



**Human Resources platform meeting for joint TB/HIV activities  
From DOTS to the Stop TB Strategy - Reaching the targets for HRH  
9-11th June 2009, The Hague, The Netherlands.**

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



**USAID**  
FROM THE AMERICAN PEOPLE

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.

#### Disclaimer

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.

# Table of Contents

<b>Acknowledgements</b>	<b>4</b>
<b>List of Abbreviations</b>	<b>5</b>
<b>1. Introduction</b>	<b>7</b>
<b>2. TB Control context</b>	<b>7</b>
2.1 Stop TB Challenges .....	7
2.2 TB HRD Status; The Global Perspective.....	8
2.2.1 Progress with HRD for TB .....	8
2.2.2 HR in major events and initiatives.....	9
2.2.3 New tools on HRH .....	9
2.3 TB CAP Human and institutional capacity building; Strategic approach summary and progress on key indicators .....	9
<b>3. HR Challenges and Obstacles in Countries</b>	<b>10</b>
<b>4. Tools and Strategies for Improvement</b>	<b>11</b>
4.1 Performance Improvement Framework.....	11
4.2 Strategic planning for HRH for Stop TB.....	13
4.2.1 The planning process: .....	13
4.2.2 What an HRH plan for Stop TB should cover .....	14
4.2.3 The process of developing an HRH strategic plan for TB control .....	14
4.3 Improving facilitation skills .....	15
4.3.1 To train or not to train, decide whether training is the best solution.....	15
4.3.2 How do adults learn? .....	15
4.3.3 Six steps in the preparation of a training course.....	15
4.4 Integrating priority disease requirements with the education cycle.....	16
4.5 Providing supportive supervision .....	17
4.6. TB CAP e-portal for HRD .....	19
<b>5. Experiences from Countries</b>	<b>19</b>
5.1 Intentions .....	19
5.2 Actions associated with the HRH Action Framework .....	20
5.3 Actions related to IR-5 HRD output indicators .....	21
5.4 Actions related to IR-4 HIV Collaboration .....	25
<b>6. Best practices and tools reported by countries</b>	<b>27</b>
6.1 TB/HIV Control in Mvuzi Health Centre DR Congo.....	27
6.2 Building Capacity for Facilitative Supervision in Malawi .....	27
6.3 Participatory Quality Improvement in Mexico .....	28
6.4 A Performance Appraisal Tool from Pakistan.....	28
6.5 Supporting Countries with HRH for TB in South East Asia .....	29
6.6 HRD Information Management Tool from Tanzania .....	29
6.7 Boosting TB Control in Thailand, the Mr & MS TB project.....	31
6.8 Developing HR for TB/HIV Collaboration in Uganda .....	31
6.9 A Tool for Intensified Case Finding in Uganda .....	32
6.10 A Model for TB/HIV Management in Vietnam .....	33
<b>7. Further Support Requirements</b>	<b>33</b>
<b>8. Discussion</b>	<b>34</b>
<b>9 Resolutions and Next Steps</b>	<b>36</b>
9.1 Resolutions June 2009 .....	36
9.2 Next Steps.....	36

<b>References</b>	<b>37</b>
<b>List of Participants</b>	<b>39</b>

## Acknowledgements

This report has been prepared by Dr. Peter Petit, an independent consultant, it was coordinated by Ineke Huitema, HRD coordinator and Tristan Bayly, Knowledge Exchange Officer from the Project Management Unit of the Tuberculosis Assistance Program (TB CAP)<sup>1</sup> at the KNCV Tuberculosis Foundation.

The author is grateful to all the participants of the HR/TB platform meeting who have provided the foundation for this report. The report is based on participant country reports, discussions during break-out sessions, presentations and other input during the meeting as well as materials used during the capacity building workshops on day three. The commitment, expertise and knowledge of participants and facilitators have made it possible to develop this important publication.

The author would also like to thank the working group on Human Resource Development of TBCAP: Dr. Jeff Glassroth (ATS), Dr Wanda Walton (CDC), Ando Nobutaka (JATA), Dr. Seraphine Kabanje (FHI), Marleen Heus (KNCV) Jamshed Chhor (The Union) Dr Elena Yurasova (WHO), Jacob Creswell (WHO), Dr. Asik Surya (Regional member Asia), Dr Mustapha Gidado (Regional member Africa) as well as Dr. Maarten van Cleeff (PMU/TB CAP) and Andrée Willemse (PMU/TB CAP) for their valuable input and guidance during the platform meeting and the final review of this document.

---

<sup>1</sup> Tuberculosis Control Assistance Program (TB CAP) is a five-year program (2005-2010) funded by the United States Agency for International Development (USAID). TB CAP is carried out by the Tuberculosis Coalition for Technical Assistance (TBCTA). TBCTA comprising of eight member organizations: the American Thoracic Society (ATS), Centers for Disease Control and Prevention (CDC), Family Health International (FHI); The International Union Against Tuberculosis and Lung Disease (The Union), Japan Anti-Tuberculosis Association (JATA), KNCV Tuberculosis Foundation (KNCV); Management Sciences for Health (MSH) and the World Health Organization (WHO)

## List of Abbreviations

ACSM	Advocacy Communication Social Mobilization
AFB	Acid Fast Bacilli
ART	Anti Retroviral Treatment
BMAF	Benjamin Mkapa HIV/AIDS Foundation
CBO	Community Based Organization
CDC	Center for Disease Control and Prevention
CDR	Case Detection Rate
CENAT	National Centre for Tuberculosis and Leprosy C
CHW	Community Health Worker
CTC	Care and Treatment Centers
CTRL	Central TB Reference Laboratory
CPT	Cotrimoxazole Preventive Therapy
DCT	Diagnostic Counseling and Testing
DEWG	DOTS Expansion Working Group
DGHS	Director General of Health Services
DLTLD	Division of Leprosy, Tuberculosis and Lung Disease
DOTS	Directly Observed Treatment Short Course
DR	Drug Resistance
DRS	Drug Resistance Survey
DST	Drug Susceptibility Testing
DTLC	District TB Leprosy Coordinator
DTO	District TB Officers
EHCP	Essential Health Care Package
EHP	Emergency Hiring Project
EPQI	Evidence Based Participatory Quality Improvement
EQA	External Quality Assurance
GAVI	Global Alliance on Vaccines and Immunization
GDF	Global Drug Facility
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GFR	Global Fund Round
GHWA	Global Health Workforce Alliance
GLC	Green Light Committee
HBC	High Burden Country
HCT	HIV Counseling and Testing
HRD	Human Resource Development
HRH	Human Resources for Health
HRM	Human Resource Management
HRIMS	Human Resource Information Management System
HRMIS	Human Resource Management Information System
HTP	Health Technology and Pharmaceuticals
HW	Health Worker
IC	Infection Control
IEC	Information Education Communication
IMAI	Integrated Management of Adult and Adolescent Health
IMCI	Integrated Management of Childhood Illness
IMSS	Instituto Mexicano del Seguro Social
ISTC	International Standards for Tuberculosis Care
JATA	Japan Anti Tuberculosis Association
KNCV	KNCV Tuberculosis Foundation
LGU	Local government Unit
LHS	Local Health System
LTI	Leprosy TB Inspector
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MDR TB	Multi Drug Resistant Tuberculosis
MDR	Multi Drug Resistance
MIS	Management Information System
MJAP	Mulago Mbarara Teaching Hospitals' Joint AIDS program
MOH	Ministry of Health
MoHSW	Ministry of Health and Social Welfare
MoLG	Ministry of Local Government
MOST	Management & Organizational Sustainability Tool

MSH	Management Sciences for Health
NGO	Non Governmental Organization
NTP	National TB Program
NLTP	National TB/Leprosy Program
NUMAT	Northern Uganda Malaria AIDS & Tuberculosis Program
OD	Opportunistic Diseases?
PAHO	Pan American Health Organization
PDP	Priority Disease Program
PHC	Primary Health Care
PIH	Partners in Health
PITC	Provider-Initiated HIV Testing and Counseling
PIF	Performance Improvement Framework
PMU	Program Management Unit
PPM	Private Public Mix
PPMD	Public-Private Mix DOTS
PPP	Public Private Partnership
PTLC	Provincial TB Leprosy Coordinator
RCC	Rolling Continuation Channel
RCQHC	Regional Centre for Quality of Health Care
RSA	Republic of South Africa
SARA	Support for Analysis and Research in Africa
SDCP	Select Disease Control Program
SEARO	South-East Asia Regional Office
SMART	Specific, Measurable, Achievable, Relevant with Time indication
SNRL	Supra National Reference Laboratory
SOP	Standard Operating Procedures
SS-	Sputum Smear negative
SS+	Sputum Smear positive
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB CAP	Tuberculosis Control Assistance Program
TB	Tuberculosis
TBC	Tuberculosis Control
TBCTA	Tuberculosis Coalition for Technical Assistance
TB-IC	TB Infection Control
TDFI	Tropical Disease Foundation Inc.
TFT	Task Force Training
TLCU	TB/Leprosy Central Unit
TMIH	Tropical Medicine and International Health
TQM	Total Quality Management
USAID	United States Agency for International Development
VAAC	Vietnam Administration for HIV/AIDS Control
VCT	Voluntary Counseling & Testing
WHA	World Health Assembly
WHO	World Health Organization
WHR	World Health Report
XDR	Extremely Drug Resistant

## 1. Introduction

The Tuberculosis Control Assistance Program (TB CAP) is a five-year program (2005 -2010) funded by the United States Agency for International Development (USAID) and executed by the Tuberculosis Coalition for Technical Assistance (TBCTA).

**TB CAP continues to support the areas of political commitment under the DOTS strengthening and expansion; “From the DOTS to the Stop TB Strategy”, building human, institutional and financial capacity for DOTS-Stop TB implementation that can be sustained beyond the life of the program, receives special emphasis.**

TB CAP operates within the context of 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”, which is described in the introduction to the proceedings of the previous HR / TB platform meeting (May 28 – 29 2008).

The 2008 platform meeting made recommendations concerning the appointment of either part or full time HRD focal persons, human resource for TB control development plans, and scaling-up by conventional and innovative means availability and productivity of staff, especially those with laboratory skills. It was proposed to focus on priority and hitherto neglected patient groups, such as prison in-mates, TB in children and people with MDR-TB. Also stressed, was the need for advocacy, information, evidence, monitoring and evaluation for human resource development for TB. Quarterly monitoring meetings, quality improvement through a participatory approach and creating opportunities for further development were identified as ways of motivating and securing the commitment of health workers. Infection control and other aspects of health worker access to prevention, diagnosis, treatment and care with relation to TB and HIV were also mentioned as means to attract and retain health workers.

Attention was further given to intensifying and decentralizing the training effort, to be supported by appropriate curricula and learning materials. Tools and technologies need to be created not only to assist health workers during their training but also while performing their job, preferably through reducing their workload. Any existing training materials, tools, good practices should be shared widely and made accessible to anybody involved in TBC. The importance of fostering partnerships was clearly demonstrated while TB agencies / programs were encouraged to support national health systems, ultimately aiming at integrating HRD and HRM for TB control into sector-wide efforts to develop and adequately manage human resources for health. All this, the 2008 meeting concluded, requires the scaling up of financial and technical assistance to HRH for TB, including the development of more consultants but more than anything else, initiative, the courage to innovate, flexibility and readiness “to think outside the box”, since “Together we can achieve”.

This booklet comprises the proceedings of the third HRD / TB platform meeting, which took place in The Hague, The Netherlands, on 9th and 10th of June 2009, with skills building workshops on the 11th June.

Chapter 2 describes the TB control and HR for TB Control context with reference to the WHO Global Tuberculosis Control report of 2009 and TB CAP strategic approach summary. Chapter 3 summarizes HR challenges and obstacles in countries, reported by participants. Chapter 4 is devoted to tools and strategies as presented in the platform meeting and further discussed in the skills building workshop. Tools include a performance improvement framework; a Handbook for Planning the Development of Human Resources for Health for Implementation of the Stop TB Strategy; Improving facilitation skills and integrating priority disease requirements with the education cycle providing supportive supervision and TB CAP e-portal for HRD. Chapter 5 summarizes country reports, giving an overview of stated intentions and actions taken to realize these intentions. As in the proceedings of the previous meeting, the main body of this publication is the report on a number of unique initiatives and innovations by counties (Chapter 6). Chapter 7 briefly mentions further support requirements, whilst Chapter 8 summarizes the experiences and discusses them in the light of the HRH Action Framework, the IR-5 output indicators and TB/HIV collaboration. Chapter 9 lists the resolutions adopted by the platform meeting as well as the next steps for follow-up.

Hopefully this collection of cases will continue to serve as a source of inspiration for all who struggle to develop the human resource capacity for TB control.

## 2. TB Control context

### 2.1 Stop TB Challenges

The Stop TB Strategy Consists of 6 components:

1. Pursue high-Quality DOTS expansion and enhancement.



2. Address TB/HIV, MDR-TB and other challenges.
3. Contribute to health systems strengthening.
4. Engage all health care providers.
5. Empower people with TB, and communities.
6. Enable and promote research.

The Global Tuberculosis Control WHO Report 2009 assesses the TB control situation in the context of global targets set for 2015, noting a slow increase of incidence in absolute terms due to population growth, with most new cases occurring in Africa and Asia. However, per capita incidence is decreasing slowly. Prevalence and mortality rates are also falling globally and in all six WHO regions, even though the African and European regions are still far from achieving the Stop TB Partnership targets.

DOTS is the component of the Stop TB Strategy that is most widely implemented with a global case detection rate of 63%, 5% less than the Global Plan milestone for 2007. The WHA target of successfully treating 85% of new TB patients detected by DOTS programs was exactly met globally in 2006. However, the African, American (75%) and European (70%) regions are still lagging behind.

The 2009 Report notes that expansion of diagnosis and treatment of MDR-TB falls far short of Global Plan milestones, notably in China, India and the Russian Federation, where almost 60% of the world's 0.5 million MDR-TB cases occur. On the other hand, there has been progress on scaling up collaborative TB/HIV activities, especially in the African Region, even though it still falls short of milestones set in the Global Plan.

Most countries report integration of diagnosis and treatment into primary health care, and alignment of strategic planning for TB control with broader health sector planning frameworks. There are also encouraging examples of public-private mix initiatives contributing to increased case detection in for instance, Pakistan and the Philippines and increased attention to advocacy, communication and social mobilization.

