Human Resource Development
HRM	Human Resource Management
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
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
UPHOLD	Uganda Program for Human and Holistic Development
XDR-TB	Extensively 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.

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

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

Although the experiences from the platforms form a rich resource which is already documented in the proceedings of the individual meetings<sup>1</sup>, this publication intends to bring into focus seven main lessons learned from the four years of HRD platform experience.

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<sup>1</sup> Proceedings of HRD Platform Meeting in The Hague 2008/Proceedings of HRD Platform Meeting in The Hague 2009  
Download from <http://www.tbcta.org/Library>

# Lessons Learned:

**Training is Key and Should be Part of a Package**



**Go beyond training:  
Supervision and Quality Improvement**



**Political and HRM Support are Crucial**



**Create Opportunities for Professional Growth**



**Think Outside the Box**



**Plan for Human Resources**



**Partnership is a Requirement for Success**



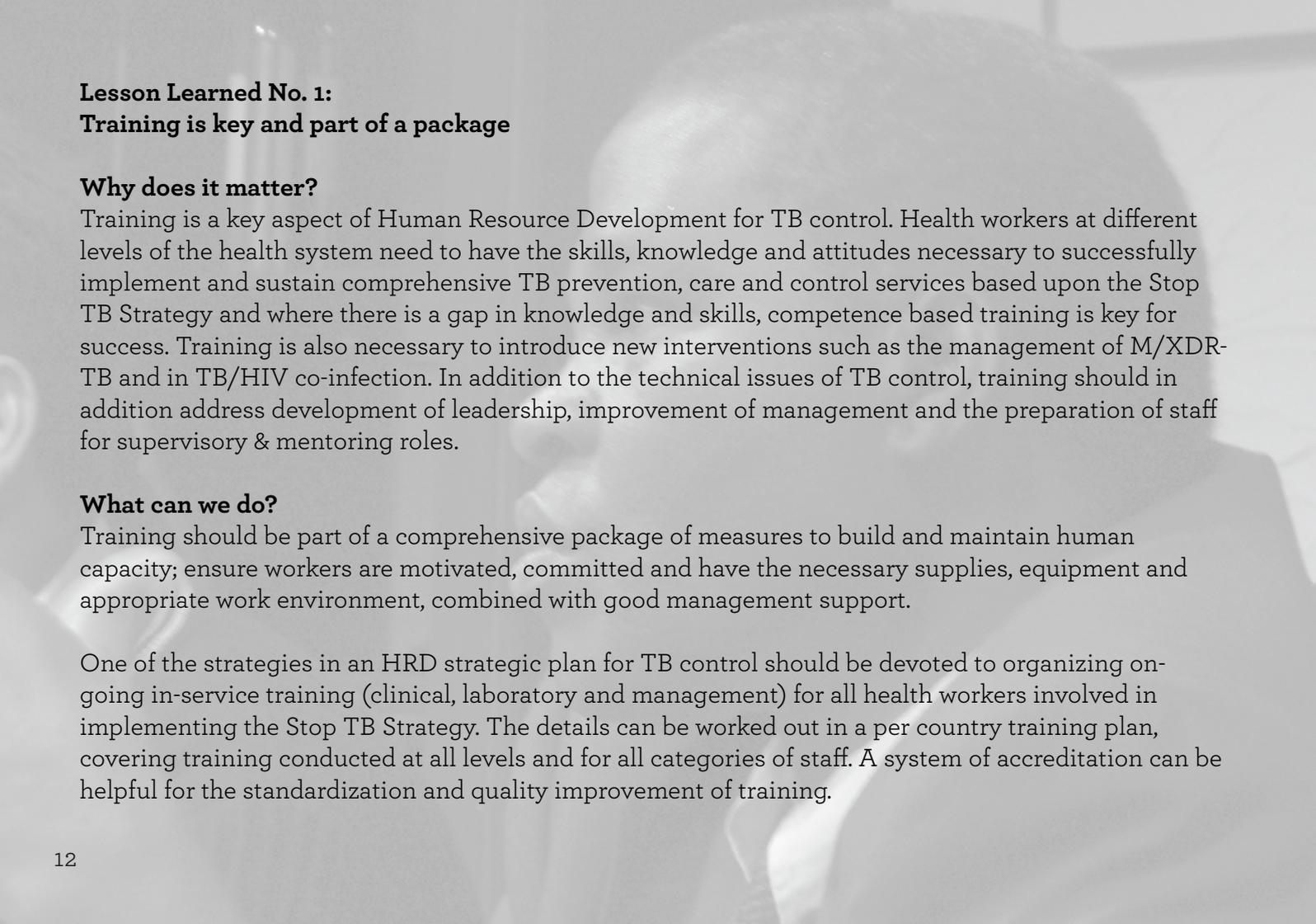
The first lesson highlights training as a key component of HRD and although current training is effective much more is required. It is also recognized that training on its own is not enough; therefore the second lesson learned is devoted to supervision and quality improvement.

