

Planning the development of human resources for health for implementation of the Stop TB Strategy

A handbook



**World Health
Organization**



CENTERS FOR DISEASE™
CONTROL AND PREVENTION

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**World Health
Organization**

**Stop TB Department
Department of Human Resources
for Health**



CENTERS FOR DISEASE™
CONTROL AND PREVENTION

**United States Centers for
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Abbreviations

DOT	directly observed therapy
DOTS	The internationally recommended strategy for TB control until 2005, and the foundation of the new Stop TB Strategy introduced in 2006
FBO	faith-based organizations
FTE	full-time equivalent
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHI	global health initiative
HBC	high-burden country (for tuberculosis, of which there are 22)
HR	human resources
HRD	human resource development
HRH	human resources for health
HRM	human resource management
MDG	Millennium Development Goal
MDR-TB	multidrug-resistant tuberculosis
MOH	Ministry of Health
NAP	national aids control programme
NGO	nongovernmental organization
NTP	national tuberculosis control programme
PAL	practical approach to lung health
SMART	specific, measurable, achievable, realistic, time-bound
SWOT	strengths, weaknesses, opportunities, threats
TB	tuberculosis
TBCAP	Tuberculosis Control Assistance Programme
TBCTA	Tuberculosis Coalition for Technical Assistance
WHO	World Health Organization
XDR-TB	extensively drug-resistant tuberculosis

Preface

Planning human resources to achieve the international goals and targets set for global control of tuberculosis (TB) is a complex and challenging management task. Furthermore, countries highly affected by the disease have the additional challenge of tackling a general workforce crisis, and managers of national TB control programmes are faced daily with the daunting tasks caused by this double crisis.

Managers of health systems are thus confronted by an enormous challenge, or double-bind: how to find the right balance between devoting sufficient staff time to specific diseases and meeting the general health needs of populations in a primary health-care environment. Health priorities compete for attention. Maximizing the quality and quantity of existing human resources to achieve one health goal without jeopardizing another is never an easy decision. Integrating human resources at all levels of the health system provides one way of serving the different needs for health care. To achieve such integration, close working ties between departments responsible for disease control, health planning, human resources, and health administration need to be established.

The central theme of this handbook points to the need for close collaboration between, and coordination among, national TB control programmes and the departments of health system management or human resources for health of the Ministry of Health and their respective partners. This is necessary to ensure that the health workforce is able to carry out the specific tasks necessary to implement the Stop TB Strategy.

By offering this practical guidance, we hope to fully equip managers of TB control programmes with the tools necessary for effective collaboration. This in turn will foster the development of integrated human resources equipped to deliver services for TB control within the context of primary health care to reach the TB-related Millennium Development Goals. This handbook offers an opportunity to help countries establish a balanced workforce that will respond to the gamut of primary health-care needs while rigorously pursuing the objective to stop TB.



Dr Mario Raviglione
Director
WHO Stop TB
Department



Dr Manuel Dayrit
Director
WHO Department of
Human Resources for Health



Dr Kenneth Castro
Director
CDC Division of
Tuberculosis Elimination



Preparation of this document

This handbook was prepared following a review of the available literature on TB control, human resource development, and health system structures and reforms. Key WHO documents included the 2006 World Health Report (Working Together for Health), the documentation of the HRH Action Framework (available at web site <http://www.who.int/hrh/tools/en/>) and the report of the Joint Learning Initiative (Human Resources for Health: Overcoming the Crisis). Other important literature in these areas was identified through a continuous review of the WHO web site as well as web-based searches of the available literature. Selected managers of national TB control programmes and focal points for human resource development were also consulted.

Valuable experience contributing to the development of this handbook was also gained during a series of regional and national workshops held in 2002–2005 on human resource development for TB control in high-burden countries of Asia and Africa. These workshops were supported by the United States Agency for International Development through the Tuberculosis Coalition for Technical Assistance. Additional experience in the strategic approach advocated in this handbook has been obtained through ongoing technical assistance to high-burden countries, in particular China, India, Indonesia, Myanmar, the Philippines and Thailand.

The handbook was drafted by Palitha Abeykoon, Karin Bergstrom and Wanda Walton. A draft version was presented at a postgraduate course during the World Lung Health Conference in Cape Town, South Africa in 2007 and to the meetings of managers of national TB control programme managers in the WHO African, Eastern Mediterranean, European and South-East Asia regions in 2007–2008. Staff of the WHO departments of Stop TB and Human Resources for Health provided valuable feedback on the draft, which was then circulated to all WHO regional TB advisers and selected country-based staff, to the TBCTA-TBCAP working group on Improved Human and Institutional Capacity, to selected experts on human resources for health, and to other individuals interested in human resource development and disease control. Significant contributions to the completion of the handbook were made by Carmelia Basri, Pierpaolo de Colombani, Norbert Dreesch, Suksont Jittimane, Virendersingh Salhotra, Asik Surya, Mukund Uplekar and Rosalyn Vianzon.

No relevant conflicts of interest were declared by the contributors.

It is intended that this document will be reviewed for possible revision in 2013.

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Introduction

Human resources, the different kinds of clinical and non-clinical staff who make each public health intervention happen, are the most important of the health system's inputs. The performance of health care systems depends ultimately on the knowledge, skills, and motivation of the people responsible for delivering services.

The world health report 2000 – health systems: improving performance.
Geneva, World Health Organization, 2000

Developing capable, motivated, and supported health workers is essential for overcoming bottlenecks to achieve national and global health goals.

The world health report 2006 – working together for health. Geneva, World Health Organization, 2006

People deliver health

Human resources for health: overcoming the crisis. Cambridge, MA, Harvard University Press, 2004

All countries, rich and poor, need health workers who are well trained, motivated, sufficient in numbers, and evenly distributed geographically and by type and level of services in order to ensure that their health-care systems perform well. Few countries, however, can claim to have successfully met that need. Even among rich countries, few, if any, have been able to recruit and train a workforce that adequately meets the needs and expectations of their populations, or have achieved a distribution of health personnel that guarantees equitable access to health services.

The health workforce is one of the key building blocks of health systems. Salaries represent up to two-thirds of recurrent health expenditure. The performance and attitudes of providers of health services shape perceptions about how well the needs for health care of their clients are being met, and influence how well available resources for health are converted into effective health outcomes. In any country, a well-performing workforce is one that is available, competent, responsive, and productive.

Despite the importance of human resources (HR) to the effectiveness of health programmes and of interventions such as tuberculosis (TB) control, scant attention has been paid to adequately developing this area in the past. Traditionally, efforts to develop HR in health have been restricted to training and, to a lesser extent, planning and personnel management. The areas of HR policy development, performance management, health worker motivation and retention, and personnel management have not received due importance, partially as a result of their complexity. This neglect, combined with the effects of a global labour market, has led to what is now described as the global crisis in the health workforce.

There are no shortcuts or straightforward solutions to resolve this crisis. Evidence shows, however, that effective workforce strategies enhance the performance of health systems, even under difficult circumstances. Developing a workforce to meet national health needs will require sustained efforts over time, building coalitions among all stakeholders, including national TB control programmes (NTPs).

Human resource development (HRD) for implementation of the Stop TB Strategy is integral to overall HRD in the health system.

Using this handbook

Why is this handbook needed?

The strengths and sustainability of NTPs depend on timely, adequate, and ongoing hiring, training, deployment, motivation, and management of health workers to ensure that the Stop TB Strategy can be implemented in the context of national guidelines to reach the TB-related Millennium Development Goals (MDGs).

Services for TB control are provided within the framework of national health systems. It is now widely accepted that the dire shortage of health workers in many places is among the most significant constraints to achieving the health-related MDGs: to reduce child mortality, improve maternal health, and combat HIV/AIDS and other diseases such as TB and malaria.

The development of the health workforce is concerned with the different functions involved in planning, managing, and supporting the professional development of the health workforce within the health system. HRD aims to secure the right people, with the right skills and motivation, in the right place, at the right time. Terminology in this area is constantly evolving, with lack of consensus on definitions. In this document, health workforce development, human resources for health (HRH), and human resource development are used interchangeably. HRD in this context refers to the process of planning, managing, and supporting the health workforce for comprehensive TB control within overall health workforce development. Annex 1 provides a glossary of terms used in this handbook.