Challenges remain: an estimated 37% of cases of smear-positive TB are not being treated in DOTS programs; more than 90% of MDR-TB is not being diagnosed and treated according to international guidelines. The majority of HIV-positive TB patients do not know their HIV status, whilst the greater part of those who do know their status are not yet accessing ART. In view of the global financial crisis, closing the funding gap of US\$ 1.6 billion - required mostly for MDR-TB diagnosis and treatment in India and China and for DOTS and collaborative TB/HIV activities in Africa - will be a major challenge.

## **2.2 TB HRD Status; The Global Perspective**

### **2.2.1 Progress with HRD for TB**

HRD for the implementation of the Stop TB strategy refers to the process of planning, managing and supporting the health workforce involved in the delivery of comprehensive TB control services, within overall health workforce development.

A vision for HRD for TB control could be a world where every person everywhere has access to a motivated and supported health worker who is skilled in TB control based on the Stop TB Strategy, whereby:

Health workers at different levels of the health system have the professional competence for successfully implementing and sustaining comprehensive TB control services based on the Stop TB Strategy.

A sufficient number of health workers of all categories involved in comprehensive TB control is available at all levels of the health system with the required support systems to motivate staff to use their competencies to provide quality preventive and curative TB services for the entire population according to their needs.

The Global Tuberculosis Control Report 2009 noted very little difference compared to the previous year. A total of 94 countries, including 14 HBCs have conducted a recent HRD needs assessment (11 HBCs in the 2008 report), while 90 countries, including 14 HBCs reported having a comprehensive plan for HRD related to TB control (13 in 2008 Report), however, among the HRD plans which do exist, most could be strengthened.

The job descriptions of staff involved in the implementation of the Stop TB strategy were up-to-date or almost all up-to-date (in line with current policies and recommendations) in 17 HBCs.

Training related to TB control was reported to be included in the basic curriculum of doctors in 18 HBCs, in the basic curriculum for nurses in 16 HBC and in the curriculum of laboratory technicians in 17 HBCs. However, such updating

of basic training curricula to correspond to NTP guidelines is often not formalized and in line with formal processes for curriculum revision<sup>2</sup>.

Routine monitoring of staff availability, turnover and training appears weak across HBCs.

## 2.2.2 HR in major events and initiatives

HR issues figured prominently in the background paper to the ministerial meeting of high M/XDR-TB burden countries Beijing, China, 1–3 April 2009, addressing the key bottlenecks hampering the prevention and scale-up of M/XDR-TB control and patient care, resulting in the Beijing Call for Action on TB control and patient care.

Agenda item 12.9 of the Sixty-Second World Health Assembly, 22 May 2009 resulted in WHA resolution 62.15 reading: “to achieve universal access to diagnosis and treatment of multidrug-resistant and extensively drug-resistant tuberculosis, ... by means of ... (d) making available sufficiently trained and motivated staff in order to enable diagnosis, treatment and care of tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis, as an integral part of efforts to address the overall health workforce crisis;”

The Global Fund for AIDS, TB and Malaria reported several HRD aspects in grant proposals for TB (*GF information*), including increasing the number of HR, salaries for health workers & community health workers, salary top-up and saving lives of health workers to return to work. All TB grants have training activities; 3.5 million people were trained in TB programs by mid-2008 (*GF data*). However, most grant proposals could be much more comprehensive with respect to HR, beyond training activities and emphasis on numbers trained.

During the Partners Forum, organized by the Stop TB Partnership in Rio de Janeiro in March 2009, the Joint Working Group meeting (TB/HIV, MDR-TB, DOTS Expansion and Global Laboratory Initiative) recommended the Establishment of a task force to address the cross cutting issue of human resources across the working groups. TB must be part of the broader global health workforce movement. This will be discussed further during the DEWG meeting in October 2009.

## 2.2.3 New tools on HRH

The following publications were or would become available before the end of 2009;

- Planning the development of human resources for health for implementation of the Stop TB Strategy - A handbook (WHO7HTM/TB/2008.407)<sup>3</sup>;
- A revised set of training modules for Management of TB at Health Facility Level, reflecting the Stop TB strategy; it includes a module on infection control;
- A new page on HRD on the WHO Stop TB Department’s website;
- A set of WHO MDR-TB Training Modules, based on material developed in Philippines by TDF and NTP; the package includes 7 participant modules, a Facilitator Guide and Reference Booklet; WHO can provide technical assistance to countries to adapt the material for use in MDR-TB scale-up.

## 2.3 TB CAP Human and institutional capacity building; Strategic approach summary and progress on key indicators

TB CAP activities respond to the 5 Intermediate Results (IR) of the USAID Strategic Framework. The HRD projects (IR-5) aim at increasing the pool of competent TB workers at all levels in a sustainable and systematic fashion using a two-pronged strategic approach:

1. Development of HRD tools and guidelines.
2. Harmonizing training at all levels through:
  - Decentralization and institutionalizing global training courses to regional training institutes
  - Integration of the Stop-TB Strategy to all pre- and in-service training programs in countries

Overall expected outputs for Human Resource Development for comprehensive TB control include:

1. Improved competence of staff at different levels of the health system; i.e. staff having the professional competence and motivation to manage TB control services including new strategies.
2. Improved availability of staff in all categories involved in comprehensive TB control, whereby HRH is an essential component of a country’s NTP medium term plan.

<sup>2</sup> Integration with the education cycle is discussed in section 4.4.

<sup>3</sup> A pre-final version was provided during the meeting

The focus for the last year of TB CAP in all areas of intervention should be on their sustainability after the lifetime of TB CAP. It is recommended to:

1. Develop leadership for HRH for comprehensive TB Control including capacity building for HRD focal persons, teaming up recently trained HRH consultants with HRH experts in countries, using local institutions, supporting HRD focal points and planning processes, instating full time HRD for TB focal persons in HBC, conducting practical HRH courses and organizing annual HR Platform meetings.
2. Develop, update and disseminated generic tools and strategies.
3. Organize training courses and other learning opportunities as much as possible which are country specific and at country level, with (sub-) regional training of higher level staff in TB program management MDR-TB and TB-IC.
4. Build institutional capacity of regional training institutions in particular, to become more business orientated, using business plans and marketing of courses.
5. Develop capacity for TA through training and expanding the pool of (inter-) national general and specialized TB consultants.
6. Utilize the IR-5 working group for strategic guidance and advice.
7. Collaborate with partners outside of TBCTA.

#### **IR5 output indicators<sup>4</sup>:**

1. Number of countries that have HR plans prepared based on global HRH guidelines for comprehensive TB control.
2. Number of NTPs which have a HRD focal point in the NTP.
3. Number of TB CAP countries that have an upgraded/revised pre-service curricula.
4. Number of TB CAP Countries where NTPs have a HRD MIS in place.
5. Percentage of all TB CAP HR consultant trainees who have completed at least two consultancies (in the technical area that they have been trained) in the last 12 months.
6. Number of regional training courses conducted by regional institutions meeting international technical and educational quality standards.

### **3. HR Challenges and Obstacles in Countries**

TB emergency state, TB/HIV co-infection, Drug Resistant TB (MDR/XDR), Pediatric TB and TB/HIV co-infection were challenges related to the burden of disease (Botswana, Malawi). Thailand reported a negative attitude to MDR/XDR TB among health personnel, while Mexico gives priority to Dengue and other diseases.

Staff shortages were the most frequently mentioned challenge: Cambodia mentioned lack of capable and qualified persons in the country; Namibia shortage of nursing staff, Tanzania operates with 65% shortage of skilled work force (MoHSW, 2006), only 29,063 skilled health workers providing services to 40 million people. Thailand, Uganda and Zimbabwe reported general shortages and understaffing, while Vietnam had a lack of staff at peripheral level. Zambia specifically mentioned inadequate numbers of laboratory personnel.

In Botswana and Cambodia qualified staff were overburdened with relation to workload and new demands (Primary Health Care approach) are leading to low staff morale and other problems. The workload was also mentioned by Tanzania, one of the 57 countries with an HR crisis. The work burden affects efficiency at all levels including supportive supervision. Handling the increasing number of TB/HIV patients is therefore particularly taxing. In Thailand health workers are already overstretched with routine work.

High staff turn-over was a common problem in Botswana the regular staff transfers are part of the system. Indonesia, SEARO, Namibia, Thailand, Kenya (High staff turnover of trained and skilled staff at all levels), and Mexico (Staff turnover in local health systems).

Mal-distribution, brain drain, high attrition and difficulties with staff retention were common and specifically mentioned by Botswana, Mexico, Pakistan, DR Congo (poor staff retention mainly in rural areas), Zimbabwe (Ability to retain staff is a challenge), and Tanzania (No staff retention mechanism in isolated areas).

Several country teams referred to specific tasks as challenging; Ghana wondered "How can we quickly increase human resources for TB control?" and "How can we identify knowledge and skills gaps and change the negative attitudes of staff which do not enable them to perform optimally?" Indonesia identified challenging new training needs: e.g. TB/HIV, TB for NGO's, DOTS plus, TB Leadership, ACS, etc. whilst Kenya mentioned integrating TB/HIV strategies into both the TB control and the HIV/AIDS plans and Thailand reports task shifting to local authorities and village health volunteers. Pakistan considered performance tracking a challenge.

<sup>4</sup> Progress on IR-5 indicators as of June 2009 is reported in section 5.3

Inadequate management skills and capacity were a recurrent theme; there was a shortage of trained staff at management level in (Botswana), weak HR management for health sector (DR Congo), low capacity of program management, including HRH planning (Indonesia), inadequate capacity in HRH planning/ projection, inadequate skills and tools to diagnose TB/HIV co-infections and an inadequate number of staff sufficiently equipped to manage drug resistant TB (Tanzania, Namibia). Inadequate capacity to offer supportive supervision was singled out by Indonesia, SEARO and Zimbabwe.

Specific staff management issues included “some general physicians in management positions” (Mexico), staff under-utilization (SEARO), no open performance appraisal system in place (Tanzania) and a lack of incentives and career advancement, especially at lower levels (Cambodia, Namibia respectively). Uganda found redeployment of health workers in an integrated system a challenge, while Zimbabwe queried the capacity of staff to deliver services. Zambia found that new people joining the system know little about TB management and control, while Cambodia had a recruitment constraint due to a limited number of posts determined by Council of Ministers). Namibia deplored the lack of clarity on the sustainability of their community field workers initiative.

Country teams also had to face up to issues such as coordination, (over-) reliance on partners and soliciting political and other support. Botswana mentioned Coordination of Human Resource between MOH and MOLG and over- reliance on partner support for TB control and on expatriate doctors and other cadres. Pakistan also mentioned reliance on technical assistance as a liability. DR Congo noted insufficient involvement of the private sector, while the Ghana team wondered: “How can we improve collaboration between the Human Resource Division and NTP to strengthen Human resource capacity for TB control?” Nigeria pointed to the differences in incentives among partners, Pakistan also referred to the fact that there was no policy on incentives and enablers. Lack of involvement or political support were also hurdles to be tackled: Vietnam lacked policies to encourage TB staff, Zambia suffered “exclusion” of the TB position at Provincial level from the establishment, in Tanzania HRH is not considered as an area of priority in TB control planning, in Indonesia decentralization and health reform are putting commitment, HRH, and funding at risk, whilst in Mexico some of the local MOH’s showed lack of involvement.

Low funding levels and a lack of resources were to be expected; they were mentioned by Botswana (Funds, human resources and technical support), Cambodia (Lack of financial input for training, curriculum and guidelines development), DR Congo (Low budget allocated to health sector), Kenya (Inadequate funding for training of non-technical staff working at the national level), Malawi (Financial resource challenges affecting implementation of activities and general TB control issues.), Tanzania (Inadequate allocation of resources and support to Health training institutions, low salary packages promoting brain drain, and the low budget ceiling of local government authorities limiting their capacity to recruit or fill up the gaps). Vietnam has a lack of resources for new staff, whilst Cambodia can only afford low salaries even through the government is already committed to a 10-15% net salary increase. Zimbabwe mentioned a shortage of resources and tools, while Malawi lacked basic medical supplies including medical equipment and protective materials.

Countries mentioned several problems and challenges related to training; Nigeria witnessed many partners organizing training activities that were not in line with the program guidelines. Indonesia noted that the numbers of medical, nursing, public health schools and NGOs involved in DOTS are low; Tanzania saw inadequate involvement of training institutions in TB control. SEARO reported that in the region there are no criteria for the selection of staff for training, 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, and pre-service training is not accordance with NTP guidelines with exception of India, Indonesia. Monitoring and evaluation of training programs, and an HRD information system in the public sector has yet to be established in most of the countries in the region.

A lack of planning and information were mentioned by a few teams: Nigeria lacked an HR MIS, while SEARO noted that there was no information on staff requirements and trained staff in most of the countries, Tanzania observed inadequate HR information management systems at all levels. Botswana and Pakistan had no HR plan for TB, while in Nigeria it is still in draft form.

External factors posed challenges in a small number of countries; DR Congo faced a lack of security in 2 provinces and an inaccessibility to services by patients due to geographical and natural constraints and an inadequate distribution of health centers throughout the country. Thailand was facing political unrest and also suffering from the wide-spread economic crisis. Finally Pakistan has a public health delivery system functioning as an integrated health complex and is administratively managed at a district level. For HR issues in TB control this is a challenge.

## **4. Tools and Strategies for Improvement**

### **4.1 Performance Improvement Framework**

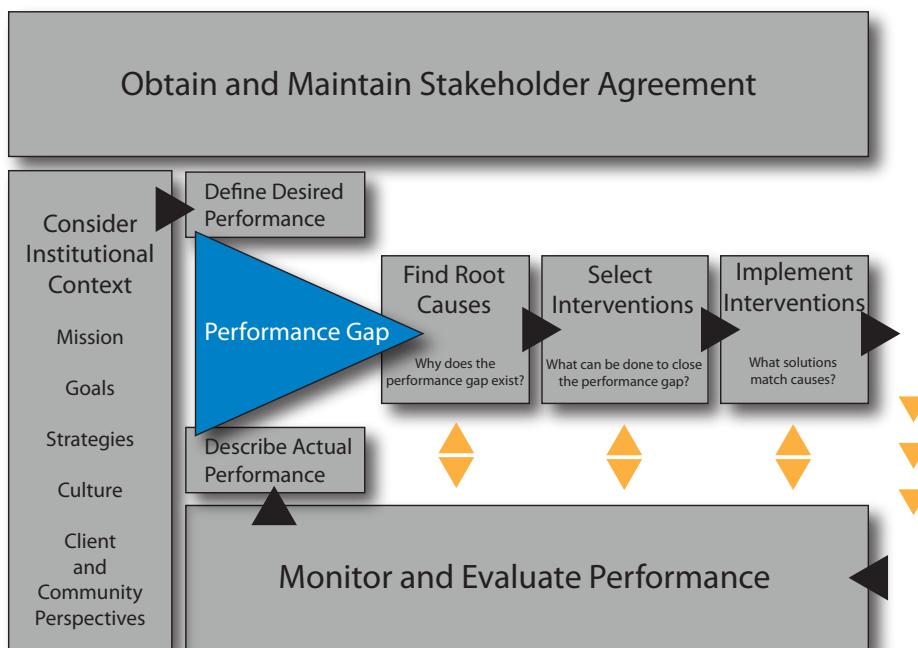
USAID sponsored development of a Performance Improvement Framework (PIF) to improve worker performance in the

first instance in Uganda (Regional Centre for Quality of Health Care, (RCQHC) Kampala). Application of the PIF was subsequently disseminated to other countries in East Africa and also applied for capacity building for TB control.