It was shown that even the best trained and supervised staff cannot work according to the standards unless there is sufficient financial, material and moral backing. This forms the third lesson, which documents the importance of political and HRM support.

TB control personnel often perform under difficult circumstances so it is important to create opportunities for their professional growth and to establish forums where they can exchange experiences which is the fourth lesson. 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 summed up in lesson number 5.

Planning Human Resource Development for TB control has been strongly promoted throughout the entire platform period. All the above mentioned lessons have a much better chance if they are well planned, which is lesson 6. However, no plan will succeed unless there is wide support, for that reason, number 7 (the final lesson), is about partnership and wide involvement among all stakeholders, which are the key conditions for success.

The final conclusion discusses how staff competence and availability can be improved and how this contributes to program performance.



## **Lesson Learned No. 1:**

### **Training is key and part of a package**

#### **Why does it matter?**

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 necessary to successfully implement and sustain comprehensive TB prevention, care and control services based upon the Stop TB Strategy and 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 the technical issues of TB control, training should in addition address development of leadership, improvement of management and the preparation of staff for supervisory & mentoring roles.

#### **What can we do?**

Training should be part of a comprehensive package of measures to build and maintain human capacity; ensure workers are motivated, committed and have the necessary supplies, equipment and appropriate work environment, combined with good management support.

One of the strategies in an HRD strategic plan for TB control should be devoted 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.

## **Lessons Learned**

Training should be responsive to adult learning needs; make sure that learners can:

- Take responsibility for their own learning based upon their own needs,
- Participate actively rather than passively in their learning process,
- Share their experiences, learning from one another, and the trainer learning from the trainees 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.

Training courses and curricula should be competence based, with an 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.

Capacity building and subsequent international training activities of two regional training centers, 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.

## **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, TB/HIV 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 available to train trainers at all levels and the strategy of decentralization of training was successfully implemented. 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 and 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. An HRD assessment was done on the basis of performance by the service

providers identified during supervisory visits. Communication improved, which resulted in the Government and NGOs identifying and listing staff turn-over and handing the lists to the NTP, which subsequently made an effort to include new staff on the ongoing courses.

Although this is not a long-term solution to the problem of staff turn-over, it has been a step in the right direction towards improving the HR situation.



## **Lesson Learned No. 2: Beyond Training: Supervision and Quality Improvement**

### **Why does it matter?**

Training is essential, however, it is not enough. Much more is required to improve performance and to sustain results in real life situations.

Regular supervision as a follow-up to training is fundamental. It should be of a supportive nature, 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 as it stimulates better performance. Mentoring is another way of improving performance by providing on the job guidance; it consists of assigning a senior, or more experienced worker to provide regular guidance to one which is less experienced or recently appointed.

Quality improvement initiatives stimulate health workers to take responsibility for the enhancement of program performance into their own hands.

### **What can we do?**

The development, introduction and utilization of supervision and appraisal tools is one way of providing follow-up and adding to training.

Several countries provide examples:

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 which identified staff availability for TB diagnosis and treatment.

In addition to providing tools, supervisors also need to be trained on how to be better supervisors.

The 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 specific interventions and finally evaluating if you reached your designated standard. An important aspect of PIF is creating networks of practitioners or “collaboratives”.

### **Lessons Learned**

Supportive supervision in South Africa improved TB control outcome indicators.

It was found that staff learned more in a friendly and nonthreatening environment and that supportive supervision increases staff motivation, whilst self-assessment reinforces and improves learning. On-site learning was found to be more effective than classroom learning. The Pakistan team also found that appraisal should be participatory and supportive.

Facilitative supervision works, but only if other supportive mechanisms and conditions are in place. In particular adequate resources should be available to enable people to effectively perform (Malawi) and work organization should be appropriate (Kenya).