In an increasingly complex environment, effectively planning and managing the workforce will require innovative approaches and involvement from high-priority programmes (such as HIV/AIDS, TB, and malaria), as well as a commitment to both short-term and long-term solutions. For example, the occurrence of drug resistance, especially for TB (MDR-TB and XDR-TB) can complicate HR management and should therefore also be considered by health programmes (or NTPs) in their analysis of the situation and the development of future strategies. Global health initiatives (GHIs), such as the Stop TB Partnership, are a critical part of a well-balanced approach to health workforce development in the health sector.

Within NTPs, the overall management of the health workforce is often not given its due importance. In the context described above, NTPs need to take a more proactive role, and develop and support strategic approaches to staffing, competence development, and creating an enabling environment for all staff involved in implementation of the Stop TB Strategy, as well as coordinating their efforts with overall health workforce development. There are tools and guidelines related to HRD, of which many are listed in Annex 2 of this document. However, until now, there has been no specific tool available to guide the overall development of a plan for human resource development for comprehensive TB control for implementation of the Stop TB Strategy.

For whom is this handbook intended?

This handbook is intended to give guidance to those responsible for developing country-specific strategic plans and annual implementation plans for HRD for comprehensive TB control within overall HRH development.

It is also intended for use by consultants, donor agencies, and others involved in supporting NTPs to prepare and implement strategic plans for HRD in support of the overall Strategic Plan for TB Control, and to prepare subsequent annual implementation plans to manage HRD activities in the NTP.

What does this handbook contain?

Part I of this handbook provides background information on the current workforce situation in the health sector and summarizes the issues and challenges. The HRH Action Framework and the Stop TB Strategy are introduced. The Framework is then applied to HRD for comprehensive TB control.

Part II describes how to prepare a strategic plan for HRD in support of comprehensive TB control within the NTP.

Part III gives a step-by-step guide on how to develop HRD plans based on the structures and processes described in Parts I and II. It includes a template for developing a strategic plan and an annual implementation plan, with examples of actions that need to be taken to develop each section of the respective plan. This document is not a comprehensive handbook on HRD. Rather, it is intended as a practical guide for those involved in HRD as it relates to control of TB. Annex 2 provides a list of reference material on various aspects of HRD and TB control.

This handbook expands the HRH Action Framework described in Part I, Chapter 3. The definitions of planning terms are described in Part II, Chapter 2.

How is the HRD plan encompassed within the overall NTP strategic plan?

The HRD strategic plan for implementation of the Stop TB Strategy can be either a separate document or a comprehensive plan included in the overall country strategic plan for TB control. Irrespective of its presentation, the strategic plan should be developed by the NTP using the planning process described in this document.

As we focus on delivering, using a single country plan of action, let us remember that it is only a strong and stable health system that can absorb more resources. The backbone of any strong health system is the workforce, and I must say at this point that we are losing too many well-trained young people to partners. It is therefore imperative that we build the capacities of Ministries of Health so that they can deliver their mandate effectively.

Dr Wilfred Machage, Assistant Minister for Health Services, Kenya
Afro Partners Forum, March 2007

Part I: Developing the health workforce: background, issues, challenges and a way forward

Part I provides an overview of human resources in the health sector, and outlines key challenges to the development of the health workforce globally at different levels of the health system. The HRH Action Framework is introduced, and the building blocks of the health system, other than the health workforce, are briefly described to clarify the context. The Stop TB Strategy, which is the basis for the development of the necessary human resources for TB control, is also described. Finally, the roles and functions of HRH departments and NTPs within the context of the HRH Action Framework are described.

Achieving the Millennium Development Goals will depend on finding effective human resource approaches that can be implemented rapidly. But simply training people to deliver disease-approaches should also consider the larger health systems challenges that are related to the pervasive disadvantages associated with low income.

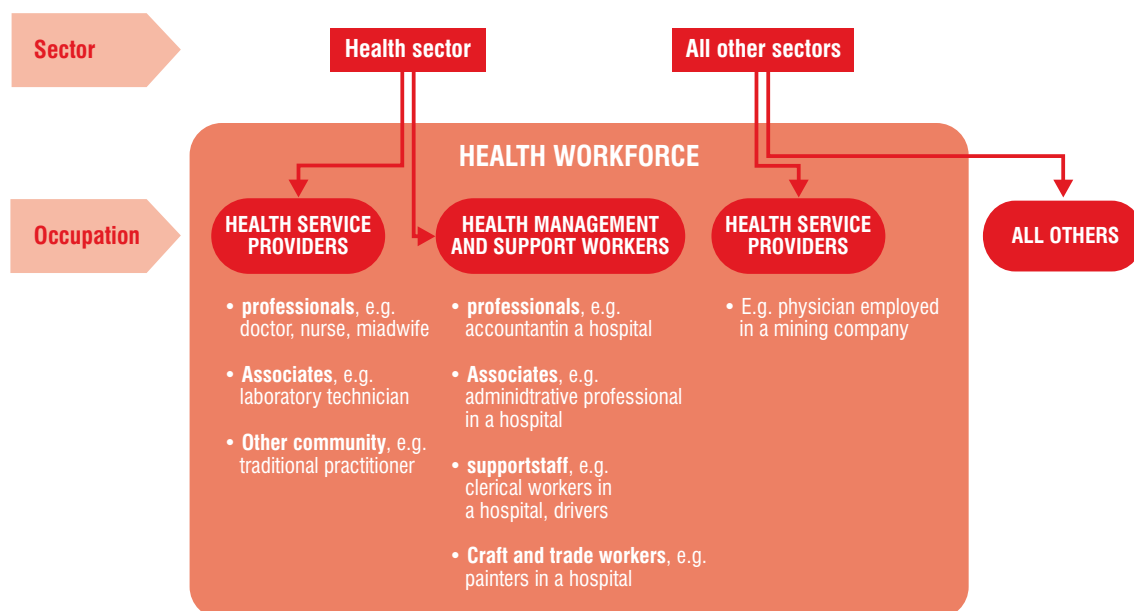
The world health report 2006 – working together for health. Geneva, World Health Organization, 2006

Chapter 1 - Human resources in the health sector: an overview

It is the job of health workers to protect and improve the health of communities. Together, these health workers, in all their diversity, make up the global health workforce. This workforce is at the core of each and every health system and is essential to advancing health. The definition of health workers used in this document is drawn from the system described in the World Health Report 2006¹. This system distinguishes two groups of health workers: those who are directly involved in delivering health-care services (i.e., health service providers such as physicians and nurses), and those who are indirectly involved in providing these services (i.e., health management and support workers such as accountants and administrative officers) (Figure 1).

The World Health Organization (WHO) estimates that there are a total of 59.2 million full-time, paid health workers worldwide¹. Health service providers constitute about two-thirds of the global health workforce, while the remaining third consists of health management and support workers.

Figure 1
Health workers in all sectors^a

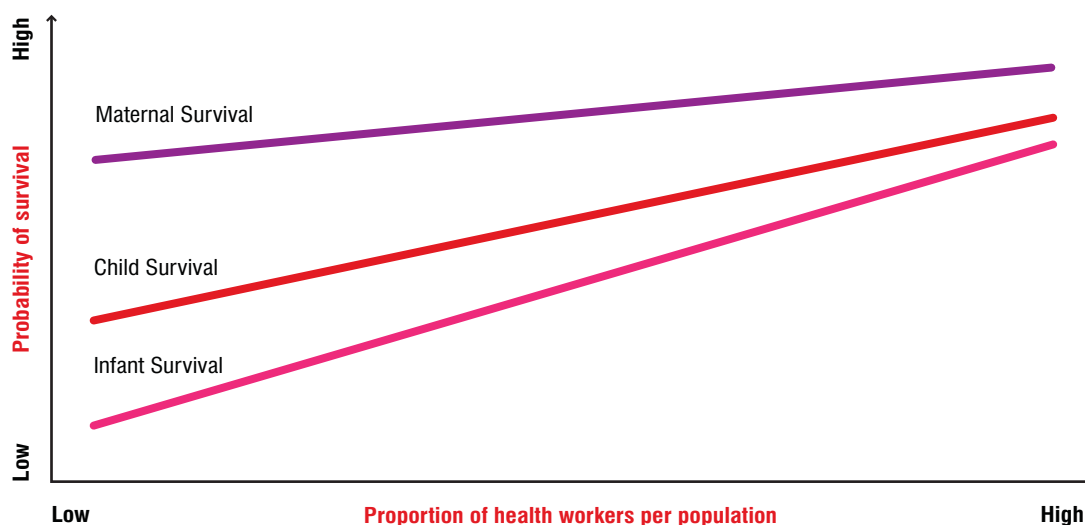


^a Source: *The world health report 2006 – working together for health*. Geneva, World Health Organization, 2006.