PIF is a management tool that has similarities with the human performance framework. It is justified because an incredible amount of resources have been spent on training in technical areas with little evidence of improved health indices in developing countries.

The Performance Improvement Framework is shown in Figure 1.

**Figure 1: Performance improvement framework:**



**Key Features in application of the PIF are:**

Know the context in which you are operating: gather information; analyze and identify the driving forces – positive and negative; capitalize on the positive and preempt the negative.

Conduct an inclusive and broad stakeholder analysis, then narrow it down to those you must work with, those you must keep informed, those you should be wary of (since they could potentially be destructive) and those you should encourage to come on board.

Define your desired performance with your stakeholders: state what you want to achieve in a given time frame, given the reality of your unique situation, resources and stakeholders; define measurable indicators to track your progress; define roles and responsibilities amongst stakeholders that will make success more probable.

Make a realistic and honest assessment of your current performance levels using the same indicators that you defined in the desired performance definitions as baseline for assessment and impact evaluation.

Identify the gap between your current performance and where you want to be and find the root causes of your shortfall in performance using any of the tools available: problem analysis; flow-charting; causal analysis e.g. fish bone or why-why tree; Pareto charts etc. but please verify your suspected causes with data!

Determine what you are going to do in order to close the performance gap. Find solutions to your root causes. Many tools are available for this: brainstorm; use affinity diagrams to generate ideas; assess the feasibility of interventions using defined criteria and select interventions using prioritization matrices; develop/design, M&E and implementation plans.

Implement interventions, monitor and finally evaluate if you reach your goals, if not re-think the root causes. You might have been addressing the wrong root cause(s) or have set yourself un-achievable targets given your environment!!!

RCQHC applied the PIF organizing learning sessions, introducing a special toolkit and creating networks of practitioners or “collaboratives” for the spread of best practices. Collaboratives can hold countries accountable for commitments made; setting new targets for the next action period; bringing on board new members; providing technical updates in both quality improvement and TB control and sharing best practices documented during the implementation period.

Table 1 shows commitments and achievements for an action period.

**Table 1: TB control targets and achievements for an action period in East Africa**

Country	Commitment Dec 2009	Achievement by March 2009
Uganda	Improve CDR in Kiboga from 46.5% (3rd quarter) to 50 % 4th quarter)  Improve CDR in Mukono from 38.9% to 69%	CDR 4th quarter reached 82.1%  CDR moved to 52% (target not hit)
Kenya (Nairobi South)	Provide IEC materials and job aids  Sensitized staff on importance of health education	Done  Done
Tanzania (Iringa)	Increase counseling and testing for TB patients from 45% to 80%  Registration at CTC from 35% to 80%	83%  Achieved 63% (below target)
Tanzania (Iringa)	Increase TB/HIV on ART from 10% to 40%	25% (below target) – did not take into account rules around ART admin.
Tanzania (Ilala)	DCT uptake from 85% to 95%.  Treatment success rate from 75% to 85%.	93% (slightly below target)  85.62% (target reached)

Countries must be allowed to set targets which they feel they can achieve. Leadership is critical and managers and decision makers must be constantly engaged, especially as staff turnover is high. NTLPs are so busy, that it is critical for an independent body to oversee, coordinate and keep up the pressure. Countries must further be encouraged to document and present what they do. It is very motivating for implementers to be given the chance to attend meetings where they can present their own work. Recognize performance and celebrate even small successes; it keeps the fire burning! Implement what you agree to implement as a team, holding each person in the team accountable for success or failure.

There is no quick and easy road to success; it requires resolute determination, continuous upgrading of knowledge and skills, and learning from the past; “Mountains are not easy to climb but the mountain top view is priceless”.

## 4.2 Strategic planning for HRH for Stop TB

### 4.2.1 The planning process:

The planning process consists of answering the following questions:

- What are we trying to achieve? The vision and goal;
- How will we achieve it? A strategy or set of interventions necessary to achieve the goal;
- What are we doing now? What are the obstacles? A review of the current situation;
- Where do we want to be in the medium term? SMART objectives describing expected results in measurable terms;
- What will we do to implement the strategies to achieve the objectives? Activities and specific tasks for each strategy, the time when they should occur, and the persons responsible;
- How much will it cost and how will we pay for them? A financial plan or budget;
- How will we know whether we are making progress and achieving our objectives? Monitoring and Evaluation;

#### 4.2.2 What an HRH plan for Stop TB should cover

The HRH Action Framework, mentioned in the proceedings of the previous meeting shows six action fields; policy, finance, education, partnership, leadership and human resource management. Each of these fields includes a role for the NTP to play and has to be covered in a strategic plan for HRH for Stop-TB.

The role of the NTP in the **policy field** is to assess needs for HR policy revisions to enable the implementation of the Stop TB strategy.

In the **finance field**, the role of NTP is to align with and use TB specific funds ensuring donor coordination to support overall health workplace development, enabling the implementation of the strategic plan for HRD for comprehensive TB control.

In the **education field**, NTPs have a considerable role to play, developing in-service training programs and materials for health workers involved in the implementation of the Stop-TB Strategy, ensuring that all continuing education and its evaluation is competency based, and follows NTP guidelines. NTPs should select and train course facilitators for the different TB training programs, prepare and organize TB training courses (long term, as well as short term) in close collaboration and coordination with other priority health programs and interventions. They should involve existing training institutions, ensuring continuous learning for all health workers involved in the implementation of the Stop-TB strategy and establish the NTP organizational structure and TB supervisors' capacity for follow up after training. Finally, NTPs' educative role is to ensure that pre-service training programs meet the competency needs for the implementation of the Stop-TB Strategy.

The role of NTPs in the **partnership field** is to forge relations with other public sector, private sector, and community networks with common links to TB; for example, HIV/AIDS national programs, medical associations, faith-based organizations, bilateral and international organizations.

In the **leadership field**, the role of the NTP is to provide visionary leadership and advocacy for TB control program needs, ensuring leadership development for managers at all TB program levels; empowering managers to solve problems at service delivery level, ensuring the required resources are available and offering supportive supervision to develop work plans and monitor performance.

The role of the NTP in human resource management involves:

1. Personnel management: assessing staffing needs at all levels for the implementation of the Stop-TB strategy, contributing financial resources to TB staff retention strategies and incentive packages for rural postings, determining minimum data requirement for adequate HR management, ensuring that all TB HRH activities conform to overall HR management systems and policies currently in place, and finally communicating staffing problems (e.g., vacant posts, severely understaffed health centers) identified during supervisory visits;
2. Performance management includes the updating and listing of functions and tasks by level and by professional category, covering all components of the Stop-TB strategy. The development or revision of job descriptions for staff involved in TB control to correspond with current policies and recommendations, developing competence and staffing for supportive supervision - for implementation of the Stop-TB Strategy - with other high priority programs and contributing expertise and resources to the development and implementation of strategies for TB staff motivation and retention.

#### 4.2.3 The process of developing an HRH strategic plan for TB control

First create sufficient interest and support buying in for the HRH strategic plan with NTP management, the MOH and all other relevant stakeholders. Next, establish leadership for HRH strategic planning process; decide who should take the lead and who should do what. Set up an HRH strategic plan working group giving attention to tasks and responsibilities, number and profile of members as well as the required time investment. The planning process will at some early point require an assessment of the HRH situation, which can be based on document review but usually requires field work that may have to be outsourced (financial implications!). Planning will require the organization of HRH strategic planning workshops which will require thinking about goals and objectives, participants and how to use the workshop output for the strategic plan.

The next stage is writing the strategic plan, usually several versions; decide who should do it, how much time it will take. Refinement of the draft versions requires that they are presented or circulated for feedback from relevant stakeholders at national, provincial, and district level. Ultimately the plan needs to be endorsed at the highest possible level and launched to give it legitimacy and publicity. Once there is the go-ahead, annual operational plans can be developed and implementation started.

## **4.3 Improving facilitation skills**

### **4.3.1 To train or not to train, decide whether training is the best solution**

Before embarking on a training program it would be wise to consider whether the performance issue at stake is actually a training problem. Training is most likely to result in better performance if it addresses individual shortcomings in knowledge and skills among otherwise motivated and committed workers with the necessary supplies, equipment and management support and an appropriate work environment. Also important for effective training is a short time interval between the learning event and the application of the newly acquired knowledge and skills.

### **4.3.2 How do adults learn?**

Adults can share responsibility for their own learning because they know their own needs and prefer to participate actively rather than passively in their learning process. The most effective learning is from shared experience; trainees learn from each other and the trainer learns from the trainees. Mutual trust and respect between the trainer and trainees is important and helps the learning process. Providing a safe and comfortable environment is not a luxury; a person who is hungry, tired, cold, ill or otherwise physically uncomfortable cannot learn with maximum effectiveness; a cheerful, relaxed person learns more easily than the one who is fearful, embarrassed or angry. It is also easier to change a person's ideas, attitudes and behavioral patterns when he or she accepts membership in a group where these ideas, attitudes and behavior are the norm. The discussion and agreement that takes place within a group provides a personal commitment and encouragement for change that is not present when only one person is involved.

### **4.3.3 Six steps in the preparation of a training course**

#### **1. Situation Analysis**

The purpose of a situation analysis is to assess the need for training. A situation analysis allows you to assess the feasibility of a training program in view of the available resources (human, financial and material) and logistics. It should enable you to determine whether training is the most appropriate answer to the problem

#### **2. Design of the course**

Consider the principles of adult learning and pay attention to training techniques, then define the overall course objective, decide on the contents of the course (curriculum), investigate collaboration (exchange of resources, materials, trainers, curriculum, recognition of the course, certificate). An evaluation plan and instruments should be designed and planned during the initial stages of the training course and included in the course timetable.

#### **3. Preparation**

Ample time must be devoted to this stage, preparation is a very time-consuming process. Use local sources and resources to the maximum, plan the timetable (including evaluation).

Decide on suitable teaching methods (Knowledge/Skills/Attitude), prepare lesson plans, prepare checklists of sub-tasks, order teaching materials, prepare training materials (visual aids, readers, handouts, etc), translate teaching materials if necessary, prepare training logistics (venue, tea breaks, audiovisual equipment), consider certificates and finally, consider payment/incentives/per diem's (depending on local situation)

#### **4. Implementation**

The actual implementation of the course should be in line with the course objectives. It is important to keep the real world in the trainee's mind and what lessons they learn they are able to transfer from the course into reality.

#### **5. Evaluation**

Evaluation is the quality control part of training. It provides feedback on the trainer's performance, the quality of the training design and the delivery of the training activities. Topics to be covered in future workshops and refresher courses can be chosen, depending on the results.

#### **6. Follow-up**

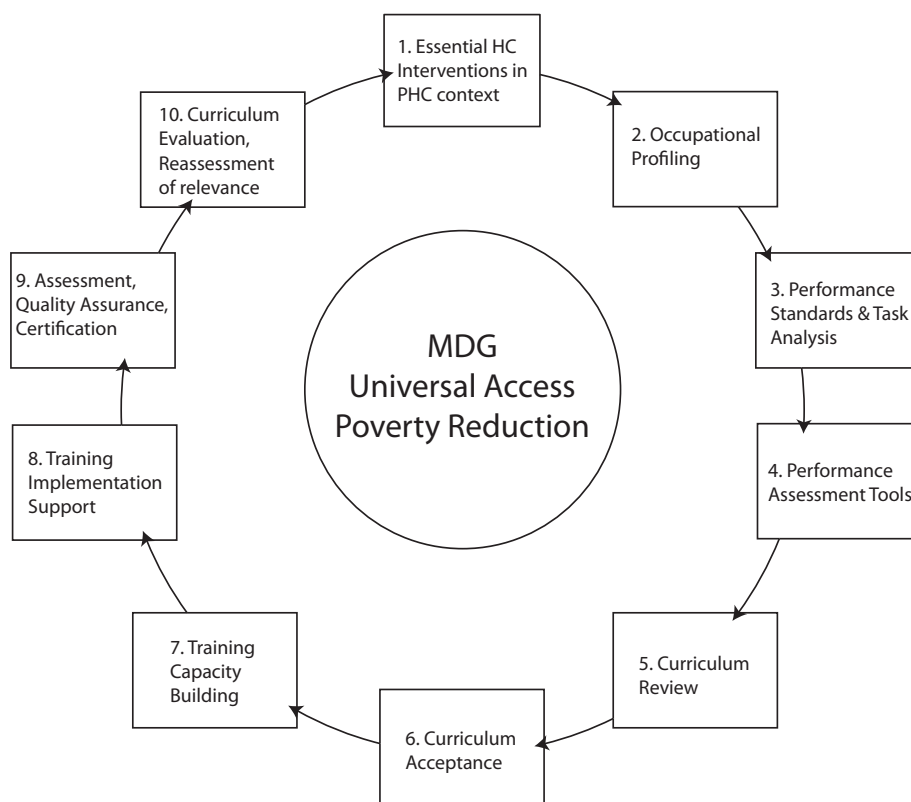
It is important for participants to establish a personal action plan for post-course follow-up within a realistic time frame. Regular supervision visits should be planned in order to give relevant feedback and to discuss solutions to problems with trainees, colleagues, supervisors and target group of trainees and to determine additional training needs.