The PIF led to the 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 both managers and decision makers must be constantly engaged, especially when staff turnover is high. Countries must be further encouraged to document and present what they do. Giving implementers the chance to attend meetings and to present their work increases motivation as does recognizing performance and celebrating small successes.

## **Case Study: Participatory Quality Improvement in Local Health Systems for TB Control in Mexico**

Mexico NTCP has the ambition to take the lead in obtaining a “Mexico Free of TB”, however, the present situation shows that they still have a long way to go. The Evidence based Participatory Quality Improvement (EPQI) is a methodology designed to obtain better results in patient care and specifically adapted to TB. The method involves teams of health workers committed to and directly responsible for patient care.

A variety of quality assessment tools for data analysis and decision making were introduced to teams of health workers (managers and operative personnel) and this empowered them to improve the quality of a Local Health System for TB control in a participatory manner. Each team consisted of 35-45 health workers: physicians, nurses, lab technicians, social workers, managers, supervisors and those responsible for TB, HIV and drug management.

All levels were engaged including the NTP, state level staff, local health systems, health centers up to the level of medical care and the patients themselves. The activity resulted in action plans for:

- Detection of bad cough in the waiting room and other health promotion activities,
- 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 social mobilization and health workers working as a team.

It was observed that data analysis for the use in decision making, is better with the active participation of health workers. The empowerment of the basic ‘work team’, along with teamwork and the involvement of leadership, 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.

The benefits included:

1. Increased commitment from health workers,
2. Increased teamwork,
3. The quality improvement of district health services in relation to public health,
4. 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%.

High staff turnover presented a challenge and some leaders lacking in public health training (specifically the Chief of District Health Services) failed to take any actions, despite it being part of their job descriptions.

In total 651 health workers from 16 of the 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 publication called “Practical Guide To Improve Quality TB Patient Care” (Spanish) was developed and subsequently translated into English so the wider community could also benefit.

## **Lesson Learned No. 3: Political and HRM Support**

### **Why does it matter?**

Political and HRM support is of immense importance. Where the support exists, the morale of program staff is boosted and plans are more likely to be given priority and funding. With political will, government and development partners are likely to be motivated to allocate both financial and human resources. Political support also generates goodwill with the public and facilitates advocacy for TB control.

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.

### **What can we do?**

Leadership development is important and should be given even more emphasis in the future. 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 the review of the staff structure in order to create more designated TB persons TB at the provincial level. Thailand attempts to convince policy makers to prioritize TB control. Mexico focuses its attention on tackling TB in high burden districts. The Philippines advised using international opportunities to strengthen TB initiatives requiring a 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.

### **Lessons Learned**

Where political or HRM support existed, it was identified as an vital factor for success; Where this support is lacking, there is a clear need to advocate for it.

Strong advocacy and leadership development can change the balance and more efforts are required to build leadership for change. It is worth noting that it is not always possible to find and control political support, sometimes it is simply a matter of luck.



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

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

The Permanent Secretary of the Ministry of Health was at the centre of an initiative, reported to the 2009 platform. As he was very much in favor of good TB services, he designated specific key persons to enhance TB activities at all levels within the provinces. Through his concerted action, health care workers working in TB care were motivated to achieve the TB control targets

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

It is expected that the assignment of responsibilities to specific people will result in Quality DOTS application and provision of action based information which is relevant to TB control and achievement of 85/70 targets.

Increasing the success rate to achieve the Millennium Development Goals target and to reduce the rate of increase of MDR-TB, will remain a challenge. However, since this initiative, the NTP team reported: “We haven’t had such strong commitment like this since 1979”, this is the golden period of TB Control in Thailand.

## **Lesson Learned No. 4: Creating Opportunities for Professional Growth**

### **Why does it matter?**

It is of utmost importance to attract and maintain health workers for TB control and HIV, both fields are perceived as risky and are therefore unpopular. Health workers should not only be retained in the service, they should remain competent and highly committed to dealing with new challenges.

Providing opportunities for further learning and exchanging experiences is extremely motivating, which is an important factor in retaining health workers in the service and in enhancing their commitment to challenging tasks in difficult working environments.

### **What can we do?**

Organize quarterly monitoring meetings at national or regional level; they will be 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.

Opportunities for professional growth and international learning experience are also important motivators. The platform meetings themselves were an important opportunity for growth and development.