¹ *The world health report 2006 – working together for health*. Geneva, World Health Organization, 2006 (available at <http://www.who.int/whr/en/index.html>; accessed April 2008).

Evidence is now available to demonstrate that the number and quality of workers are positively associated with positive outcomes (Figure 2).

Figure 2
Health workers save lives^a



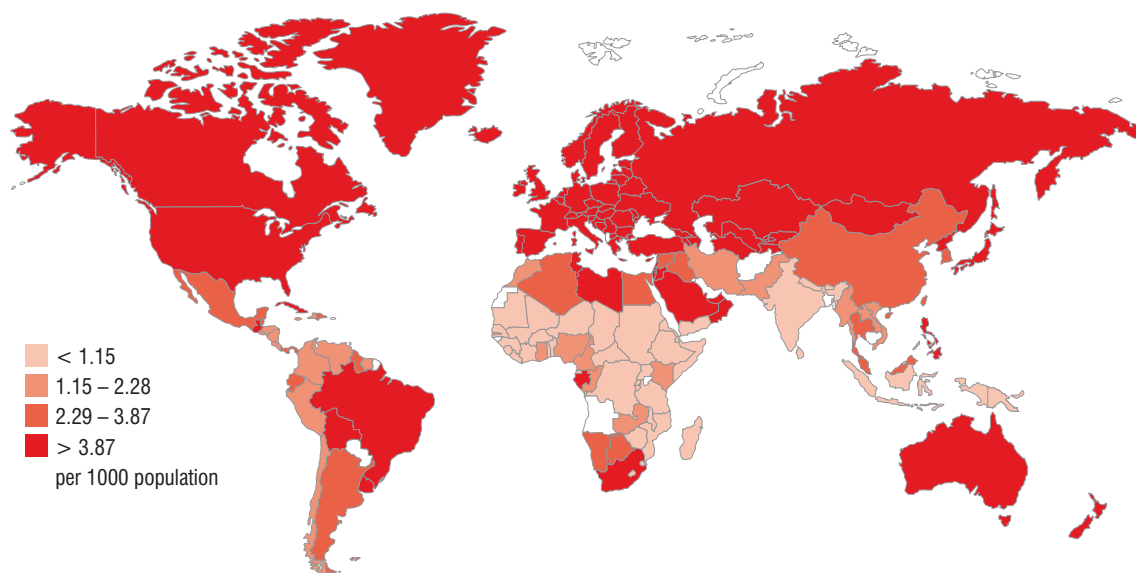
^a Source: *The world health report 2006 – working together for health*. Geneva, World Health Organization, 2006

Health interventions cannot be carried out without health workers. Developing a competent, motivated, and supported health workforce is therefore essential for overcoming obstacles to achieving national and global health goals. Efforts to improve global health face an unprecedented crisis in human resources, generating not only a health crisis, but also developmental, security and moral crises. The causes are not new, but new dimensions have been added, including the TB and HIV/AIDS epidemic, distortions in the global and national health worker markets, and under-investment to support needs. The consequences are complex and interrelated, raising issues of worker shortages and uneven distribution, public sector reform, health sector reform, donor behaviour, and politics and governance.

WHO has defined a threshold in workforce density below which high coverage of essential interventions, including those necessary to meet the health-related MDGs, is very unlikely. This threshold has been estimated at 2.28 health-care professionals (qualified doctors, nurses and midwives) per 1000 population. Based on these estimates, there are currently 57 countries with critical shortages, of which 36 are in sub-Saharan Africa (Figure 3). Out of these 36, there are 7 which are also classified as high TB burden countries (HBCs).

Shortages in the workforce are neither universal nor uniform across low-income countries or even within countries. Inadequate skills mix, distributional imbalances, unfilled vacancies, and poor working conditions compound the problem.

Figure 3
Distribution of the global health workforce^a



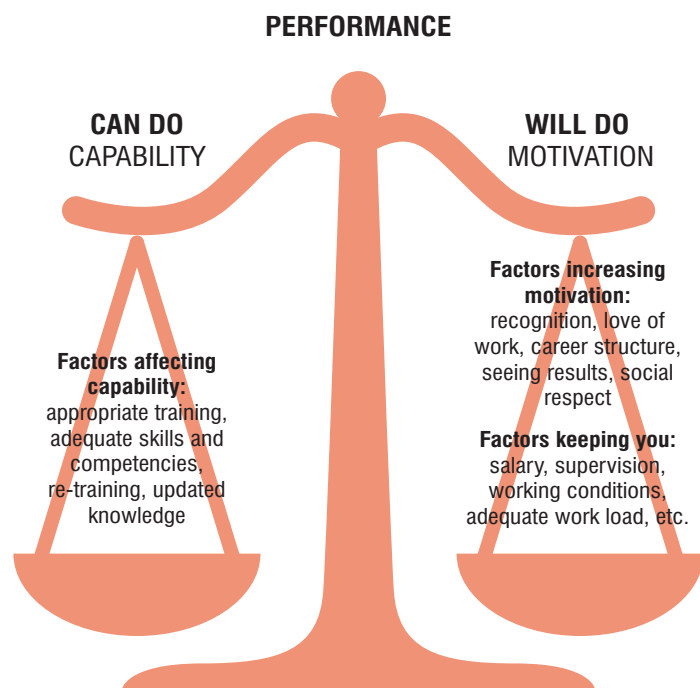
^aSource: The World Health Organization. *Global Atlas of the Health Workforce* (<http://www.who.int/globalatlas/default.asp>, accessed January 2006).

Developing the health workforce is one of the key issues in overall health systems development. The quality of service delivery, including interventions for comprehensive TB control based on the Stop TB Strategy, depends largely on the performance of personnel, enabled by the availability of sufficient facilities, equipment and drugs, and a supportive environment. The performance of personnel depends on various factors, including motivation, training, supervision, salaries, working conditions, and job certainty and stability (reducing planned staff turnover or rotation), all of which require health workforce policies that are carefully formulated and implemented (Figure 4).

The various levels of the health system face different challenges with regards to the health workforce.

- At the **macro level** (national health-care system), the main issues and challenges relate to:
 - the size and composition of the health workforce, i.e. the stock of HRH;
 - distribution of workers among health service delivery levels and across the country;
 - the regulation of education and professional practice for health workers; and
 - the general parameters of working conditions, incentive systems, payment mechanisms and labour relations for health workers.

Figure 4
Factors affecting the performance of the health workforce



- At the **intermediate level** (regional or local health authorities and health organizations), health workforce issues relate to the application of policies and decisions made at a higher level, which are addressed in a more or less autonomous manner, depending on the degree of decision-making and management decentralization. Also important at this level is the capacity to provide and ensure that the peripheral or micro level is appropriately equipped and capacitated to do the job.
- At the **micro level**, health workforce management is less concerned with groups and categories of personnel, as is the case at the other levels, but rather with individuals. Issues are more likely to be performance management, including relevance of acquired skills, supervision, evaluation or conflict resolution.

All three levels perform their duties according to their capabilities. However, each level requires an adequate support system to solve day-to-day problems, as well as providing the support necessary to maintain motivation at an optimal level.