#### 4.4 Integrating priority disease requirements with the education cycle

The following education cycle (Figure 2) is based on the principles of competence based curriculum design for pre-service training. Typical for the competence based design is that setting of performance standards and design of performance assessment tools occurs very early in the process, before embarking on curriculum design.

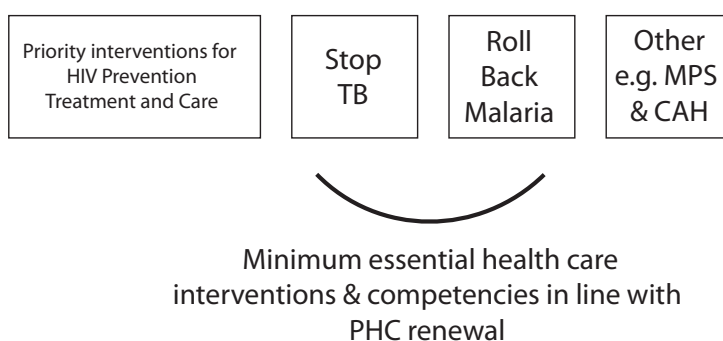
**Figure 2: The education cycle based on competency based curriculum design**



Fruitful engagement in the education cycle requires close and harmonized collaboration between Stop TB and other priority disease programs on the one hand and educationists, pre-service trainers on the other hand. The ten stages in the cycle are:

1. Define essential health care interventions & competencies in line with PHC renewal.

**Figure 3: Set of minimum essential health care interventions:**



At this stage it would be important to consider synergies and to identify and settle important policy questions, e.g. related to task shifting, should health workers other than doctors prescribe? If so, what are the doctor's prerogatives? And what are the various implications?

2. Determine occupational profiles matching priority interventions and competencies taking into account technical

considerations (who can do what), professional and political considerations (expect varying opinions concerning the 'who does what' e.g. for task shifting), career development, personnel management and cost considerations and finally, administrative, legal, ethical and regulatory considerations.

3. Develop performance standards and task analysis for priority interventions, describing in very precise terms how various tasks related to the priority interventions should be performed. Formulation of standards is the domain of technical Stop TB experts. Translation into tasks requires dialogue with curriculum experts and may require observing an expert at work.

4. Develop performance assessment tools including questions and case studies to test knowledge and decision making skills and observation tools to check performance including psychomotor aspects (e.g. avoidance of prick incidents) and affective / communicative aspects (empathy, ways of communicating, e.g. for counseling & testing in HIV). This, often neglected phase is extremely important. Developing assessment tools should be done in collaboration between curriculum and Stop TB experts.

5. Curriculum review for priority PDP interventions involves technical and other considerations. Technical considerations are very similar to those of developing a training course as described in section 4.3.3. However, there are other, non-technical considerations which should also be examined if one wishes to address the problem mentioned in section 2.2.1, that "updating of basic training curricula to correspond to NTP guidelines is often not formalized and in line with formal processes for curriculum revision". Curriculum development is a change process involving many stakeholders including winners and losers, champions and blockers. Expect and be prepared to deal with resistance to proposed changes.

6. Curriculum acceptance; new /revised curricula need to be recognized by relevant bodies including professional councils, examination boards, and accreditation bodies. Issues of recognition and accreditation often spark heated political debates.

7. Developing capacity for the implementation of required training is a very important and includes training of tutors, clinical instructors, student supervisors, mentors and also highly positioned authorities who sit in examination and accreditation boards. Unless the final assessment changes, pre-service training (aiming at passing the highest number of students) will not change. Developing capacity for training further requires practical training arrangements with implications for number of students per supervisor and number of students per patient. Community based practice is commendable, but where should students sleep? What are the costs of transport (for students and supervisors)? Is there a budget for allowances to enable students to eat? Could TB control programs on the ground provide those required practical training experiences? Do the links with the schools / the education system in general exist? Ultimately, training capacity has a financial aspect with the question whose budget ceiling will be affected (health, education or local government?). Is the NTP prepared to allocate funds for pre-service training? If so, what are the methods of disbursing those funds?

8. Training implementation and support; no curriculum revision is successful unless it is implemented correctly. However, classrooms are often overloaded and tutors and clinical instructors are commonly in short supply, while curricula demand more practical, hand on or community based training. For schools with unmanageable student teacher ratios, short of funds, short of transport and short of a lot more, keeping students in the classroom may be the only option they have. NTPs and other priority disease programs should support health training schools in their neighborhood. Such support can take the form of providing guest lecturers, finances, materials and practical training grounds.

9. Assessment, quality assurance, certification; prior preparation of standards and test items will be of great help when assessing students, however it can also be argued that these a priori developed items should be kept in reserve for occasional monitoring and evaluation purposes. NTP staff should contribute to and participate in examination committees providing examination questions and practical skills tests. Maintaining links and participating in occasional inspection or support supervision visits to the schools will ensure that interventions are taught as intended.

10. Maintaining the cycle; by the time the new interventions will be taught and examined properly in all the concerned schools, at least 5 years will have passed and the recommended interventions will certainly have changed. It is therefore important that curricula remain to some extent "open" and amenable to minor changes "on the way". An evaluation once every 5 years, in collaboration with another PDP will be an eye opener and will show what has happened to the original message over time.

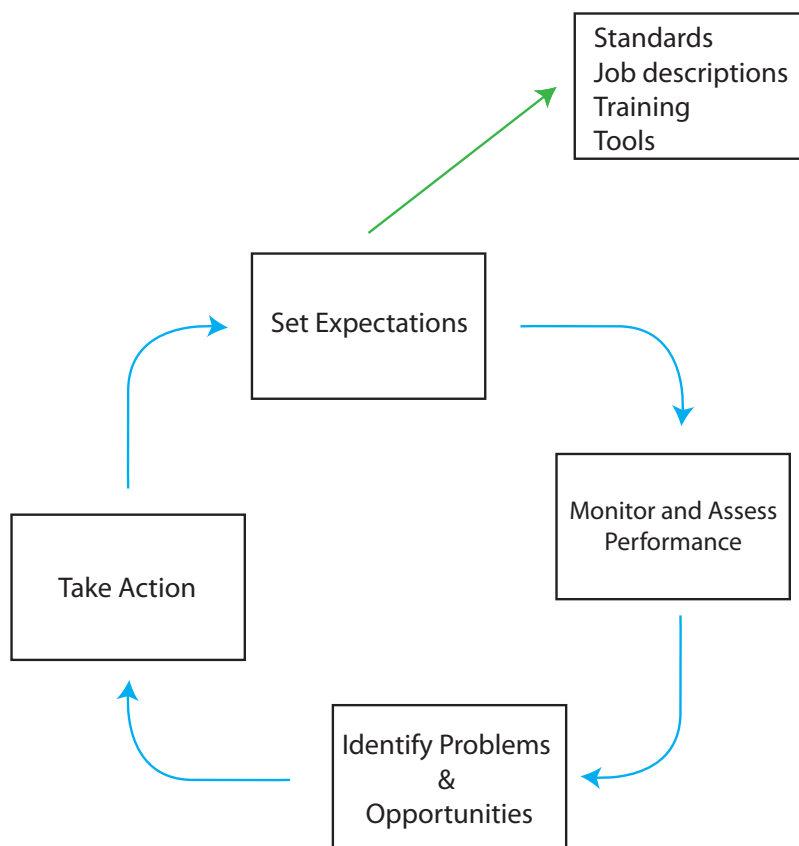
#### **4.5 Providing supportive supervision**

Supportive supervision is defined as "A way of ensuring staff competence, effectiveness and efficiency through observation, discussion, support and guidance".

It is a process connected to a series of events over time, it involves guiding, helping and encouraging changes to improve staff performance according to defined standards. Supportive supervision promotes quality by resolving problems. It encourages continuous improvement and improves the focus of supervision.

The process is depicted schematically in figure 4.

**Figure 4: The supportive supervision process**



Supportive Supervision requires a clear commitment by top management to supervision and documented/well-known standards of expected performance (standards are the baseline against which actual performance is measured).

Advance planning will allow for proper preparation and ensures that staff are present and ready. Careful preparation by the supervision team before their field visits, should cover at least the checking of HMIS data and health indicators; reading of previous supervision reports and discussion with all departments to identify follow-up issues.

Supervision should involve key members of staff at the facility/office being supervised to ensure wide involvement, good understanding of issues discussed and commitment to results.

Appropriate behavior during the meeting is necessary to promote cooperation: treat problems as “our” problems (the supervisor is also responsible), each side should show respect for the other. The supervisor should be firm but not “accusing” so that staff will get actively involved. Supervision should confirm whether performance standards are being met or not.

Use of a supervisory tool should ensure that all key areas and documents findings are covered. A “checklist of supervision” has been developed.

A follow-up action plan should be agreed, to ensure that problems identified are accompanied by clear actions which address them. Reporting back to the management committee ensures that all departments are aware of the results of the supervision and know what actions they are expected to take. Action plans must be reviewed and followed up by the management committee until all necessary actions are completed.

## 4.6. TB CAP e-portal for HRD

The aim of the e-portal for HRD is to build the community of HR focal persons and to create peer networks for sharing experiences, guidelines, articles, tools and best practices. The information is shared during e-tutorials and facilitated discussion sessions. The e-portal is also used for coaching and ongoing support to individuals, professional groups and programs. It serves as a link between people in the programs at country level and with resource persons-experts in the HR field and uses a personal approach.

The members of the e-portal for HR are HR focal points at national TB program levels in Africa, Asia, Latin America and Europe, HR consultants providing consultancy work at country level as well HRH experts from all TB CAP partner organizations. Members have a variety of backgrounds and field experience. More than 60 members from 25 different countries are currently registered.

The e-portal is organized as a “one stop shop” for professionals and the opening page directs the members to access documents on HR related meetings/workshops, latest guidelines, articles and tools, links to websites of organizations and e-tutorial and discussion sessions.

Topics discussed are HRH/HRM/HRD basic concepts; management competency; motivation of staff and satisfaction level; the importance of job descriptions and how to develop them; Task shifting; supervision and its importance; training planning, curriculum development and developing HR strategic plans for TB control. The information on these topics is still available in the e-portal.

During the HR/TB Platform meeting 2009, participants were involved in the try-out session on the e-portal and were able to test e-portal capacity. They participated in the survey of the e-portal and gave suggestions for improvements and topics for discussions and tutorials. Based on the target group needs the following steps were taken: communication sessions will be organized once per month; co-facilitators will be chosen from e-portal participants, all on-going discussions will be “labeled”, alerts will be send directly to the participants e-mail account.

The e-portal is open for registered members only. It is possible to get individual access sponsored by TB CAP or to share access through members from a specific country who are already registered, using the same password and username. More detailed information and requests for access can be obtained through the contact person for the e-portal lema Leimane (HRH consultant KNCV) leimanei@kncvtbc.nl

## 5. Experiences from Countries

### 5.1 Intentions

The Bangladesh team mentioned as the goal of HRH for TB control that adequate numbers of health workers at different levels of the health system are motivated and have the skills, knowledge, attitudes and professional competence necessary to successfully implement and sustain comprehensive TB control services, based on the Stop TB strategy. Adequate numbers were also mentioned as goal by Ghana, Namibia, Kenya, Mexico and Vietnam, several countries adding “at all levels”, and or specifying specific levels, e.g. District level (Thailand), Provincial level (Namibia) or communal/village level (Cambodia).

Goals include having staff well distributed and available at the right time/place, equipped with the right skills, levels of commitment/motivation, whilst filling their job requirements. Several countries linked the HR goal with TB/HIV service requirements and to goals or targets for TB control, Stop TB strategy and MDG's. SEARO specified that an NTP department should have 6 – 12 staff, while Uganda aimed at having at least 5-6 staff. Several countries aimed at integration; e.g. Nigeria mentioned integration with the TB – Lung disease hospital, Uganda and Cambodia aimed at integrating TB/HIV with Public Health Care, and primary health care system respectively. Several countries mentioned specific staff including doctors, doctor's assistants, nurses and laboratory staff, Kenya also aims to have volunteers.

Vietnam intended to establish a system to continuously identify new staff working in TB control and train them as soon as they take up new positions. Several countries (Vietnam, Indonesia, Malawi, Indonesia and Pakistan) mentioned training goals with specific targets either referring to numbers of staff trained or associated with the number of training institutions with revised curricula. Indonesia mentioned among its intentions to have a strategic HR development plan for TB HR in place. Indonesia also mentioned empowerment of health workers (managers and operative personnel), to improve quality using normative documents. The aim to provide tools, and other support including an appropriate socio-professional environment was also mentioned.

## **5.2 Actions associated with the HRH Action Framework**

### **Policy**

Various countries reported action or advocacy at, or directed at policy level. Bangladesh formulated a policy to address turn over and career development. In Botswana, restructuring was done at National Level in 2008 in order to focus on all the components of the Stop TB Strategy. Cambodia advocated for more positions for the MoH government services for all levels and the Ministry of Health will seek to ensure that priority is given to investment in human and material resources for TB control activities. Meanwhile DR Congo advocated increasing the part of the national budget allocated to the health sector. Malawi also lobbied for reasonable funding to sustain TB control activities, while Nigeria campaigned for technical and logistics support and for uniformity in incentives among partners. Tanzania attempted to convince Local Government authorities to absorb the hired staff through the Emergency Hiring Project (EHP), while Thailand struggled to promote TB control as national policy, prioritizing TB control as ministerial rather than department agenda. Both Namibia and Zambia reported restructuring at the level of the Ministry of Health; in Zambia the structure has been upgraded and has positions for TB/HIV coordinators at the district and facility levels.

### **Finance**

Several countries mentioned action in the area of financial resource mobilizations. Cambodia reported to be mobilizing resources to address the issue of poor salaries and lack of incentives, especially at lower levels and also to improve development of curricula and guidelines. DR Congo initiated incentives for health professionals in term of job training, loans, school fees and housing. Tanzania listed various sources of funds including Benjamin Mkapa AIDS Foundation, Global Fund round 3 & 6, assistance from CDC under PEPFAR support and PATH under USAID support. Tanzania further included some HR issues including recruitment and training in the Global Fund Round 9 proposal. Zimbabwe is also maximizing opportunities offered by GF resources to ensure long term sustainability.