### **Lessons Learned**

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 was also recognized as an important factor in the enhancement of learning and the acceptance of new human resource development related ideas.

SEARO noted the high level of motivation of the TB HRD Teams in its region as a factor contributing to the success in developing HRD capacity. At the 2009 meeting it was reported that regional advocacy and support contributed to several benefits at country level:

- Quarterly monitoring meetings increased staff motivation in both government and NGOs,
- High quality and sustainable partnerships helped tackle HRD issues,
- Joint review missions in countries improved health staff performance,
- Fellowships, development and accreditation of higher level training courses created opportunities to learn and grow.

## **Case Study: Country Support for HR Development by WHO/SEARO**

The WHO/SEARO team shared a vision of human resource for TB development. This vision is 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 TB control staff/personnel (based on their job description/task) available, in the right numbers, at the right place and the right time, with the necessary support system to motivate them, thus enabling the achievement of the NTP goals.

Unfortunately, the region faces a number of staffing difficulties, for instance HRD information systems in the public sector are not yet established in most countries and there is no information on how many staff have been trained, what they were trained on, nor on staff requirements. HRD capacity (management, supervision and trainers) is in short supply at national and district levels and 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, and paradoxically, in view of the shortages, there is also a high probability of staff being under-utilized.

The training effort is also compromised because, with exception of India, Indonesia, Myanmar and Nepal, no criteria for the selection of staff for training exist. There is little or no follow-up of trained staff or activities in Bangladesh, Nepal and Thailand nor is there any monitoring and evaluation of training programs. Finally, with the exception of India and Indonesia, pre-service training is not in accordance with NTP guidelines.

To meet these challenges, WHO/SEARO is supporting the development of HR plans, decentralizing training, developing HR capacity and building up a critical mass of master trainers in countries.

WHO/SEARO advocates for quarterly monitoring meetings to increase staff motivation for both government and NGOs whilst promoting high quality and sustainable partnerships for tackling HRD issues in countries. Joint review missions in countries were instated to improve health staff performance.

WHO/SEARO are supporting countries in creating opportunities to learn and grow through fellowships, higher training and accreditation of training. To achieve these goals, the TB Unit of WHO/SEARO worked in close collaboration with the HR Teams of the National TB Control Programs and with technical assistance from TB CAP.

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

## **Lesson Learned No. 5: Thinking Outside the Box**

### **Why does it matter?**

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 it should be combined with HIV training and be shared among partners to increase efficiency. More personnel are usually needed, but there are restrictions on 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.

### **What we can do?**

In The Gambia the inadequate number of laboratory assistants was a constraint in 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.

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. Tanzania and DR Congo (see case study page 26) successfully deployed ex-TB patients in TB control.

## Lessons Learned

It is crucial to be proactive and to show initiative, both of which are leadership qualities; Mozambique pioneered DOTS in 1984 as well as working with Volunteers for Community Based DOTS, while using “brigadas móveis” (mobile brigades) in prevention.

As a result of training Leprosy/TB inspectors (LTI) in smear microscopy, the numbers of new smear microscopy centers in The Gambia increased from 6 in 1990 to 22 in 2007, now newly trained lab assistants are gradually taking over smear microscopy from LTIs. It was ascertained that specialized staff can be used to achieve a higher coverage of smear microscopy within a short period of time - a great example of task shifting.

Recruiting and training microscopists was a different approach, which also worked.

Task shifting involving community members has not only been possible, but has had demonstrable positive effect, e.g. on the treatment success rate.