At all levels, health workforce decisions and practices impact the outcomes of the health-care system. For example, failure to train sufficient numbers of one category of providers (such as nurses) reduces accessibility to and efficiency of services. Without incentives to encourage providers to work in remote or poorer regions of a country, workers migrate, with subsequent inequities in access to services. Basic training that is not relevant to the needs of the population results in a health-care system less effective at improving health status. Poor management of personnel and unsatisfactory working conditions, usually associated with a discouraged workforce,

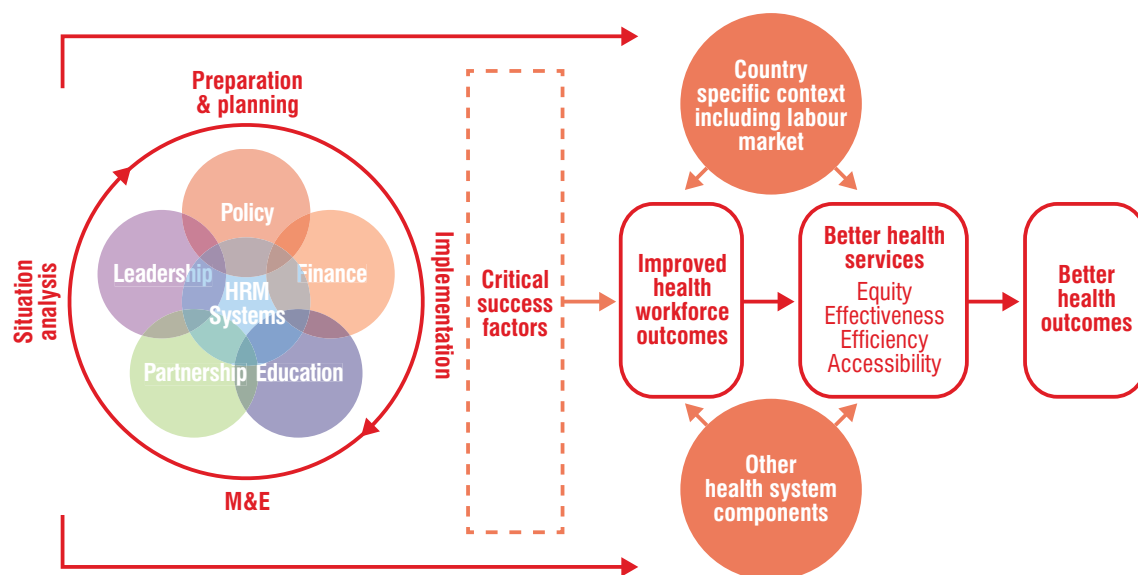
make it difficult for health-care systems to respond to consumers' expectations. In summary, success in reaching the health-related MDGs will depend on adjustments in the number, skills mix, distribution, education and training, management, and working conditions (including incentive systems) of the health workforce.

While the challenges are daunting and will require long-term investments from all stakeholders beyond the health sectors, opportunities also exist. After years of neglect and underinvestment, the central role of the health workforce to the effectiveness of health programmes and health outcomes is finally recognized. Experience from a number of countries has shown that scaling up HRH is possible with determined and sustainable action, and with support from internal and external technical and financial partners.

Chapter 2 - The Human Resources for Health Action Framework

The Human Resources for Health (HRH) Action Framework is designed to assist countries in developing and implementing strategies to achieve an effective and sustainable health workforce². Developed by representatives of partner countries, multilateral and bilateral agencies, donors, nongovernmental organizations (NGOs), and the academic community, the Framework provides a roadmap for developing national HRH plans for addressing the overall health workforce crisis (Figure 5).

Figure 5
The HRH Action Framework^a



^a Source: *The HRH Action Framework* (available at: <http://www.who.int/hrh/tools/en/>; accessed April 2008).

Although the Framework is applicable in all countries, its use will be influenced by the elements specific to the country context (for example, the economy, the political situation), including the labour market (the capacity of the health workforce in general, international labour influences). The outcomes of applying the Framework will also be influenced by the strength of other components in the country's health system (for example, the availability of drugs and equipment, the level of technology available, and the number and condition of health facilities).

The HRH Action Framework contains six action fields (policy, finance, education, partnership, leadership, and HR management systems) and four phases of the action cycle (situational analysis, planning, implementation, and monitoring and evaluation). It provides a simple but comprehensive technical framework to help countries develop a national HRD plan that can be supported by

² The HRH Action Framework is available at www.who.int/hrh/tools/en

donors and implemented systematically. Ensuring a comprehensive approach to an HRH challenge requires that all action fields and phases of the action cycle be eventually addressed. However, the Framework is constructed such that, based on a particular area of interest or programme responsibility, any action field or phase can be selected for in-depth analysis and planning.

These six action fields, when in balance, contribute to a coordinated approach to developing the health workforce. When emphasis is given only to some of the action fields, the outcome will be less than optimal. The Framework should not be seen as a static tool, but rather as a flexible tool for a comprehensive and systematic approach to health workforce development.

Other components of the Framework are not discussed in detail in this handbook. However, some observations related to the other building blocks to health systems and to the country-specific context that are important to consider in the planning process are outlined below.

Human resources for health is not only the most expensive building block of the health system, but also the most important component in delivering better health services. However, the impact of an improved health workforce on services, and thus on health outcomes, may be limited if other components of the health system essential to health worker productivity remain underdeveloped. Therefore, although the focus of this handbook is HRH, the importance of other building blocks that contribute to more equitable, effective, efficient, and accessible health services should be recognized.

A health system consists of all organizations, people, and actions whose primary intent is to promote, restore, or maintain health. This includes efforts to influence determinants of health as well as more direct activities aimed at improving health. A health system is, therefore, more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, a mother caring for a sick child at home, private providers, behavioural change programmes, vector-control campaigns, and health insurance organizations. It includes intersectoral action by health staff, for example, encouraging the ministry of education to promote female education, a well-known determinant of better health.

Table 1 details the six action fields and defines for each field the key areas of intervention.

The outcome or goal of health systems can be defined as improving health and health equity in ways that are responsive, financially fair, and make the best or most efficient use of available resources. There are also important intermediate goals: the route from inputs to health outcomes is through achieving greater access to and coverage with effective health interventions without compromising efforts to ensure the quality and safety of providers.

WHO has defined the critical health system components, or building blocks, needed to improve health outcomes (Table 2).

Table 1
The HRH Action Framework: action field, definition, and areas of intervention^a

Action field	Definition	Areas of intervention
Policy	Legislation, regulation and guidelines for conditions of employment, work standards and development of the health workforce	<ul style="list-style-type: none"> • Professional standards, licensing and accreditation. • Authorized scopes of practice for health cadres. • Political, social and financial decisions and choices that impact HRH. • Employment law and rules for civil service and other employers.
Finance	Obtaining, allocating and distributing adequate funding for human resources	<ul style="list-style-type: none"> • Salaries and allowances. • Budget for HRH. • National health accounts with HRH. • Mobilizing financial resources (e.g., government, Global Fund, PEPFAR, other donors).
Education	Development and maintenance of a skilled workforce	<ul style="list-style-type: none"> • Development and standardization of training material. • Pre-service education tied to health needs. • In-service training including continuing education. • Capacity of training institutions. • Training of community health workers and non-formal care providers.
Partnerships	Formal and informal linkages aligning key stakeholders (e.g., service providers, priority disease control programmes, consumer/patient organizations) to maximize use of human resources for health.	<ul style="list-style-type: none"> • Agreements in place between MOH and other health providers to supplement the delivery of health services. • Mechanisms in place to mobilize community support for health services. • Mechanisms in place for coordination of donors and other stakeholders.
Leadership	Capacity to provide direction, align people, mobilize resources and reach goals	<ul style="list-style-type: none"> • Identification, selection, and support of HRH champions and advocates. • Leadership development for HRH managers at all levels. • Capacity for multi-sector and sector-wide collaboration. • Modernizing and strengthening professional associations.
Human resource management systems	Integrated use of data, policy, and practice to plan for necessary staff, recruit, hire, deploy, develop and support health workers	<ul style="list-style-type: none"> • Personnel systems: workforce planning (including staffing norms), recruitment, hiring, and deployment. • Work environment and conditions: employee relations, workplace safety, job satisfaction, and career development. • HR information system integration of data sources to ensure timely availability of accurate data required for planning, training, appraising, and supporting the workforce. • Performance management: performance appraisal, supervision, and productivity. • Staff retention: financial and non-financial incentives.

^a Source: *The HRH Action Framework* (available at: <http://www.who.int/hrh/tools/en/>; accessed April 2008).

Table 2
Building blocks for improving health outcomes^a

Good **health services** are those that deliver effective, safe, good-quality personal and non-personal health interventions to those who need them, when needed, and with minimum waste of resources.

A well-performing **health workforce** is one which works in ways that are responsive, fair, and efficient to achieve the best health outcomes possible, given the available resources and circumstances (i.e. there are sufficient staff, fairly distributed, who are competent, responsive, and productive).