### **Capacity building, education and training**

As to be expected, training, education and capacity building featured again prominently among actions taken by countries. Bangladesh is developing basic training modules to address components of Stop TB Strategy within the country context. Botswana intends to send 5 doctors to Philippines/Latvia for MDR training. In Malawi training is one of the means used by NTP to improve the performance of the workforce. It also motivates the workforce by equipping them with new skills. Certification is also an incentive. Pre-service training involves training of undergraduate health workers to provide understanding to both the clinical and program aspect of TB Control, while in-service TB orientation aims at all general staff working in TB clinics and wards. Malawi uses WHO modules for the training of District TB Managers. Mexico used training as an approach for expanding the PPM strategy: in the public sector it organized training of trainers in international standards, covering IMSS, and other Health Institutions (DOTS and information system improvement), hospitals (primary care level patient reference) and community involvement in DOTS. With the private sector and Medical Science Schools agreements were made for collaboration and curriculum updating. On line courses are done through Chiapas, DOTS network and other partners. DR Congo is training private health providers and traditional healers to facilitate their involvement in TB control. Indonesia is strengthening the facilitator team, and organizing PTC workshops (management, planning), stepwise hospital training and an advanced course. In 2008, Kenya organized training for the TB staff on ISO 9000, a "Quality Assurance" system. Meanwhile, SEARO has been supporting countries, through fellowships, higher training, and accreditation of training, opportunities also mentioned by Bangladesh. Tanzania trained 30 tutors from paramedical and nursing school on facilitation skills for TB/HIV joint activities. Since 2007, 5000 health workers have been already trained on TB/HIV joint activities while 5 medical schools have been oriented in ISTC. Uganda also mentioned to have been conducting in- and pre-service training. Zambia specified to have trained microscopists and to train or orient the available staff in "grey areas" in order to address gaps. Zimbabwe simply requested to simply have an intensive training program.

### **Forging partnership relations**

Partnership is an important aspect of both the Stop TB Strategy as well as the HRH Action Framework. Bangladesh prided itself on a high quality and sustainable partnership to address HRH issues, while Botswana mentioned coordinated collaboration among all partners in TB Control. Kenya however mentioned that getting the HR department in the ministry on board is an uphill task; nevertheless, the HTP is working closely with the ministry and involving them in the activities of the program e.g. in February 2009, with the assistance of the HR in the ministry the program was able to recruit 88 lab technicians. In Malawi efforts are ongoing to strengthen collaboration in TB and HIV activities, while Mexico reported community involvement in DOTS. Further, in Mexico, after the HR platform meeting of May 08, HIV leaders were included in TB workshops to discuss quality issues of the local health system.

## Leadership

Mexico was the only country specifically mentioning leadership development, training leaders in advocacy, communication and social mobilization.

## Human resource management

The HRH Action Framework distinguishes two aspects of human resource management. Personnel management is the first aspect that a number of countries reported on.

Bangladesh emphasized clear explanation of job responsibilities or ToR, while Botswana is engaged in recruitment and replacement of staff, having staff retention plans through packages such as "scarce skill allowance", Cambodia listed a whole range of HR management measures including improved capacity building and new recruitment of qualified staff and reviewing the job description of staff at all levels (since it could reduce some of the workload of qualified staff.). Cambodia also looked for ways to improve staff motivation through supplementary salaries for Provincial TB supervisors and OD Supervisors to be funded through GFATM R7 with plans to include salary supplements for HC staff in GFATM R10. In addition, Cambodia is exploring other motivating factors such as training, study tours and supervision.

DR Congo is recruiting health professionals to be equally distributed in all areas of the country, while Malawi NTP continues to liaise with the MOH on staffing levels in the TB program.

Namibia reported career advancement for HR for TB control (such as making the post of DTC a promotional post), expansion of staff establishment and task shifting through the use of TB field promoters. The MOHSS has also started a process to establish a formal structure for community based health workers.

The Government of Tanzania launched an Emergency Hiring Program in 2007 in collaboration with partners. So far, 285 staff have been recruited and deployed. BMAF contributed funds for 176 (doctors, clinicians and nurses), GFR3&6 funded 41 TB/HIV officers (clinicians), CDC/PEPFAR: 40 TB/HIV officers, PATH: 28 TB/HIV officers and GFR6: 14 TB and Leprosy Central Unit (TLCU).

Thailand worked on task shifting and motivation of HR working in TB Control, whilst Uganda talked about action in the area of support supervision. The Ministry of Health of Zambia has put in place the Health Worker Rural Retention Scheme for doctors, nurses and other staff.

Performance management is the second aspect of human resource management that countries reported on. Bangladesh strengthened the central M & E unit for HR and continued its practice of quarterly monitoring meetings that increased staff motivation for both government and NGOs. Bangladesh made further efforts to increase the competence of supervisors for quality supervision at different levels. Botswana has currently 2 referral centers for MDR-TB management. Malawi is practicing supervision, monitoring and evaluation to provide continued support and on the job training to implementers and to enable the program to monitor progress and identify gaps in performance. Monitoring and evaluation meetings also allow for the sharing of skills amongst implementers and motivate poor performers to improve. Mexico reported enhanced coverage of its "Participatory Quality Improvement on Local Health System" workshops that will be further elaborated upon in section 6.3. SEARO found that joint review missions in countries improved health staff performance, Tanzania noted that performance can be boosted by provision of essential tools such as the TB screening tool for clinical TB control staff.

## 5.3 Actions related to IR-5 HRD output indicators

### 1 - HR Plan

Bangladesh has a Comprehensive HRD Strategy (2009-2015) finalized as a draft document.

Botswana has a plan for the training of health workers both internally and externally, but no current and specific human resource strategic plan for TB.

Cambodia has HR for TB control included in the National Policy and Strategic Plan 2006- 2010 with the intention to put it into the 2010- 2015 plan. Planned strategies include building staff capacity, health workforce planning for TB control, motivation of TB health workers and seeking appropriate technical assistance.

DR Congo NTP initiated a HRD strategic plan to be submitted to the MOH. The first draft was completed in March 2009; inputs have now been received from the peripheral and intermediary levels.

Ghana has an HR Policies and Strategic Plan for the health sector (2007 - 2011) but no strategic plan specifically for

TB Control. The team is now determining the HR requirements and distribution at the various levels which are needed to achieve MDG -6.

Kenya has a strategic plan in place, however it is yet to be proof read and launched, but activities which have funding and those that can be done without funds are in progress.

Malawi plans to have a Comprehensive Five-year plan, which is considered an important tool to set HRD goals and to deal in a long term and systematic way with the HR challenges that the NTP encounters. The HRD plan should form an integral part of the 5 - year TB strategy plan.

Mexico has had an HR plan for TB control since June 2007; strategies include workshops on quality tools to improve TB Control, empowerment of National TB program personnel, benchmarking and publications on quality tools.

Namibia has a five year HR Strategic plan covering 2009-2013. An HR strategic plan for TB control is not yet in place but in the process of being developed.

Nigeria does have a draft HRD strategic plan (2007-2011), the content of which was used in the development of the Global Fund Round-5 proposal.

Pakistan is still at the planning stage.

WHO/SEARO assist Member States in developing HR strategic plans for TB control based on global guidelines. The office reports that Bangladesh and Nepal recently revised and updated comprehensive HRD TB plans, while Bhutan, DPR Korea, India, Indonesia, Maldives, Myanmar, Sri Lanka, Thailand and Timor-Leste plan to revise, update and develop HRD TB plans.

Tanzania planned to perform a workload study in July 2009, while an HRH framework is ready for integration in a 5 year NTP strategic plan (2009- 2014).

Thailand has an updated HR strategic plan (2008-2009) for TB control in line with global guidelines.

Uganda has no HR strategic plan specific for TB control based on global guidelines since TB control is integrated into the general health care system.

Vietnam has a HR strategic plan for TB control based on global guidelines (2006 to 2011)

Zambia has a HR for Health Strategic plan (2006-2010) for the general workforce.

In Zimbabwe no TB specific HR development plan as yet exists. The MOH is working on a national HR strategy but it doesn't give specific attention to a particular disease. However, HR development is a component of the National TB 5 year Strategy (still under development) focusing on training, supervision, retention.

## **2-HR Focal person**

In Bangladesh the Deputy Program Manager (Training) is the designated focal point for human resources in NTP, supported by Medical Officer (Training) and the WHO National Consultant (Training).

Botswana does not currently have a formal specific person responsible for Human Resource for TB, however, the Chief Health Officer (CHO) who is the head of the Disease Control Unit acts as such. Full-time TB Coordinators at district level are now in post as demanded by the Global Fund application.

In Cambodia a specific person within the NTP is responsible for HR issues under the leadership of the Director of the NTP. They work in collaboration with focal person for TB/HIV of the NTP, the focal person of AIDS program, provincial TB/HIV coordinators and operational district TB/HIV coordinators.

In DR Congo, until now there has been no specific HR focal point; it is one of the problems to be addressed in the HR strategic plan.

In Ghana HR for TB control is integrated as of now. Only at national level a total of 10 staff at the NTP office work full time on TB. None of these 10 is specifically assigned as HR focal person for TB. At regional - provincial level there is a focal person who devotes about 50% of his/her time to TB. At district and institutional levels, the focal persons spend even less time on TB (20-30%).

In Kenya a health administrative officer at the Division of Leprosy, TB and Lung Disease is the focal person for HR issues. They are being trained on the job.

Malawi has an HRD focal point person in place; about 90% of positions are filled at the central and zone level while all treatment centers have two focal point TB officers.

In Mexico the NTP Director has worked together with the HR advisor from PAHO/WHO since May 07.

Mozambique has a TB Manager at the Central Unit; however, it was not mentioned whether this person acts as HR focal point. There are further nurses and technicians working as provincial supervisors and their deputies at all the 11 Provinces. There are also district supervisors at 169 health centers who have other duties besides TB management.

In Namibia the head of the TB Control Program in the Directorate Special Program at National level is responsible for TB Control Program HR issues.

Nigeria NTP has a HRD unit called the National TB & Leprosy Training Centre, Zaria. The center is responsible for the training of general health workers for the TB program, the development of training materials and guidelines as well as supervision in the field.

Within the NTP; someone has also been assigned to be HRD focal person.

SEARO reported that all the countries in the region have an HR focal person.

Pakistan mentioned the Health System Strengthening Coordinator.

In Uganda no one within the NTP is responsible for HR issues.

In Vietnam the Chair person of the NTP is responsible within the NTP for HR issues, supported by the Secretary of the NTP.

The Ministry of Health (NTP) of Zambia is in the process of employing a Human Resource Officer for TB control, now that the structure has expanded from Central to facility levels.

In Zimbabwe the NTP Manager is the focal HR person at National level.

### **3-Pre-service curricula**

The NTP of Bangladesh plans to incorporate the Stop TB Strategy in the pre-service curricula for nurses, doctors and other categories of health professionals.

Botswana revised curricula in 2008 as guided by the Stop TB strategy, pre-service training curricula for nurses and other health related professionals are now available, but not as yet for doctors.

Cambodia revised the pre-service curricula for nurses, doctors and other categories of health professionals to reflect the Stop TB strategy in 2004. The 8 month treatment regime was change to a 6 month regime and in 2007 the drugs were changed to 4 fixed dose combinations. Plans exist regarding upgrading/revision of pre-service curricula in 2009- 2010 to include the MDR-TB, TB in prison, TB in Children, PPMD and CDOTS. It is planned to mobilize financial resources for this purpose.

DR Congo is not yet there, but curricula for nurses and doctors are being processed adjusted to integrate the Stop TB strategy.

Ghana, in 2004 experienced a high failure rate for final year diploma general nursing students. The reason was that the curriculum and the knowledge of their tutors was based upon the old TB treatment strategy. Pre-service curricula for doctors, nurses and other categories of health professionals in Ghana all now have the Stop TB Strategy included. The NTP had to train all tutors and assisted revising the curricula.

Indonesia developed and revised curricula, modules and guides of medical, nursing and public health schools to accommodate current issues.

It is in the HR strategic plan 2009-11 of Kenya to involve the medical training institutions in upgrading the pre-service curricula. A TWG that is currently developing an in-country DTLC course curriculum will be tasked with the activity.

Mexico has 109 schools for nurses at professional level and 470 at technical level; 60% include the Stop TB strategy in their curricula while 40% curricula will be revised during 2009 through PPM strategy. In the Schools of Medicine: curricula, practical service and investigation line are included. At the National Institute of Public Health TB line investigation is a priority activity.

In Namibia the Stop TB strategy module is part of the pre-service curricula for health related pre-service training programs. The Ministry's Health Training Centre curricula were revised in 2008, while the University of Namibia is



revising the Nursing Science Curriculum this year, 2009.

The curricula of both medical and nursing schools of Nigeria were reviewed in 2007 to reflect the current TB & leprosy control guidelines. 150 Nursing tutors from the different regions were trained as master trainers. The institutions are linked to TB programs in the field. In addition 30 university tutors had an update workshop on the revised curriculum. National guidelines and other important program documents are supplied to university and school of nursing libraries to assist implementation of the new curricula.

In Pakistan pre-service curricula for nurses, doctors and other categories of health professionals do not completely reflect the Stop TB strategy since the last revision was done 5 years back. Consultation started with Pakistan Medical and Dental Council to revise curricula in 2010.

SEARO reported that India and Indonesia have pre-service curricula for nurses, doctors and other categories of health professionals that reflect the DOTS strategy with plans for further revision for inclusion of Stop TB Strategy. Bangladesh, Nepal, Thailand and Timor-Leste, plan to develop pre-service curricula for nurses, doctors and other categories of health professionals.

In Tanzania pre and in-service curricula on TB/HIV joint activities are in place and are used for training.

Thailand, with respect to development pre-service curricula for TB control reports has made moderate progress with nursing and para-medical schools, but little progress with medical schools.

Uganda presenters had no adequate information on the presence of the Stop TB strategy in pre-service curricula for nurses, doctors and other categories of health professionals. The last time pre-service curricula for nurses and midwives were upgraded/revised was in 2006/7. Some nurse training schools' students spend one week at Buluba TB/Leprosy training centre. Upgrading/revision of pre-service curricula needs to be recognized by the NTP which requires technical assistance in this area.

In Vietnam pre-service curricula for nurses, doctors and other categories of health professionals do reflect the Stop TB strategy. The last revision was done in February 2009. Evaluation and standardization of the curricula is in the plans.

In Zambia the pre-service curricula for nurses, doctors and other categories of health professionals only have general information on TB. The Stop TB Strategy is taught as part of service training. The MOH in collaboration with partners is revising the curriculum to include programmatic management of TB which includes the Stop TB Strategy.