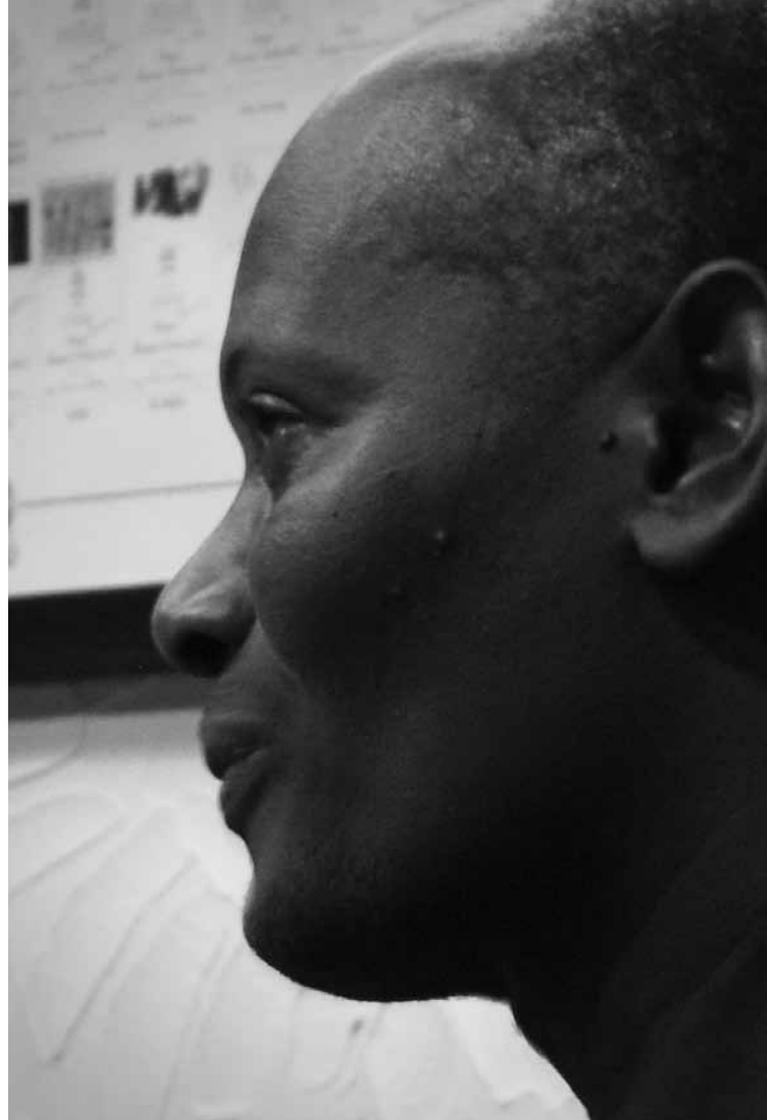
There are however limitations; using microscopists requires a good quality control system and relying on community members requires close collaboration with well trained health workers.

## **Case Study: Community DOTS in DR Congo**

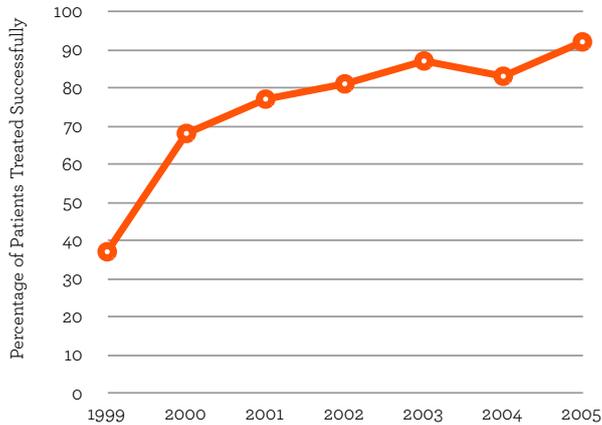
In DR Congo health workers are both overburdened and poorly motivated, and health centers are distributed unevenly throughout the country. Therefore, many people are unable to get precise information about TB and patients are often incorrectly followed up, which in turn leads to treatment defaulting.

In a unique initiative, former patients have established an association to assist health workers in following TB patients until they are cured. They provide health education to patients and their families, visit patients at home and even bring them their medication. This exceptional partnership includes former patients, other trained members of the community and health workers.

As a result, some health centers with a low treatment success rate have improved their performance, e.g. in Molende Health Center as shown in the graphs on the next page.