A well-functioning **health information** system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants; health systems and health status.

A well-functioning health system ensures equitable access to essential **medical products and technologies** of assured quality, safety, efficacy, and cost-effectiveness, and their scientifically sound and cost-effective use.

A good **health financing** system raises adequate funds for health in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.

Leadership and governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system-design, and accountability.

^a Source: *Everybody's business: strengthening health systems to improve health outcomes. WHO's framework for action*. Geneva, World Health Organization, 2007.

Decisions about HR strategies should be viewed in the context of the broader policy environment of the country. Major policies may be concerned with areas such as: the devolution of political power; stabilization or national reconciliation in the aftermath of war or conflict; improving the performance of government through civil service reform; public sector administrative and/or economic reforms; the expansion of the private sector; reducing unemployment; and achieving greater equity in resource distribution. Broader public sector reform may provide an opportunity to address a particular HR problem such as the management of staff performance. On the other hand, the poor economic situation in a country may mean that although salaries are low and it is therefore difficult to attract and retain staff, the ministry of finance is not going to support pay increases. A scan of the policy environment should be undertaken as part of the situation analysis.

The "labour market" refers to the market in which workers compete for jobs, and employers compete for workers. An analysis of the labour market will establish the likely source of health workers and the type, volume, and direction of losses that employers are experiencing. In the health sector, this is a global labour market that results in international migration, as well as internal migration between employers and between different segments of the labour market (public sector, faith-based organization or NGO, private-for-profit). Migration even occurs within a large single organization; for example, employees often try to move from rural to urban postings. Both the internal labour market and the position in the global labour market will differ from country to country. Therefore, an analysis of the labour market should be included in the overall situational analysis.

Chapter 3 - The Stop TB Strategy

Reaching and sustaining the TB-related MDGs requires a comprehensive and sustained response, with complementary measures intended to address the social and environmental factors that increase the risk of developing TB. Poor people bear the greatest burden of morbidity and mortality caused by TB. The Stop TB Strategy was designed as a key component of broader international, national, and local strategies to alleviate poverty (Table 3). The Stop TB Strategy builds on the DOTS strategy, while also broadening its scope to address remaining constraints and modern challenges in TB control. This expanded scope is needed to achieve the MDG and related Stop TB Partnership targets for TB control. Such expansion is deemed necessary to attune TB control efforts in the context of the current global TB scenario.

NTPs and partner agencies and organizations involved in TB control must address a number of challenges to fully implement the Stop TB Strategy. At the heart of these challenges are the following issues related to the health workforce:

- ensuring that existing staff in the health system, (i.e., health service providers and health management and support workers) are competent in relation to their job descriptions to implement the Stop TB Strategy;
- ensuring that the necessary support systems are in place to enable staff to perform their tasks; and
- ensuring that sufficient staff are available.

A strategic HRD plan and an annual HRD implementation plan for comprehensive TB control should support implementation of all components of the Stop TB Strategy. These plans should be based on an analysis of the achievements and constraints in reaching national targets for TB control; and, as outlined in the long-term strategic plans for TB control, to reach the TB-related MDGs.

Table 3
The Stop TB Strategy at a glance^a

VISION	A world free of TB.
GOAL	To dramatically reduce the global burden of TB by 2015 in line with the Millennium Development Goals and the Stop TB Partnership targets.
OBJECTIVES	<ul style="list-style-type: none"> • Achieve universal access to high-quality diagnosis and patient-centered treatment. • Reduce the human suffering and socioeconomic burden associated with TB. • Protect poor and vulnerable populations from TB, TB/HIV, and multidrug-resistant TB. • Support development of new tools and enable their timely and effective use.
TARGETS	<ul style="list-style-type: none"> • MDG 6, Target 8: Halt and begin to reverse the incidence of TB by 2015. • Targets linked to the MDGs and endorsed by the Stop TB Partnership: <ul style="list-style-type: none"> – By 2005: detect at least 70% of new sputum smear-positive TB cases and cure at least 85% of these cases. – By 2015: reduce TB prevalence and death rates by 50% relative to 1990. – By 2050: eliminate TB as a public health problem (<1 case per million population).
COMPONENTS OF THE STRATEGY & IMPLEMENTATION APPROACHES	
<p>1 Pursue high-quality DOTS expansion and enhancement</p> <ul style="list-style-type: none"> a. Political commitment with increased and sustained financing. b. Case detection through quality-assured bacteriology. c. Standardized treatment with supervision and patient support. d. An effective drug supply and management system. e. Monitoring and evaluation system, and impact measurement. <p>2. Address TB/HIV, MDR-TB, and other challenges</p> <ul style="list-style-type: none"> – Implement collaborative TB/HIV activities. – Prevent and control multidrug-resistant TB. – Address prisoners, refugees and other high-risk groups, and special situations. <p>3. Contribute to health system strengthening</p> <ul style="list-style-type: none"> – Actively participate in efforts to improve system-wide policy, human resources, financing, management, service delivery, and information systems. – Share innovations that strengthen systems, including the Practical Approach to Lung Health (PAL). – Adapt innovations from other fields. <p>4. Engage all care providers</p> <ul style="list-style-type: none"> – Public-Public, and Public-Private Mix (PPM) approaches. – Interational Standards for Tuberculosis Care (ISTC). <p>5. Empower people with TB and communities</p> <ul style="list-style-type: none"> – Advocacy, communication, and social mobilization. – Community participation in TB care. – Patients' Charter for Tuberculosis Care. <p>6. Enable and promote research</p> <ul style="list-style-type: none"> – Programme-based operational research. – Research to develop new diagnostics, drugs, and vaccines. 	

^a Source: *The Stop TB Strategy: building on and enhancing DOTS to meet the TB-related Millennium Development Goals*. Geneva, World Health Organization, 2006 (WHO/HTM/TB/2006.368; available at http://whqlibdoc.who.int/hq/2006/WHO_HTM_STB_2006.368_eng.pdf; accessed April 2008).

Chapter 4 - The HRH Action Framework and HRD for implementation of the Stop TB Strategy

Services for TB control are implemented through and by the existing health workforce within the national health system. Establishing and understanding the roles, functions, and responsibilities for development of the health workforce at different levels of the system and among different stakeholders is essential in developing a strategic approach. This will ensure that the NTP is able to foster adequate staffing, development, retention, and performance of the health workforce involved in implementing the Stop TB Strategy. This handbook assumes long-term close collaboration and coordination between the NTP and the health system management/HRH departments of the ministry of health.

Table 4 describes the role and functions for developing different aspects of HRD for comprehensive TB control based on the HRH Action Framework presented in Table 1. To enable implementation of the Stop TB Strategy, NTPs need to establish the organizational structure at the central level of the programme. This includes, but is not limited to:

- assigning a dedicated focal person or point person for HRD in the NTP (in bigger countries this corresponds to a full-time job);
- appointing an HR coordination group with representatives from training institutions, health workers, concerned professional organizations, and other disease control programmes; and
- determining roles and functions for HR management at subnational levels (within the context of NTP).

Although not an exhaustive list, Table 4 provides the guiding principles; the overall structure and situation will vary from country to country. The HRD functions within the NTP should be carried out in close collaboration and coordination with the overall HRH department to ensure optimal efficiency and results.

The template for the strategic plan and the annual implementation plan outlined in Part III of this handbook focuses on the planning and management of HRD for implementation of the Stop TB Strategy based on the role and functions outlined in Table 4.