In Zimbabwe the Stop TB strategy is not yet reflected in the pre-service curricula for nurses, doctors and other categories of health professionals. Pre-service curricula have not been upgraded / revised for more than 10 years. Upgrading/ revision of pre-service curricula is urgently required. A consultation was held with the Director of Nursing on the process and an all stakeholders meeting has also been planned.

#### **4-TB HR Information systems**

The NTP of Bangladesh is presently using an excel program to maintain HR MIS. Software to monitor in-service training has been developed but has yet to be applied. Training on the program still needs to be implemented.

The system captures: Number of training courses provided by category of staff, Number of HR staff trained, training needs by category, training budget and training plan. Still missing is information on vacant posts and information on identification of the names of trained person for all training. Botswana currently has separate databases, but discussions on devising a system that will promote the integrated monitoring of TB and HIV (Patient Information Management System II) are in an advanced stage. The TB surveillance system captures some HIV data, while the HIV surveillance system captures some TB data. The country does not have the HR MIS for TB Control, but there is a plan to develop one.

Cambodia has an incomplete HR MIS database in place, but still needs the experience from facilitators and other countries in this area.

DR Congo does not have an HR MIS for TB control in place, but is planning to develop one. Required information which is missing at the moment includes, numbers, qualification, training in Stop TB strategy, place of work and payment of salary.

There is no HR MIS specific for TB control in Ghana; however, there is an HR MIS for all staff; as part of an integrated HR Management System. Information provided by this system comprises: staff ID, name, age, sex, date of first appointment

and grade. In addition, staff members have in-service training and development log books which capture all forms of training they participate in.

Indonesia simply reported that it is strengthening its MIS-HRD.

Kenya has data and it is in the work plan to have the system in place at the end of 2009. It is one of the activities identified in the HR strategic plan for the program in the Division of Leprosy, Tuberculosis and Lung disease (DLTLD).

Mexico is organized through 32 responsible nurse leaders of TB Program and DOTS at State Level and 490 TB Program and DOTS Nurse Leaders per each Local Health System. They are in charge of updating the National information system (SUIVE) (<http://www.dgepi.salud.gob.mx/boletin/>)

Namibia has an HR MIS for TB control in place which indicates the No. of positions/establishments/ region/ district/ health facility, No of positions filled or vacant and staff particulars including name, gender and age. Also captured is information on staff mobility for instance recruitment and losses.

Nigeria does not have an HR MIS at the moment and information on staff turnover, attrition and also when staff were last trained is missing.

Pakistan also does not have an HR MIS for TB control in place but is planning to develop one. Therefore there is no information on capacity, training needs or performance easily accessible from a database.

SEARO reports that most of the Member States do not have adequate human resource management information system for TB control; however countries receive sporadic information from the field. If countries have any information at all, it is on the categories of staff trained, when the staff were trained and how well the staff is doing in terms of implementation. Most countries in the region are missing information on; the number of years worked in TB since last training, the percentage of time spent on TB control activities, the type of training received and when training was last received.

Tanzania NTP is piloting an HRIMS tool to capture information on TLCU staff and MOH. See detailed description in section 6.6.

Thailand maintains information in Excel on training (time, place and number of days trained) for the following categories of health workers: MD, TB clinic nurses, TB coordinators at national, regional and provincial levels, laboratory personnel, village health volunteers and pharmacists.

Uganda has a manual HR MIS in place for TB control at Buluba training center. It contains name, cadre/qualification, district, health unit and updates on trained HWs in the field.

Vietnam has HR MIS for TB control integrated in annual plans. It describes the organizational model (for details see section 6.9) and provides information on the number of staff and the numbers of staff trained. Missing, is data required for long term development, such as number of staff who are going to retire and the number of staff which need to be recruited (including staffing standards).

Currently the MOH of Zambia has no information system for TB Control.

In Zimbabwe an HR MIS for TB control is not yet fully in place, however, separate documents are available including training plans, supervision guidelines and schedules.

#### **5.4 Actions related to IR-4 HIV Collaboration**

Bangladesh established a National TB/HIV coordination Committee with approval from the DG Health and has developed an operational plan for the comprehensive management of TB/HIV Co-infection. The NTP further established functional linkages with National AIDS and STD Program and DGHS, as well as with NGO partners having functional VCT. Orientation / Training / Workshop on TB/HIV co-infection were conducted jointly with NTP's DOTS partners and HIV – NGO partners and HIV Program Staff trained on TB ( Management, Mid-level, Field level). A well structured referral network was further initiated by NTP for TB and HIV diagnosis and management. Finally, the NTP is providing Anti-TB drugs and other necessary logistics to HIV partners.

Botswana has a Kitso HIV/AIDS Training program. It offers TB Case management training (TB/HIV surveillance, Isoniazid Preventive Therapy, Community TB Care, Infection Control). Although these training courses are conducted separately, both have components of either.

In Cambodia the NTP has some joined training sessions with the AIDS program. On other occasions, the training was dominated by an individual program.

DR Congo has a 5 years common work plan at the provincial (intermediate) level relating to diagnosis, referral, health education and care of opportunist infections. It involves health centers, laboratory technicians and nurses.

Ghana programs collaborate in the fields of planning, equipment, procurement of reagents and review meetings. At national level, National Program Managers for the two programs, and their staff, the director General and Deputy Director General, Director Public Health, Director Procurement engage jointly in training programs, review meetings and planning meetings. Regional focal persons for TB and HIV/AIDS, Regional directors of health, deputy director public health and training coordinators jointly organize training programs, review meetings, and counseling and testing of clients. District focal persons, District Director, Hospital Superintendent, nurses and technicians also collaborate in these areas.

In Kenya, the program (DLTLD) works closely with the National AIDS Control Program at various levels. Recently TB/HIV reviewed the TB/HIV curriculum together and the HIV/AIDS program was involved in the HR strategic planning process for the DLTLD program.

Mexico engaged in collaborative activities with attention to the 12 points of the PAHO recommendations. National and local levels are working together since 2007 in areas of supervision, sharing information and data analysis between focal points from HIV and TB programs.

The TB program in Nigeria works with the HIV/AIDS program at all levels of health care delivery, including the facilities. At the Federal level, there is a TB/HIV Working group headed by the Program manager for HIV/AIDS. Joint activities include: training; basic DOTS & HCT, IMAI, DOTS expansion which involves HIV/AIDS collaborative activities, planned training on infection control, intensive case finding, IPT, development of TB/HIV guidelines, TB/HIV Working group meetings, planned supervision and finally, monitoring & evaluation.

Pakistan did not report on collaborative activities.

SEARO reported that the NTPs at country level work with National HIV/AIDS programs. Bangladesh, India, Indonesia, Myanmar and Thailand are implementing TB/HIV collaborative activities involving staffs of both programs. NTP-HIV/AIDS program collaboration at the central level occurs in terms of policy and planning. SEARO supports countries establishing mechanism for collaboration; setting up coordinating bodies for TB/HIV activities at all levels; conducting surveillance of HIV prevalence among TB patients; carrying out joint TB/HIV planning and resource mobilization for TB/HIV.

SEARO further assists with TB/HIV capacity building; TB/HIV communication, operational research and conducting monitoring and evaluation.

The following thresholds for TB/HIV collaboration are proposed by SEARO (Table 2).

**Table 2: Thresholds for TB/HIV collaboration proposed by SEARO**

Category	Recommendation
Category 1 Countries with national adult HIV prevalence rate >1% Or Countries in which national HIV prevalence among TB patients is $\geq$ 5%	Implement all recommended collaborative TB/HIV activities
Category 11 Countries with national adult HIV prevalence rate below 1% Or Administrative areas with adult HIV prevalence rate $\geq$ 1%	Implement all recommended collaborative TB/HIV activities in areas with high HIV prevalence and in other areas as in Category 111
Category 111 Countries with national adult HIV prevalence rate below 1% Or No administrative areas with adult HIV prevalence rate $\geq$ 1%	HIV surveillance among TB patients Activities to reduce burden of TB among PLWHA (with special emphasis on high HIV risk groups)

TB/HIV joint activities in Tanzania started in 2005 in all 21 regions/provinces in the country under the support of: CDC/PEPFAR: 10 Regions, GFR 6: 2 Regions, GFR 6: 7 Regions, PATH/USAID: 2 Regions. The goal is to reduce the burden of TB/HIV in individuals affected by the two diseases.

In Thailand the TB/HIV focal person is responsible for NTP and NAP coordination at national level. There are also

responsible focal points and health personnel responsible for coordination at regional and provincial levels.

In Uganda the NTP also works together with the HIV/AIDS program. At national level a NCC/TB/HIV exists that deals with policy development, revision of tools and partner coordination.

In Vietnam the NTP works with the Vietnam Administration for HIV/AIDS Control (VAAC), in areas of training (clinic, planning, management, supervision, IEC), deployment, supplies, information and supervision.

The NTP in Zambia interacts with the HIV/AIDS program at the planning and implementation levels. Joint activities include policy development, guidelines production and dissemination and service provision.

In Zimbabwe TB/HIV collaboration exists at all levels. Activities include planning, joint supervision, reviews and training. HIV counterparts at various levels are National ART Manager, Provincial ART focal person and DMO.

## 6. Best practices and tools reported by countries

### 6.1 TB/HIV Control in Mvuzi Health Centre DR Congo

Matadi is the main port in DR Congo where the HIV risk is very high and the question was how TB health center HR may be involved in dealing with HIV activities concerning the patients affected by both TB and HIV.

TB patients were tested for HIV. Results since 2006 are shown in table 3.

**Table 3: TB patients tested for HIV in Mvuzi Health Centre DRC, 2006-2008**

Indicators	2006			2007			2008		
	M	F	Total	M	F	Total	M	F	Total
Number of TB patients	44	60	104	89	100	189	99	102	201
Number of TB patients tested for HIV	42	55	97 (93.2%)	89	100	189 (100%)	99	102	201 (100%)
Number of TB patients HIV+	3	13	16 (16.4%)	5	19	24 (12.6%)	8	19	27 (13.4%)

Out of the 67 HIV+ TB patients, 46 were treated with TARV as shown in Table 4.

**Table 4: HIV+ TB patients treated with TARV in Mvuzi Health Centre DRC**

	M	F	TOTAL
TB patients HIV+	16	51	67
Treated with TARV	9 (56%)	37 (71%)	46 (69%)

Out of the 46 TB HIV+ patients 41 were cured (89%), 4 died (9%), whilst treatment failed in one case.

Five doctors, 8 nurses, 5 social workers and 3 lab technicians were involved in developing the program that was implemented by all health care professionals, benefiting the community depending on the health center.

It was determined and is advisable to others who wish to replicate the initiative, that the same health care professionals are able to take care of TB patients who are also affected by HIV, provided that they are trained and motivated through incentives and are provided with all the necessary equipment and materials.

### 6.2 Building Capacity for Facilitative Supervision in Malawi

To address inadequate facilitative supervision skills amongst NTP supervisors, a one week facilitative supervision skills training course was organized.

Training aimed at imparting skills on supervision which also looks at problem solving whilst providing adequate support to the supervisee.

All supervisors at zone level were equipped with facilitative supervisory skills, while plans are underway to cascade the trainings to district level. To monitor implementation trained supervisors were followed-up.

The initiative involved; Zone TB supervisors, Zone Laboratory supervisors and all central unit staff.

It was determined/noted that facilitative supervision requires a lot of supportive mechanisms, in particular adequate resources that enable people to effectively perform.

### **6.3 Participatory Quality Improvement in Mexico**

Health workers (managers and operative personnel) were empowered to improve the quality of Local Health System for TB control in a participatory manner, using different quality tools for data analysis and decision making. The process is known as “Evidence Based Participatory Quality Improvement” (EPQI) and was already described in the proceedings of the previous HRH TB Platform meeting.

Workshops on quality tools to improve TB control were continued from last year and 16 Local Health Systems were trained on EPQI methodology. Each team includes 35 – 45 health workers: physicians, nurses, chemistry, social workers, managers, supervisors and those responsible for TB, HIV and DM. More than 650 health workers to total were trained .

#### **People at various levels were involved:**

At State level; those responsible in the TB Program; epidemiologist, DOTS leader, Laboratory leader, Health Promotion, HIV and DM responsible;

At local health system level; the Local Jurisdiction chief, TBP responsible, epidemiologist, DOTS leader, laboratory, health promotion, HIV and DM responsible, and supervision teamwork.

At health center level; director, physician, nurse, health promoter and social worker; (Between 5 – 8 people)

National NTP personnel and an HRD advisor were involved in the workshops, each of which attended by 35-45 health workers.

Benefits included commitment of health workers and integration as a team and quality improvement of district health services in public health problems. In addition local leaders felt empowered and felt proud of their job.

However, high staff turnover presents a challenge, while some leaders, lacking public health training (Chief of District Health Services) showed a lack of involvement

Overall, just 16 out of 40 priority Local Health Systems were trained whilst there are 245 LHS in the Country and TB CAP is entering its last year.

To help sustain and replicate the process, a Guideline of Participatory Quality Improvement to TB Control (Spanish) was developed. A sponsor is sought to fund the translation into English so that a wider community may benefit.

### **6.4 A Performance Appraisal Tool from Pakistan**

In order to comprehensively review the district level activities, a Performance Appraisal Tool for District TB Coordinator was developed to evaluate the district's performance in TB control by NTP supervisors and District TB officers during quarterly reviews, evaluations and performance appraisals.

The tool consisted of a checklist that was consistent with the routine reporting format, but identified the gaps in performance.

It was developed through involvement of Technical Unit NTP, M&E experts, Patients, Academics and used for Quarterly Reviews by Executive District Officer (EDO) Health, National TB Control M&E team, PTP Manager and District Program Reviewers.

It was noted that performance evaluation of district TB teams including the logistic and supply chain was possible through the use of District TB performance indicators, enabling a participatory, efficient, and rapid appraisal, which takes only 30 minutes to complete.

Others who wish to use the method are advised to include qualitative aspects and to involve patients, private providers and community workers. Appraisal should be participatory and supportive. Those who are intending to make use of the tool should be trained before using it. For repeated routine use the list can be less exhaustive.

## 6.5 Supporting Countries with HRH for TB in South East Asia

In the South East Asian Region most countries have no information on trained staff or staff requirements and criteria for selection of staff for training are lacking with exception of India, Indonesia, Myanmar and Nepal. Capacity for dealing with HRH is in short supply at national and district levels (management, supervision and trainers). In particular, there are inadequate numbers of district supervisors. The problem is compounded by a zero growth policy in combination with a high staff turnover. At the same time, staff are probably under-utilized.