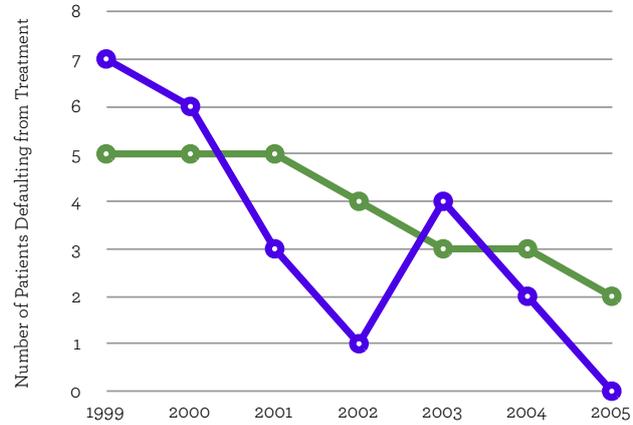


**Evolution of Treatment Success Rate in Molende Health Center from 1999-2005**



○ Treatment Success Rate

**Evolution of Defaulter Rate in Molende Health Center from 1999-2005**



○ Molende Defaulter Rate    ○ Baseline Defaulter Rate

The experience clearly shows that involving the community in the struggle against TB through the former patients' association, contributes to the improvement of TB patient's care. Former patients are better than health workers at explaining to new patients what they felt when they got the disease and how they had to behave in order to get cured. Ex-patients can also assist health workers, whilst incentives such as weekly meetings, supervision, training and bicycles, can help to sustain the work of community members.

(N.B. Although the above approach is successful, it should also be mentioned that community members do not replace health workers)

## **Lesson Learned No. 6: Planning for Human Resources**

### **Why does it matter?**

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:

- 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.

The reason for strategic planning in the development of human resources for health is to ensure that all the necessary requirements are in place. The strategic plan needs to be in line with the TB strategic plan and in harmony with the overall HR strategic plan of the country. The planning process in itself will assist in forging new partnerships and building political support.

## **What we can do?**

Have a HRD plan and if necessary use technical assistance to develop it, as has been done by several countries.

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, ‘the HRH Action Framework’ described in the handbook will provide invaluable support in the development of any plans.

As recommended in the handbook, first create sufficient interest and support/buying in for the HRH strategic plan with the NTP management, the MOH and all other relevant stakeholders. Next, establish leadership for the HRH strategic planning process; decide who should take the lead and who should do what. Set up an HRH strategic plan working group, paying attention to tasks and responsibilities, number and profile of members, as well as the required time investment.

## **Lessons Learned**

Strategic planning is possible: By the end of TB CAP, 22 out of 23 countries had started the process of developing HRD strategic plans for TB control and from these 22 countries, 9 countries have developed a comprehensive HRD plan and officially incorporated it into the country strategic plan. Strategic HRD plans based on global guidelines have been developed in Indonesia, Southern Sudan, Malawi, South Africa, Uganda, Nigeria, Vietnam, Bangladesh and Mexico. Plans are almost finished in DR Congo, Mozambique, Ethiopia, Cambodia, Afghanistan, Botswana and Kenya.

## **Case Study: Malawi National Tuberculosis Control Program Human Resources Strategic Plan 2009-2011**

In 2002 the Malawi NTP introduced the concept of Human Resource Development into the management of the Tuberculosis Control Program. NTP representatives attended the 2 African HRD 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 have been seen 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 have been trained. Quality Assurance systems have been 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). Using these two concepts in a practical exercise will provide answers to your Human Resource requirements, taking into consideration the need for sufficient numbers and a 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 global TB strategies.

The HR related National Health System issues are many 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 placed in the HRD Plan to facilitate HRD issues for TB Program:

1. Strengthen the capacity of 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 and 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 all other health workers involved in the implementation of the STOP TB strategy.