Table 4
Role and functions for development of human resources for health (HRH):
HRH department/unit and national TB control programme (NTP)

Action fields	Role of Ministry of Health HRH Department (overall HRH)	Role of NTP
Policy	<ul style="list-style-type: none"> • Develops and implements HRH policies related to health service mission and goals (policies related to all components of the HRH framework). 	<ul style="list-style-type: none"> • Assesses needs for HR policy revisions to enable the implementation of the Stop TB strategy (e.g., task shifting; hiring of additional staff above current staffing stands; incentives for disadvantaged geographical placements; HR needs in special situations; needs for and participation in special tasks forces and coordination groups).
Finance	<ul style="list-style-type: none"> • Ensures the personnel budget is in line with the expenditure needed to develop, deploy, and sustain an adequate health workforce (this includes expenses for salaries, allowances and benefits, pre-service and in-service training, staff development, rural posting/difficult area posting packages, and support to basic management functions such as information systems). Budgets should include both recurrent costs such as salaries and incentives, training costs, and general running and administrative costs. • Works with Ministry of Public Service and Ministry of Finance to streamline financial planning and management for HRH. 	<ul style="list-style-type: none"> • Align with and use TB specific funds to support overall health workplace development. • Ensures the allocation of TB specific funds; enables the implementation of the strategic plan for HRD for comprehensive TB control. • Ensures donor coordination for financial support to the implementation of the strategic HRD plan for comprehensive TB control. • Develops mechanisms for contracting for TB services.
Education, including pre-service (basic), postgraduate, in-service and continuing education	<ul style="list-style-type: none"> • Ensures future basic training needs are linked to long term health workforce plans and projections. • Ensures that pre-service (basic) training programmes and courses are up-to-date and prepare health workers for their future roles and functions. • Ensures accreditation and certification for all basic and continuing education. • Ensures specific minimum competences required for each category of health worker as a basis for certification (including minimum standards for training and evaluation). • Ensures that all continuing education is based on health service needs, is competency based, and follows de facto health authority guidelines. • Standardizes continuing education programmes. • Develops and monitors systems for “pass” and “fail” for all training. 	<ul style="list-style-type: none"> • Develops/revise in-service training programmes for different categories of health workers involved in the implementation of the Stop TB strategy according to the functions. • Develop/revise TB training material for the above. • Ensures that all continuing education is based on health service needs for TB control, is competency based, and follows NTP guidelines. • Ensures objective competency based evaluations systems are in place and used for all TB training programmes. • Selects and trains course facilitators for the different TB training programmes (paying particular attention to the technical and educational competencies of the future facilitators, as well as the ability to encourage course participants to develop skills in independent thinking and problem solving).

Action fields	Ministry of Health HRH Department (overall HRH)	NTP
Education, including pre-service (basic), postgraduate, in-service and continuing education	<ul style="list-style-type: none"> Ensures adequate number of institutions to train all required health cadres and that the capacity of those training institutions is maintained and strengthened. 	<ul style="list-style-type: none"> Prepares organization of TB training courses (long term as well as short term) in close collaboration and coordination with other priority health programmes and interventions. Ensures involvement of existing training institutions to strengthen educational quality of training activities. Ensures continuous learning for all health workers involved in the implementation of the Stop TB strategy. Establishes the NTP organizational structure for follow up after training. Trains TB supervisors for follow up of staff training. Ensures pre-service training programmes meet the competency needs for the implementation of the Stop TB Strategy.
Partnerships	<ul style="list-style-type: none"> Collaborates with ministries of finance and education. Ensures effective linkages among public sector, private sector, and community networks. Creates structures to allow community representation in health services. Facilitates joint planning for HRH between local NGOs, community based and religious organizations, and district health offices. 	<ul style="list-style-type: none"> Ensure linkages with other public sector, private sector, and community networks with common linkages to TB; for example, HIV/AIDS national programmes, medical associations, faith-based organizations, bilateral and international organizations.
Leadership	<ul style="list-style-type: none"> Provides committed, visionary leadership - including guidance and support to others to face challenges and make progress in improving health outcomes under complex conditions. Helps partners grow and develop. Advocates for and guides reform of human resource policies. Provides leadership development for managers at all levels. 	<ul style="list-style-type: none"> Provides visionary leadership and advocacy for TB control programme needs. Ensures leadership development for managers at all TB programme levels; empowers managers to solve problems at service delivery level, ensuring needed resources are available. Provides supportive supervision to develop work plans and monitor performance.
Human resource management	Personnel management: <ul style="list-style-type: none"> Provides long term HR planning. Ensures that posts are appropriately classified. Organizes recruitment and selection. Manages issues related to hiring, transfer, promotion. Manages salaries, benefits and allowances, and financial incentives. 	Personnel management: <ul style="list-style-type: none"> Assesses staffing needs at all levels, including the central level, for the implementation of the Stop TB strategy. Contributes financial resources to TB staff retention strategies and incentive packages for rural postings. Determines minimum data requirement for adequate HR management.

Action fields	Ministry of Health HRH Department (overall HRH)	NTP
Human resource management	<ul style="list-style-type: none"> • Administers discipline, grievance procedures, and termination. • Ensures compilation of and updating of employment policy manuals. • Maintains relations with unions and professional associations. • Ensures compliance with labour laws. • Manages HR information system. <p>Performance management:</p> <ul style="list-style-type: none"> • Develops and reviews job descriptions based on national health policies, and plans and ensures health workers are provided with the relevant job descriptions. • Ensures capacity development in supportive supervision in all areas of the health service. • Develops systems over planning and evaluating performance. • Develops and monitors strategies for staff motivation and retention, including career structures for all areas. • Develops systems for regular continuing education for all health workers. 	<ul style="list-style-type: none"> • Ensures all TB HRD activities conform to overall HR management systems and policies currently in place. • Communicates staffing problems (e.g., vacant posts, severely understaffed health centres) identified during supervisor visits. <p>Performance management:</p> <ul style="list-style-type: none"> • As necessary, updates and lists functions and tasks by level and by professional category, covering all components of the Stop TB strategy. • Develops/revises job descriptions for staff involved in TB control to correspond with current policies and recommendations, e.g., the introduction of management of MDR-TB. • Coordinates capacity development (competence and staffing) for supportive supervision - for implementation of the Stop TB Strategy - with other high priority programmes. • Contributes expertise and resources to the development and implementation of strategies for TB staff motivation and retention (not only financial).

Part II: Towards comprehensive TB control: developing HRD plans for implementation of the Stop TB Strategy

Part II describes the planning process required for the preparation of strategic plans for HRD in support of comprehensive TB control within the NTP.

All countries can accelerate health gains by investing in and managing their health workforce more strategically.

Human resources for health: overcoming the crisis. Cambridge, MA, Harvard University Press, 2004

Chapter 5 - The planning process

Planning, whether it is done by the ministry of health, the NTP, or the HRD component of the NTP, consists of similar activities. The complexity of each activity and the time needed to perform it will depend on the goals of the programme and their stage of development, and whether planning is being done for the first time or is already part of routine management activities. This chapter provides an overview of the planning process used in this handbook. Table 5 defines the planning terms used in this handbook.

Overview of the planning process³

Planning facilitates the review of an organization, programme or programme components and its objectives, strategies, and achievements, it systematizes the development or revision of strategies and activities to achieve its goals. Whether planning for a health centre, district, province, or central office, the questions to consider are the same:

1. What are we trying to achieve? What are our visions and goals? (see Table 3 for the vision and goals of the Stop TB Strategy and to Table 6 below for those for HRD for TB control).
2. How will we achieve it? What are the strategies? (see Table 3 and Table 6)
3. What is the current situation, and what are we doing now? What are the obstacles to achieving our goal and, ultimately, our vision?
4. Where do we want to be in the short term and in the medium term?
5. What will we do to implement the strategies, and what are the priorities?
6. How much will it cost and how will it be financed?
7. How will we know whether we are making progress and meeting our objectives?

Planners need to continuously ask themselves these seven questions in order to:

- identify and meet new needs;
- prioritize these needs for better focus;
- correct problems; and
- maintain and increase achievements.

³The planning process used in this document does not include “outputs”. An output is a product of specific activities. Avoid confusing outputs (products) with outcomes (impact/benefit) and objectives (action statements articulating desired results).

Table 5
Definitions of planning terms used in this handbook^a

The terms used to define the responses to the seven questions vary widely. What one person calls a goal, another may call an objective. What one person calls an objective, another might call a strategy. Whatever terms are used in a particular situation, they should be used consistently. In this handbook, planning terms are defined as follows.

What are we trying to achieve?

The **vision** - A **vision statement** is a vivid idealized description of a desired outcome that inspires, energizes and helps create a mental picture of the target. It focuses on tomorrow, and it is timeless. It can envision something even better than what is considered to be the best possible outcome.

The **goal** or goals will generally describe the desired situation that is the aim of the major stakeholders. A goal is a broad statement, but provides a defined target that gives you clarity, direction, motivation, and focus.

How will we achieve it?

A **strategy** is a description of an intervention or set of interventions necessary to achieve the goal.

What are we doing now? What are the obstacles?