On the training side there is little or no follow-up of trained staff or activities in Bangladesh, Nepal and Thailand, there is also no monitoring/evaluation of training programs. An HRH information system in the public sector is yet to be established in most of the countries in the region. Pre-service training is not in accordance with NTP guidelines with the exception of India and Indonesia.

The SEARO is supporting countries with the development of HR plans and the decentralizing of training, developing HR capacity and master trainers.

Regional advocacy and support contributed to several benefits at country level including:

- Quarterly monitoring meetings increased staff motivation for both government and NGOs
- High quality and sustainable partnership that tackled HRH issues
- Joint review missions in countries improved health staff performances
- Creating opportunities to learn and grow through fellowships, higher training and accreditation of training.

The regional efforts included the TB Unit, WHO/SEARO, HR Team of the National TB Control Programs and technical assistance from KNCV/TB CAP.

It was learned that firm commitments of HRH Teams has been essential for the success, however, still much more is required. Sustainable and qualitative partnership between public and private sectors can and should be built. There is further need for continued medical education, workshops, orientations and external training

It is recommended to build a strong commitment from HR teams at country level, to foster partnerships, to invest in continued medical education and to organize exchange visits to learn from other country's performances.

## 6.6 HRD Information Management Tool from Tanzania

By Irneyi Myemba, HRDO- NTLP Tanzania

The Tanzanian HRD Strategic Plan Framework includes a strategic objective to improve the program HRIMS to facilitate decision making at all levels by 2012. (see table 5)

**Table 5: Section from Tanzanian HRD Strategic Plan Framework**

STRATEGIC OBJECTIVE 2.0: IMPROVE PROGRAM HRIMS TO FACILITATE DECISION MAKING AT ALL LEVELS BY 2012	
Strengthen HRIMS at all levels	Update and harmonize HRIMS tool with that of the MoHSW- HRH
	Conduct annual stakeholders meeting to share information, experiences and challenges
	Update the current supervision tool to accommodate HR issues
	Orient supervisors at all levels on the updated supervision tool

An HRIMS in the NTP was needed to facilitate effective planning and budgeting and to provide evidence to inform program decision making. A good HRIMS would further enable monitoring the situation of the program's HR and ensures accountability of program staff at all levels. It would finally facilitate HRH estimates and projection. It was therefore decided to have an HRDIMS tool developed to support NTP in HRD&M.

The developed HRDIMS tool was intended to:

- Ascertain NTP HR actual needs at all levels
- Support HR planning and projection
- Determine attrition rate of Program staff
- Support advocacy for recruitment and filling up of gaps
- Facilitate development of Training plans
- Facilitate job description to NTP staff at all levels

Table 6 shows information from program staff captured by the tool.

**Table 6: HRD for TB information form from Tanzania**

Name	
F/M	
Year of birth	
Works in TLCU Since	
Inflow	Transfers in, Promotion, Recruitment, Demotion, Trained Staff, Secondment, Consultancy, Recall
Employment	Government
	Employment
	Outflow
	Job category
Outflow	Transfer Out, Retirements, Dismissals, Retrenchments, Deaths, Prolonged Sickness, Absconders, Resignations, Promotions, Demotions, Secondment Out, Consultancy Out, Absenteeism, Injury
Job Category	
Salary	TGS
	Others
Job Description	
Main task	TB DOTS
	Supervision
	Other
Main responsibility	
Competencies (v is ok; x for improvement)	Leadership
	Facilitation
	Communication
	Problem analyses and solving
	Writing skills
	Project management
Educational background	Below Secondary
	Secondary Education
	Certificates
	Diploma
	Post-Graduate Diploma's
	Bachelor
	Masters and Plus
Other received training related to TB strategy and date & length	Year
	Length
	Orientation
	Basic Specialization
Needs training in	Content
	Time
	Int/Ext
	Funding
International conferences Platforms	

The tool has been piloted with NTLF staff and MOH HRH department and the findings were: to use sex instead of F/M, to use Date of Birth instead of year of birth, to avoid unpopular abbreviations such as H/F to omit absenteeism, to differentiate main task from main responsibilities and to use MS Access as data base software.

The tool has been piloted with NTLF staff and MOH HRH department and the findings were: to use sex instead of F/M, to use Date of Birth instead of year of birth, to avoid unpopular abbreviations such as H/F to omit absenteeism, to differentiate main task from main responsibilities and to use MS Access as data base software.

The findings from the pilot have also been used to develop strategic objectives and tasks in the HRH strategic frame work.

The initiative involved the MoHSW (HRH), NTLF Tanzania and KNCV

It was noted that development of an HRIMS tool requires collaboration. Also, coming up with a tangible review of different tools proved to be very crucial.

Development of an HRIMS tool requires consultation with stakeholders including HRH, HIMS- MOH and Civil Service Commission; the NTP cannot work in isolation in developing HRIMS tool.

## **6.7 Boosting TB Control in Thailand, the Mr & MS TB project**

A project by the Permanent Secretary since FY 2009

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

### **Who are Mr. & Ms TB?**

Two designated persons are: the Vice Provincial Public Health Medical Doctor at Provincial Level and the Vice Hospital Director or Senior Hospital Doctor.

Their role is to enhance TB control activities at all levels within provinces, to motivate health care workers relevant to TB control and to manage information for action.

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

It will remain challenging to increase the success rate to achieve MDGs' target and to reduce or reduce the rate of increase of MDR-TB.

However, since this initiative, "We never ever had such strong commitment like this since 1979." This is the golden period of TB Control in Thailand

## **6.8 Developing HR for TB/HIV Collaboration in Uganda**

Uganda has a decentralized health system which is understaffed. TB control activities are integrated into the GHS using CB TB care with DOTS. NTLF and NACP were working parallel.

The WHO report 2008 shows high TB prevalence (561/100,000 all forms) and incidence (SS+ 154/100,000 population). At the same time there is high prevalence of HIV 6.4% (2005 sero-survey) and a high association between TB & HIV (national Data Sept 2007 show 60% of the TB patients are also HIV +)

All frontline health workers need to be trained to handle patients with both TB and HIV, but there is a challenge coordinating multiple Partners who are working on HIV/AIDS, TB and TB/HIV; (WHO, TB CAP, NUMAT-USAID, MJAP collaboration, UPHOLD-USAID, JCRC).

A TB/HIV collaborative initiative was launched to provide this orientation, through synergy with the established core activities of TB and HIV/AIDS, promoting the enhanced collaboration between TB and HIV/AIDS in the provision of a continuum of quality of care at service delivery level for PLW TB and HIV/AIDS, providing a consistent framework for implementers to use expanding TB and HIV collaborative activities.

It was decided to share information by setting up a national coordinating body for TB and HIV activities, Identifying focal persons at regional, district and health sub-district Level, conducting surveillance of HIV prevalence among the TB patients, carrying out joint TB and HIV planning resource mobilization, capacity building, Advocacy, Communication &



Social Mobilization, conducting monitoring & evaluation and coordinating Research activities on HIV/TB.

For the content of training, measures were identified to decrease the burden of TB disease among HIV positive persons, and to reduce the burden of HIV among TB patients. The results were as follows:

- WHO trained 13 districts (2006)
- Uphold trained 28 district plans to train 28 more
- TB CAP is training 12 districts with a view to reach 20 districts. Trained 3 Regional Liason Officers to coordinate training
- NUMAT trained 5 districts of the North (Apac, Lira, Pader, Kitgum and Gulu).
- MJAP –trained Regional Hospitals ( Mulago, Mbarara, Jinja, Hoima plan to expand to 11)

Other benefits were:

- A standardized Training Package in Modular form (10 modules)
- An updated M&E system to capture TB/HIV collaborative activities routinely (Modified NTLP monitoring stationery-Unit TB register, District TB registers, Quarterly Report Forms and National Data Base)
- The increased number of HR for TB/HIV and resulting improved Quality of care for clients. Demand for HIV testing among TB clients has increased.
- Country coverage integrating TB/HIV collaborative activities into the General Health service has been good.
- Coordination of Partners has improved.

It was noted that coordination of partners is a challenge which needs to be addressed as a priority, with preference for a programmatic, rather than a project approach. Having standardized training materials in the form of modules has been a great help, nevertheless there is need for refresher sessions in view of high staff turn over that requires thinking about appropriate modalities. TOTs are further required to build sustainable training capacity in districts, at central, regional and DHO offices as well as the larger health facility level. Finally there is need for appropriate IEC materials.

## 6.9 A Tool for Intensified Case Finding in Uganda

An Intensified case finding (ICF) tool was developed to standardize TB screening by health workers and to screen HIV positive clients for TB symptoms.

It consists of a questionnaire with an action guide for Intensified TB Case Finding in People living with HIV and in HIV care settings that should be administered by either a health care provider or lay provider at the health facility (The tool should not be self administered). The form asks for: date of TB assessment, name of district and health facility, location, e.g. OPD, HIV Clinic and patient ID/registration number. Five yes / no questions are asked:

1. Has the patient been coughing for 2 weeks or more?
2. Has the patient coughed up sputum stained with blood?
3. Has the patient had persistent fevers for 3 weeks or more?
4. Has the patient had noticeable weight loss (more than 3 kg) in the last one month?
5. Has the patient had night sweats for 3 weeks or more?

The “Guide for actions to take” specifies:

- If ‘yes’ to question 1 or 2; request a sputum test and refer to clinician for further investigations. Direct the patient to a designated area for people with chronic cough.
- If ‘no’ to question 1 and 2 and ‘yes’ to any other question; refer to clinician for further investigations
- If ‘no’ to all questions: repeat TB Assessment on subsequent visits

### The tool further instructs:

1. If you are in a clinic attending to patients enrolled in HIV care record this information on the comprehensive ART card; this information should then be transferred to the Pre ART or ART register.
2. If you are in any HIV care setting (not attending to patients enrolled in HIV care e.g. OPD) and the patient is found to be a TB suspect record this information in a TB suspect register.

The tool is presently being introduced for use at health facilities: OPD, HIV clinics, etc. to be administered by operational level HWs. Its development involved MOH and partners (WHO, MJAP, The Union, AIC) and was endorsed by NCC/TB-HIV

Lessons learnt include the choice of symptoms to include, actions to take depending on sensitivity and specificity of the 5-question screening and the need to determine modalities of use at operational level; where, who, records, effecting

requests. Adaptation in HIV prevalence settings standardizes screening and improves TB case finding.

## **6.10 A Model for TB/HIV Management in Vietnam**

The proportion of HIV (+) among TB patients in 10 provinces with highest HIV prevalence is increasing rapidly and the reason why TB/HIV management is given special attention.

In 2001, the CDC Global AIDS Program and Viet Nam Ministry of Health entered a cooperative agreement to support Vietnam's national HIV prevention and care program through support to 40 of Vietnam's provinces with highest HIV prevalence. The program includes support for HIV prevention activities including community outreach for vulnerable populations and anonymous voluntary counseling and testing services. It also includes support for prevention of mother to child transmission, HIV outpatient clinic services including OI prophylaxis, coordination of TB and HIV services, laboratory capacity building, and STD and HIV surveillance.

In October 2002, peer driven community-outreach programs for intravenous drug users were initiated in Quang Ninh (red color province), followed closely by the initiation of anonymous voluntary counseling and testing services aimed at high risk persons. Since October, community outreach has been initiated in 15 provinces, and anonymous VCT services in 18 provinces.

The program was introduced in 6 provinces with high prevalence of HIV and subsequently extended to 11 other provinces.

### **Results:**

Between July 2006 and March 2009 the number of provincial health facilities which were developed increased from 3 to 17 and other health facilities from 29 to 98.

Cooperation between TB and HIV programs was strengthened at all levels through: quarterly meetings NTP – VAAC: 10 provinces and 105 pilot sites, evaluation cooperative activities in 10 provinces, a survey on HIV/TB prevalence and mortality at pilot sites (2007-2008), a study on smear negative PTB diagnosis (2008-2009), and routinely surveying prevalence of HIV/TB & and TB/HIV at 5 provinces (analysis is ongoing)

To reduce impact from TB epidemic on PLWHA, IPT was provided to 1,400 PLWHA in 8 provinces. TB scanning was done for 1,800 people with high risk of HIV infection (3 provinces) while 5,114 PLWHA were screened for TB.

To minimize effects of HIV/AIDS on TB patients CPT was provided for 8,200 TB/HIV patients (26 provinces: with plan to reach 10,000)

400 provincial staff and 420 district staff were trained on referral system, DOTS and caring for HIV/AIDS, 92 staff on PITC, 153 on TB screening and 109 on TQM. 15 lab technicians received advanced MT microbiology training.

Activities further included reporting and supervision, while evaluation of cooperative activities was done in 10 provinces.

Lessons learnt include the fact that there is Government concern and interest in promulgating the National Strategy for Control of HIV/AIDS (towards 2010 and 2020), supporting the NTP and approval of the National procedure on TB/HIV cases detection management. There was further technical and financial support from International Organizations: (WHO, GF, CDC) and able management from an experienced NTP. There was also a strong TB network from commune to central level, while the HIV/AIDS program has also been strengthened at all levels.

Nevertheless, remaining challenges include lack of resources: HR, equipment both for HIV and TB, especially at district level. Many trained staff have also given up or shifted to other fields. Co-ordination between the NTP and the HIV/AIDS programs should still become closer, especially from the HIV/AIDS side. Reporting (including financial reports) is still low. Price increases have put a strain on available finances.

Finally, the social stigma toward TB, HIV, TB/HIV patients as well as the self stigma from TB, HIV, TB/HIV patients remain issues of concern.

## **7. Further Support Requirements**

The most mentioned support required by countries was TA. Botswana, DR Congo, Nigeria, Thailand, Vietnam and Zimbabwe needed technical support for the development of a Strategic Human Resources Plan or policies and guidelines for TB. SEARO supports countries through TA to develop country-specific priority actions for national TB control programs in the context of health systems strengthening, including human resource development. SEARO TA also assists countries to identify opportunities and mechanisms for enhancing TB control through health systems

strengthening and supports countries in reviewing the situation and experiences including successes and challenges in addressing health systems issues relating to TB. Mexico required TA or peer support for evaluation and follow up of personnel trained. TA was also required for other purposes; Namibia needed assistance with strategies to improve TB infection control and to reduce the fear associated with working with TB patients, Uganda called for TA to address HR issues for TB control within an integrated system and reviewing pre-service curriculum and in-service training, Botswana for the development of an HR MIS for TB Control. Mexico needs the continuing support of a local HRD advisor, while Ghana was interested in peer review by others who also have integrated HR management systems. Indonesia, Pakistan and Zambia indicated to need technical support without further specification.