## **Lesson Learned No. 7: Partnership is a Condition for Success**

### **Why does it matter?**

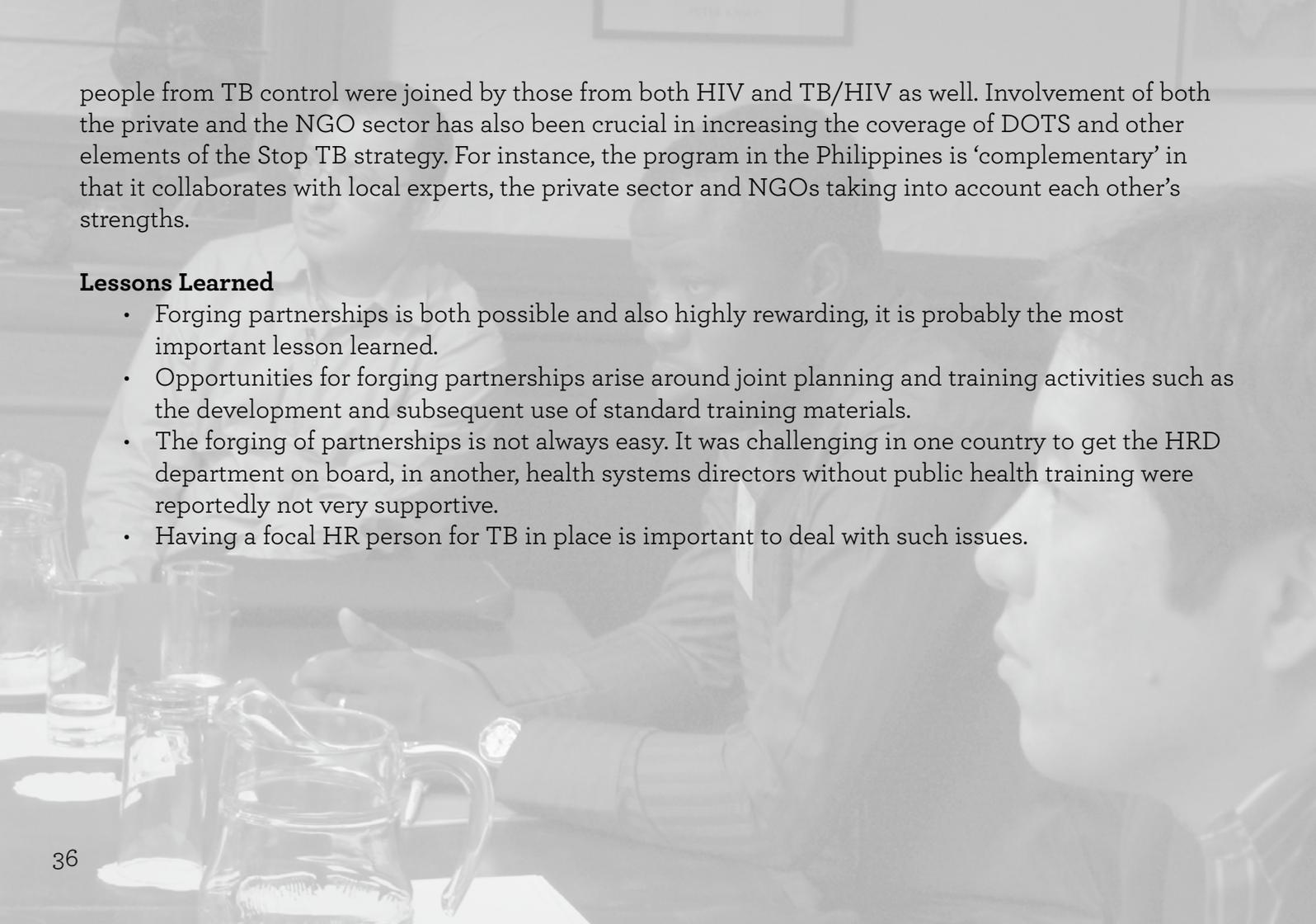
As it was a crucial element in all the previous lessons learned, partnership is cross-cutting. It is important for training as mentioned in the case studies from Bangladesh and Uganda. Supervision depends on it, whilst systematic approaches toward quality improvement include the formation of ‘collaboratives’; the Participatory Quality Improvement initiative in Mexico, involved people from health facilities, the local health system and state levels; TB control in prisons in Cambodia involved the MOH, the Ministry of Interior Affairs, prison health staff and NGOs, with TBCTA in 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.

### **What we can do?**

Two forms of partnership have been of outstanding value and have contributed to successes in many countries:

1. Partnerships between the national TB programs and the various HRD Departments for instance in Tanzania, and Zambia
2. Partnerships 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.

The strengthening of these links became apparent in successive platform meetings, as the HRD



people from TB control were joined by those from both HIV and TB/HIV as well. Involvement of both the private and the NGO sector has also been crucial in increasing the coverage of DOTS and other elements of the Stop TB strategy. For instance, the program in the Philippines is ‘complementary’ in that it collaborates with local experts, the private sector and NGOs taking into account each other’s strengths.

### **Lessons Learned**

- Forging partnerships is both possible and also highly rewarding, 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.
- The forging of partnerships is not always easy. It was challenging in one country to get the 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 there is a high association between TB and HIV with national data from September 2007 showing that 60% of TB patients are also HIV positive, there was clearly a need identified to orient all frontline HCWs to handle patients with both TB and HIV.

It was also realized 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, UPHOLD-USAID and JCRC, coordination between this wide range of partners also proved to be a challenge.