A **review of the current situation** is:

- Collection of information on standards, current activities, and needs;
- Analysis of strengths, weaknesses, opportunities and threats; and
- Identification of areas for improvement.

Where do we want to be in the medium term?

Objectives describe expected results in measurable terms (SMART objectives).

What will we do to implement the strategies to achieve the objectives?

Activities is a list of specific tasks that must be implemented 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** describes the resources that are needed to conduct the activities, the estimated cost of those resources, and sources of revenue to pay for them.

How will we know whether we are making progress and achieving our objectives?

Monitoring is the process of regularly checking the implementation of plans.

Evaluation is the process of analyzing data about planning, the process of implementation, and the resulting products for the purpose of improving future planning.

^a Adapted from Wolff JA, Suttentfield L, Binzen SC. The family planning manager's handbook: basic skills and tools for managing family planning programs. Bloomfield, CT, Kumarian Press, 1991.

Chapter 6 - HRD vision and goal, strategies and implementation approaches

The ultimate goal of HRD for comprehensive TB control is to have the right number of people, with the right skills, in the right place, at the right time, who are motivated and supported to provide the right services to the right people. The HRD vision and goal for comprehensive TB control contribute to reaching the vision and the goal for overall TB control as outlined in the Stop TB Strategy. Table 6 summarizes the vision and goal for HRD for implementation of the Stop TB Strategy.

The result of having a sufficient number of staff in all categories who are competent should be responsiveness, productivity, and client satisfaction. Specifically, responsiveness ensures that the patients being served are treated appropriately, regardless of whether or not their health improves or who they are; productivity ensures the maximum effective health services and health outcomes possible; and client satisfaction ensures there is demand for these services.

Effective strategies provide the roadmap for reaching and sustaining the goal for HRD for comprehensive TB control, and enhance the performance of the health system, even under difficult circumstances. Such strategies include, but are not limited to, those contained in Table 6. These strategies, which are derived from the HRH Action Framework and the roles and responsibilities of NTPs outlined in Table 4, apply to all countries. Each strategy will differ according to the specific country context and the planned objectives and activities.

Table 6
Towards comprehensive TB control: HRD vision, goal, key strategies
and implementation approaches

VISION	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.
GOAL	Health workers at different levels of the health system have the skills, knowledge, and attitudes (professional competence) necessary to successfully implement and sustain 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 needed 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.
KEY STRATEGIES AND IMPLEMENTATION APPROACHES FOR REACHING THE HRD GOAL FOR IMPLEMENTATION OF THE STOP TB STRATEGY	
1	Contribute to overall workforce planning and policy development. <ul style="list-style-type: none"> Assess HR needs for the implementation of the Stop TB Strategy. Participate in HR policy revisions to enable the implementation of the Stop TB strategy.
2.	Organize ongoing in-service training (clinical, laboratory and managerial) for all health workers involved in the implementation of the Stop TB Strategy; that is, promote and sustain lifelong learning including: <ul style="list-style-type: none"> Initial training in all aspects of basic DOTS implementation for existing staff and new hires. Initial training on TB-HIV and MDR-TB. Retraining (major performance problems), e.g., a formal training course. On the job training (refresher: small performance problems that can be addressed during a supervisory visit). Continued education (to gain more skills and knowledge). Training/orientation of all public and private providers in TB control. Advanced training on management aspects (e.g., such as health financing, leadership/governance, business planning, organizational development).
3.	Strengthen pre-service training (basic training) for physicians, nurses, laboratory technicians and other health workers involved in the implementation of the Stop TB Strategy.
4.	Engage in strategic partnerships for health workforce development for comprehensive TB control with, for example: <ul style="list-style-type: none"> Training divisions/institutions. Other in-service training programmes, e.g., HIV/AIDS. Ministry of Education and other relevant ministries. Professional associations. Private sector including NGOs. Bilateral and international organizations.
5.	Contribute to integrated personnel management system to foster adequate workforce planning, recruitment, hiring, deployment, and retention.
6.	Monitor and supervise health worker performance to: <ul style="list-style-type: none"> detect performance deficiencies; identify new staff in need of training, and identify additional staff needs for current interventions and for new interventions/strategies.

Chapter 7 - HRD working groups

Coordinated efforts are needed to address HR needs for comprehensive TB control, involving ministries of health, local governments and executives, NTP leadership, representatives of provincial and local staff involved in TB control activities, professional associations, training organizations or institutions, and community-based organizations. An HRD working group should be formed to include those who are knowledgeable about sector-wide HRD. These individuals will need to support strategies and innovations that foster efficiency and effectiveness in institutional and programmatic arrangements. This is needed to ensure streamlined HR actions among stakeholders at all levels of the programme.

The group should be small enough to facilitate consensus-building, allow for rapid decision-making and have authority to pull together a larger group as needed to provide information on specific issues.

Seek team members who:

- represent other priority programmes, partner organizations and key institutions;
- have authority to commit resources (e.g. staff time, facilities, materials) and possess demonstrated leadership skills and experience;
- have a history of successful collaboration;
- are knowledgeable about HRD issues;
- understand the staffing requirements for delivering TB control services or other health services; and
- can think creatively and comprehensively.

Other elements to consider should include:

- **Securing the commitment of leadership.** The leadership of concerned groups and organizations should participate in action planning and facilitate implementation of the recommendations. These leaders need to actively support your activities, especially those that involve difficult decisions regarding the use of human and financial resources.
- **Allowing sufficient time.** Realistic expectations are often the key to success in developing and implementing activities; improvements that are incremental and cumulative build to sustainable change.
- **Managing change.** Change in a programme or organization is often met with resistance. By involving people who will be affected in the planning process, as well as focusing on areas where there is the most agreement, resistance can be reduced.

The NTP should take the lead for the process of establishing the working group and developing the terms of reference.

Chapter 8 - HRD strategic plan and annual implementation plans

Planning for HRD does not differ from planning for the NTP as a whole or for any other component of the programme. Two types of plans are needed: a strategic 5–10-year plan and an annual/biannual implementation plan or an operational plan.

The **strategic plan** focuses on long-term direction and provides overall guidance for implementation and financing to ensure the achievement of the goal of an adequate, competent and performing health workforce for implementation of the Stop TB Strategy. It provides the guidance for the short-term implementation or operational plans. A sound strategic plan should:

- elaborate the vision, goal, and strategic objectives for HRD, specifying what actions or activities are required to reach the goals, including the HRD needs, for implementation of the Stop TB strategy;
- serve as a framework for decisions or for securing support or approval;
- provide a basis for more detailed planning;
- explain the work to others in order to inform, motivate, and involve;
- assist in setting standards and monitoring performance; and
- stimulate change and become a building block for the next plan.

It can also provide the basis for a country or group of countries to seek resources on relevant issues or problems from different partners.

The **annual implementation or operational plan** should be short term, tactical, focussed, feasible, and measurable. It should include short-term objectives and activities needed to progress towards the goal of an adequate and competent workforce. The annual plans are necessary tools as they take into account the country's capacity for implementation. The plan must have the flexibility for adjustments, if necessary, in accordance with the results of monitoring and evaluation during its implementation.

When developing a **strategic plan**, keep the following principles in mind:

- The strategic plan for HRD for comprehensive TB control and implementation of the Stop TB Strategy is developed to support the overall strategic plan for TB control. It is the vision, goals, objectives, and targets that provide the overall framework for the HRD planning.
- Inclusion of stakeholders is key to development of a successful HRD strategic plan and annual implementation plan for HRD.
- Disease control programmes should seek to achieve their priority targets while strengthening, not fragmenting, a sustainable workforce in the overall system.
- Collaborate and coordinate with other specific disease programmes, with other departments and services in the ministry of health, as well as other units and services in the provincial or district health services to ensure synergy and consistency with overall local health-sector plans and capacity-building frameworks.
- Share experiences of how to engage the health workforce outside the public health sector, HRD through public-private mix (PPM) and community involvement in TB control, with other disease programmes and other health-system stakeholders.
- Do not develop programme-specific solutions to speed up implementation of TB interventions without considering implications for other programmes, e.g., intervention-specific incentives, or increasing the number of emergency or longer-term staff.
- Do not develop implementation plans for HRD without being realistic about the time needed and, the opportunity-cost related to time spent on training.