Several countries mentioned the need for political support; Thailand mentioned the need for strong and sustained commitment in TB control, and better cooperation from academic sites. Vietnam required suitable policies from government: in particular, health system reform. Zimbabwe saw the need for stronger advocacy for policy shift. Botswana also talked about government commitment to HR in TB Control.

As was to be expected, countries need financial support; Indonesia and Zimbabwe simply mentioned the need for funds, Thailand will use Global Fund Round 8 to support HR activities, while Vietnam specified needing funds for incentives. Mexico required support to maintain an HRD coordinator in the NTP for management and training activities and asked partners to help fund or support the position of provincial TB/HIV coordinator which is not in the establishment.

Training, or availing of training tools as a mode of support was mentioned by Indonesia (advanced course on capacity building); Mexico needed training tools with technical and humanistic point view, whilst Namibia needed the training of program managers (TB and HIV) on TB and TB/HIV HRD planning and training support for MDR- TB management targeting various levels of health care workers.

Nigeria and Zambia reported that support on HR issues was part of their country's work plan; however, this was not the case in Ghana; the usual technical training for staff, which is carried out at program level is all that one can find on the work plan.

## **8. Discussion**

Whilst there was encouraging, though in some cases slow, progress on most indicators relating to the burden of TB, there was still an (albeit slow) increase in the absolute number of incident cases, while universal DOTS coverage, M/XDR-TB and HIV/TB form tremendous challenges in the face of a US\$ 1.6 billion funding gap.

HR for TB featured highly on the global TB agenda and was discussed during the Ministerial meeting of high M/XDR-TB burden countries Beijing, the Sixty-Second World Health Assembly and the Partners Forum in Rio de Janeiro. HRH aspects also appear in grant proposals for TB from Global Fund for AIDS, TB and Malaria.

Problems and obstacles with relation to HRH for TB control were not substantially different from those mentioned last year. This did not deter countries from having ambitious 'HR for TB' goals, aimed at having adequate numbers of health workers at different levels of the health system, who are motivated and have the skills, knowledge, attitudes and professional competence necessary to successfully implement and sustain comprehensive TB control services, based on the Stop TB strategy.

With relation to the HRH Action framework, efforts were reported in connection with restructuring and policy advocacy, use of various funding sources, capacity building, education and training, building of partnerships, strengthening of collaboration and community work, personnel and performance management. However, apart from Mexico, there was little explicit mention of leadership development.

### **With reference to the IR5 output indicators:**

Complete or nearly complete HR for TB plans are available in Bangladesh, Cambodia, Kenya, Mexico, Thailand and Vietnam, whilst Ghana, Uganda and Zambia have national HR plans, meant to cater for the health sector as a whole.

Bangladesh, Cambodia, Kenya, Malawi, Nigeria, Vietnam and Zimbabwe have assigned focal persons for HR for TB Control. In Ghana it appears to be policy not program specific HR focal persons.

Inclusion of Stop TB in pre-service curricula is by and large achieved in Cambodia, Ghana, Namibia, Nigeria, Tanzania and Vietnam, whilst Mexico is making good progress.

Progress with establishing TB-HR information systems is lagging behind; only Namibia, Thailand and Mexico seem to have an information system. Tanzania developed a data collection form, however this alone does not constitute an information system. Several training courses have been conducted in Zaria and Gadjah Mada training centre, which was also one of the indicators.

HIV/TB collaboration is encouraging, 10 countries are doing very well. It included the establishment of coordinating committees, common focal points, joint work plans, training activities and curriculum development and logistics and supplies management. Other areas of collaboration included supervision, treatment and care. SEARO developed a useful framework recommending degrees of required collaboration related to epidemiological status of HIV and TB / HIV prevalence.

Beneficial effects from government interest and policy support were reported from the model for TB/HIV Management in Vietnam, as well as the 'Mr & Ms TB' project in Thailand. The latter project further showed how a simple administrative decision, allocating TB responsibilities to Vice Provincial Public Health Medical Doctors and Vice Hospital Director could create a "Golden Period" for TB control. However, a lack of such commitment from some officials was reported as a problem in Mexico.

From reports on practices from countries, it was learned that; the same health care professionals are able to take care of TB patients as those who care for patients with HIV, provided that they are trained and motivated (Mvuzi Health Centre DR Congo).

Supportive supervision can also be learned through training, however, more than training and supervision is required to improve performance. Experiences from Malawi show that a lot of other supportive mechanisms, in particular adequate resources are required to enable people to effectively perform. Vietnam also reported that their success, apart from policy support, was also due to technical and financial support.

From Uganda it was learned that coordination of partners around harmonized training for TB / HIV is a challenge, but can be achieved with standardized training materials.

Several tools were developed by countries: Pakistan developed a performance appraisal tool, which takes only 30 minutes to complete in a participatory and supportive context, Uganda a one page Tool for Intensified Case Finding with five yes / no questions and guide for actions to take, while Tanzania presented an HRH for TB information form. It was shown that the development of a tool cannot be done in isolation and requires consultation with multiple stakeholders. It was recommended those who are intending to make use of the tool should be trained before using it. Mexico reported on progress with Participatory Quality Improvement, but will have covered only part of the country toward the end of the TB CAP period. A manual was developed that others may use to increase coverage. The wider community may benefit if it is translated into English.

Further support requirements related to TA (peer support) for HRH strategic plan, health systems strengthening reforms, evaluation, infection control, and curriculum review. In addition there was a need for better collaboration from academic institutions, and funds for incentives, to employ specific personnel and for training.

In conclusion, a lot has happened, and there were ample lessons to be learned. However, progress on the IR5 output indicators still shows that a lot more is required. Monitoring missions have further established that at closer inspection some of the reported IR5 achievements<sup>5</sup>:

- The concept of strategic planning for HRH seems still to be interpreted in a less than optimal way.
- The training aspect seems to be better addressed than issues related to (short and long term) staffing needs, motivating and support, and working environment aspects.
- However, the systematic process in developing training, educational material and programs is often not followed leading to many training activities with suboptimal educational quality and subsequent poor performance.
- Training and staffing needs related to the management of MDR-TB are in most cases only related to pilot projects.
- TB High Burden countries are facing similar challenges in maintaining achievements, enhancing quality and introducing and scaling up new interventions such as TB/HIV collaborative activities and the management of MDR-TB.
- Management of HRH varies a lot between countries and within big countries – at sub-national level HRH activities remains restricted mostly to the organization of training courses and training plans are often available.
- There is in some places a trend towards the creation of "vertical training programs" within each "component of the TB control strategy".
- The continued development and strengthening of the strategic planning of HRH within the NTP is crucial.
- Coordination and collaboration with departments for overall health workforce development at all levels also needs urgent strengthening.

Despite these problems and challenges discussed above, monitoring missions have also shown that major progress is being made in HRH for comprehensive control - progress that is not necessarily made visible through the limitations of a questionnaire.

5 This statement referred to the 23 TB CAP countries

## 9 Resolutions and Next Steps

### 9.1 Resolutions June 2009

1. Before October 2009, advocate to establish a Human Resources for Health (HRH) working subgroup to address HR as a cross cutting issue within one of the Stop TB Partnership Working Groups<sup>6</sup>.
2. By the end of May 2010, advocate to increase political commitment for HRH at country level to ensure the development of HRH strategic plans for TB control.
3. By the end of May 2010, all participating countries will have completed the development of a HRH strategic plan for TB control in line with MOH/HR strategies, TB strategic plans, and, if needed, with support of TB CAP.
4. Advocate for the appointment of TB/ HR focal points with clear job descriptions at central level of the National TB programs.
5. By the end of May 2010, TB/HR focal points at the country level will have established an action-oriented collaborative body focused on HRH requirements for TB and HIV programs.
6. By November 2009, define and share the critical indicators for an effective Human Resource Management Information System (HRMIS) system with the HR platform members.
7. By the end of May 2010, all participating countries will have pilot tested and implemented an HRMIS system based on identified critical fields and country specific needs with guidance of a TB CAP generic tool (as shared under resolution 6).
8. By the end of May 2010, all countries will have started the revision of their pre- and in-service curricula for TB and HIV (competence based) in line with the Stop TB strategy to ensure recognition by the respective regulatory bodies.
9. Participation and professional sharing among platform participants is enhanced through ongoing communication and improved access to information resources.
10. By May 2010 participants will provide evidence of concrete attributions to strengthen the general health care system.

### 9.2 Next Steps

Translate resolutions into country specific work plans (submission before the 15th of July 2009).

All information available in the e-portal including work plans.

Follow-up of implementation after 6 months (questionnaires & e-portal discussion).

On agenda next HR platform meeting.

Publication of the results of the HR platform meeting for comprehensive TB control & joint TB/HIV activities (update HR country indicators, best practices per country and recommendations).

Continue linkage with Global Health workforce Alliance.

To be part of sub working group to address cross cutting issues of human resources across the working groups (TB to be part of the broader global health workforce movement).

---

<sup>6</sup> At the time of publication this was already accomplished.

## References

- Flahault D. M. Piot, A. Franklin; The supervision of health personnel at district level WHO, Geneva, 1988
- Rodhe J. Supportive Supervision to Improve Integrated Primary Health Care, MSH Occasional Papers No. 2 (2006)
- Planning the Development of Human Resources for Health for Implementation of the Stop TB Strategy, WHO, CDC, WHO, Geneva, 2009
- Global Tuberculosis Control 2009; Epidemiology, Strategy Financing, WHO, Geneva, 2009
- Supervisor Competency Self-Assessment Inventory, The Health and Family Planning Manager's Toolkit, Family Planning Management Development Technical Unit, MSH, October 1998
- Proceedings of the HR/TB Platform Meeting; Together we can achieve: TB CTA USAID The Hague, The Netherlands, 28& 29 May 2008
- Improving Supervision: a Team Approach, MSH, The Family Planning Manager, Volume II, Number 5, October/November/December 1993
- Dr Chilunga Puta; A Performance improvement framework, PPP
- Eileen J. Petit-Mshana; Integrating priority disease requirements with the education cycle PPP
- Andrée Willemse TB CAP for Human and Institutional Capacity Building, PPP
- Elena Yurasova, WHO Russia, Karin Bergstrom, Jacob Creswell, Malgosia Grzemska, TBS/STB/WHO HQ; Moving ahead with the Stop TB Strategy; Where are we now with HRH and what are the HRH challenges from a global perspective? PPP
- Jean-Pierre Kabuayi and Emmanuel Kiangala ; TB/HIV Control in Mvuzi Health Centre DR Congo PPP
- Rhoda Banda; Building Capacity for Facilitative Supervision in Malawi PPP
- Antonio Martinez; Participatory Quality Improvement in Mexico PPP
- Ejaz Qadeer; Performance Appraisal Tool from Pakistan PPP
- Dr Md Khurshid Alam Hyder; porting Countries with HRH for TB in South East Asia PPP
- Irneyi. Myemba; HRD Information Management Tool from Tanzania
- Supasorn Suriyawongpaisal; Boosting TB Control in Thailand, the Mr & MS TB project PPP
- Charles Isabirye; Developing HR for TB/HIV Collaboration in Uganda PPP
- Baluka Jennifer; A Tool for Intensified Case Finding in Uganda PPP
- Dr. Trinh Minh Hoan; A Model for TB/HIV Management in Vietnam PPP
- Dr. Md. Nazrul Islam, Program Manager, NTP, Dr. Md. Mahbubul Islam, DPM, NTP, Dr. Subhasish Das, Medical Officer, NTP, Country Report Bangladesh PPP
- Ntukunu Makubate Country Report Botswana PPP
- Dr. Khloeng Phally; Country Report Cambodia, PPP
- Jean-Pierre Kabuayi, Emanuel Kiangala; Country Report DR Congo PPP
- Sylvester Anemana; Country Report Ghana PPP
- Surjana King; Country Report Indonesia PPP
- Mary Osano; Country Report Kenya PPP

Rhoda Banda, MPH, HRD Focal Point person, NT; Country Report Malawi PPP

Martin Castellanos; NTP Director Country Report Mexico PPP

Cesário Augusto Suege; Country Report Mozambique PPP

Ms. Celine Usiku, Director: Policy, Planning & HRD, MoHSS; Country Report Namibia PPP

DR. K. O. Adagba; Country Report Nigeria PPP

Ejaz Qadeer; Country Report Pakistan PPP

Irnei R. Myemba, HRDO- NTLN; Country Report Tanzania PPP

Supasorn Suriyawongpaisal, B.Ed., M.A.; Country Report Thailand PPP

Charles Isabirye; Country Report Uganda PPP

Trinh Minh Hoan, Tran Ngoc Buu; Country Report Viet Nam PPP

Dr Callistus Kaayunga, National TB/HIV Coordinator; Country Report Zambia PPP

Charles Sandy Country; Report Zimbabwe PPP

Dr Md Khurshid Alam Hyder, Medical Officer TB, SEARO/WHO; Regional Report WHO-South-East Asia Region PPP

## List of Participants

Adagba Kenneth  
Ando Nobutaka  
Andrea Drost  
Andrée Willemse  
Asik  
Baluka Jennifer  
Banda Rhoda  
Callistus Kaayunga  
Celine Usiku  
Cesareo Suege  
Charles Sandy  
Chilunga Puta  
Dato Chorgoliani  
Dr Hyder  
Dr Khloeung Phally  
Dr Nazrul  
Eileen Petit  
Ejaz Qadeer  
Elana Yurasova  
Emanuel Kiangala  
Gidado  
Ieva Leimane  
Ineke Huitema  
Irnei Myemba  
Isabirye Charles  
Jacob Creswell  
Janet Phillips  
Janshed Chhor  
Jean-Pierre Kabuayi  
Jeff Glassroth  
Jose Antonio Martinez  
Liesbeth Oey  
Maarten van Cleeff  
Marco Gerritsen  
Marjolein Dieleman  
Marleen Heus  
Mary Osano  
Netty Kamp  
Nonna Turusbekova  
Ntukunu Makubate  
Peter Petit  
Seraphine Kabanje  
Subhasish Das  
Supasorn  
Surjana  
Sylvester Anemana  
Tran Ngoc Buu  
Trinh Minh Hoan  
Wanda Walton  
Wilawan Somsong