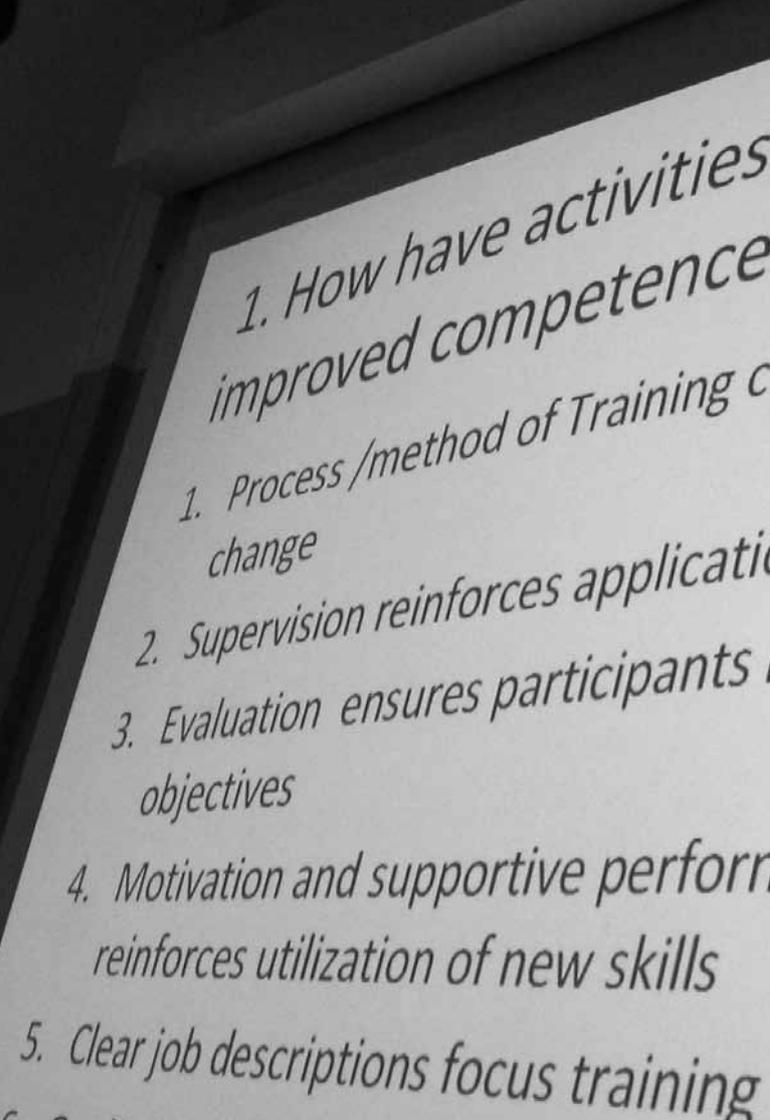
A joint effort was made for building human resource capacity to implement TB/HIV collaborative activities in Uganda, using a standardized training package consisting of 10 modules.

In the coordinated exercise WHO trained 13 districts (2006) and UPHOLD trained 28 districts whilst planning to train 28 more. TB CAP trained 12 districts with a view to reaching 20 districts. TB CAP also trained 3 Regional Liaison Officers to coordinate training. NUMAT took care of 5 districts in the North (Apac, Lira, Pader, Kitgum and Gulu) and 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, JCRC, 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 collaboration, 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 routinely capture TB/HIV collaborative activities (Modified NTLP monitoring stationery- Unit TB register, District TB registers, Quarterly Report Forms and National Data Base).

Training contributes towards improved quality of care for clients and creates an increased demand for HIV testing among TB patients. 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

Through the platform meetings, the understanding of Human Resource Development has deepened and broadened among teams from participating countries. In addition, the opportunity for sharing 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 still remains an important activity, especially if it addresses technical and managerial/ leadership aspects and if it is based on assessed performance gaps and the needs of adult learners. In order to achieve acceptable coverage of the training needs of all health workers it is important that training is decentralized through cascade trainings 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 efforts 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.

Further to training, improving staff competence also requires supportive supervision, mentoring, occasional technical assistance and also 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 PIF initiatives, and through the involvement of community members and ex-patients. Task shifting with relation to sputum examination greatly improved accessibility to and the efficiency of laboratory services.

The overriding lesson learned is that the 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. Appointing TB/HR focal persons with clear job descriptions at central level of the NTPs was advocated for and in many cases implemented.

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