When developing an **annual implementation plan**, keep the following principles in mind:

- Goals and objectives of the annual implementation plan must be linked to the goals and objectives of the strategic plan for HRD for comprehensive TB control.
- Activities should be planned to ensure timely implementation of the Stop TB Strategy, as outlined in the overall strategic plan for TB control, to reach the MDGs.
- Priorities should be specified among the planned activities.
- All activities should include an evaluation component.

The process of developing a plan is as important as the plan itself. All relevant and key stakeholders need to have a sense of ownership and the necessary levels of commitment to the plan. Once the plan has been approved for implementation, all those involved in HRD for TB control will be required to use it as a reference point.

The process outlined below⁴ is by necessity generic and is expected to be adapted to the country-specific situation.

1. Take preparatory steps

The initial internal decisions made at the most senior level of NTP management to commit themselves to the achievement of this task are important. Selecting the working group members and a focal point for the process must be undertaken.

2. Develop terms of reference and prepare relevant documentation

Developing the terms of reference for the working group, which will include representation from outside the NTP, and sending out letters of invitation endorsed by the most senior member of NTP should be done well ahead of time. This will allow for proper representation by relevant stakeholders.

All relevant documents related to implementation of the Stop TB Strategy, as well as the HRD situation (HR policy, poverty reduction strategy papers, national health plans, medium-term expenditure framework, expired HR plans, etc.), should be collected and provided to the working group to ensure good use of time.

3. Draft the plan

The first session of the working group should be dedicated to adopting the terms of reference and workplan before starting the drafting process. Its work should include an analysis and compilation of the information obtained from the documents and follow up with key informant interviews and focus group discussions with key stakeholders before developing the HRD plan. The first draft of the plan should be submitted to the pre-agreed authority in the health ministry and/or other sector representatives before holding broader consultations with stakeholders and partners. Revisions in the draft to incorporate comments or suggestions from different agencies should be made at this stage.

4. Consult with stakeholders

Preparations for consultation with stakeholders and their selection should be done carefully and broadly to allow for wider ownership. The stakeholders can include national-level directors of various governmental departments or programmes, regional TB management teams, district TB coordinators, TB-related NGOs, education and training institutions, the private sector involved in TB control and other partners interested in HRD development for TB control. Copies of relevant documents should be circulated in advance, with extra copies made available at the consultation. The consultation should be held for one or two days, depending on the size of the plan.

⁴Nyoni J et al. *Policies and plans for human resources for health: guidelines for countries in the WHO African Region*. Brazzaville, WHO Regional Office for Africa, 2006 (available at http://www.afro.who.int/hrh-observatory/documentcentre/policies_plans_guidelines.pdf).

5. Cost the final draft strategic plan

The working group should incorporate any comments or suggestions and submit the final draft to the supervising authority in the health ministry for review. Costing of the plan by a health economist and/or a financial expert should be done at this stage. Doing it earlier than this may mean duplication of effort.

6. Publish and disseminate the plan

The final plan should be published and disseminated. An official launch should be organized, and the plan should be disseminated to all relevant stakeholders for effective implementation and used as a reference document in the preparation of operational plans at facility, institutional, and agency levels. Every opportunity should be taken to raise funds by preparing an implementation framework for the plan.

7. Develop an annual implementation plan

An HRD strategic plan for implementation of the Stop TB Strategy should cover at least a five-year period. Annual implementation plans should be developed for feasibility and to address resource implications.

8. Monitor and evaluate the plan

A multidisciplinary coordination committee should be established to monitor implementation of the plan. The terms of reference of the committee and the frequency of its sessions should also be decided. This process should include extracting the monitoring and evaluation indicators that are part of the plan.

Part III: Preparing HRD plans for implementation of the Stop TB Strategy: a step-by-step guide

Part III offers a step-by-step guide to preparing HRD plans for comprehensive TB control.

**“It’s not the plan that is important,
it’s the planning.”**

Dr Graeme Edwards

Chapter 9 - Developing plans using the framework for strategic HRD plans

The key components of the HRD strategic plan for implementation of the Stop TB Strategy are outlined below (see also Table 4).

- I. Title
- II. Table of contents
- III. Foreword (to be signed by the highest possible relevant authority in the country)
- IV. Acknowledgements of contributors
- V. Executive summary highlighting the key elements for an overview of the plan
- VI. Abbreviations
 1. Introduction
 - a. Rationale of the plan
 - b. TB control in my country
 - c. HRD in the NTP
 2. Vision and goal for HRD for implementation of the Stop TB Strategy
 3. Key strategies and approaches
 4. Country situation analysis
 - a. Overall health system structure
 - b. Organization, role and function of health system staff involved in TB control
 - c. Framework of HRD management within the NTP
 - d. Strengths and weaknesses in HRD for implementation of the Stop TB Strategy (for each of the action fields of the HRH Action Framework)
 5. Objectives
 6. Major activities under each strategy to reach the goal for HRD for implementation of the Stop TB Strategy.
 7. Budget
 8. Monitoring and evaluation
 9. Conclusion
 10. References
 11. Annexes

Title

Mycountry Strategic Plan for Human Resource Development for implementation of the Stop TB Strategy: [insert year]

This should cover the same period as the NTP overall strategic plan – usually at least a 5-year period, but not more than 10 years.

Table of contents

Listing of sections and subheadings to aid in quick reference.

Forward

Brief description of why document was developed. Should also include signatures of the highest possible relevant authorities in the country in support.

Acknowledgements

Acknowledge all contributors to development of document and to the planning process.

Executive summary

An executive summary, which should be written after the plan has been fully developed, provides a short description of the overall plan and outlines the major areas. Its purpose is to summarize the plan and allow a quick understanding without all the details included. It should be no longer than one page.

1. Introduction

The introduction includes the rationale behind the plan, an overall description of the TB situation and the NTP in Mycountry, followed by an overview of the strategic issues for HRD in Mycountry's NTP.

a. Rationale of the plan

ACTION

Provide the rationale behind the plan, i.e., its aim and objectives. Give a reference to the TB control targets and explain how developing and implementing the plan will contribute to reaching those targets. Describe the socioeconomic, demographic, and epidemiological profiles in Mycountry and provide the health system context of the plan.

b. TB control in Mycountry

ACTION

Relate TB control in Mycountry to the Global Plan to Stop TB.

For example:

Commitment to the MDGs related to TB (Goal 6, Target 8) “to have halted and begun to reverse the incidence [of TB] by 2015; the Stop TB Partnership’s vision, mission, targets, and objectives; and the 6 elements of the Stop TB Strategy. (See Annex 1 for the link to the Global Plan to Stop TB.)

Describe briefly the current TB situation in country, achievements and constraints.

For example:

Mycountry has the highest burden of TB in the xx region with a total of xx# of TB cases/100 000 population reported in 2005. Other data include;

Incidence (all cases/100,000 pop/year) XX

Incidence (new SS+/100,000 pop/year) XX

Prevalence (all cases/100,000 pop/year) XX

TB mortality (all cases/100,000 pop/year) XX

TB cases HIV + (adults aged 15–49, %) X.X

New cases multidrug resistant (%) X.X

Treatment outcome data by

The vision for TB control is to eliminate TB as a public health problem and thereby, enable future generations to live in a TB free country.

The mission for TB control is to:

- ensure that every TB patient has access to high quality diagnosis, treatment and cure in order to reduce TB morbidity and mortality;
- reduce TB transmission; and
- reduce the inequitable social and economic tolls of TB.

The targets at the regional level are to reach and thereafter sustain the 2005 targets: achieving 70% case detection and 85% treatment success of TB cases under DOTS (Indicator 23), in order to then, reach the interim targets of halving TB deaths and prevalence by 2010 (Indicator 24) towards achieving the MDG s set for 2015. For Mycountry, the targets are to achieve 90% case detection and 88% treatment success rate.

The progress in Mycountry is also compelling. Case detection increased from 18% in 2003 to 45% in 2005 and is expected to reach 70% at the end of 2007; while the treatment success rate has also already reached beyond the target of 85% (i.e. 85.3%). However, some challenges remain, such as a diversified health care system unlinked to DOTS program, HIV -epidemic, and low coverage of drug resistance surveillance. Sustainability remains the biggest challenge.

Briefly describe the National Strategic Plan to control TB and reach the MDGs by 2015.

For example:

Mycountry's strategic plan for TB Control 2006–2010 is consistent with the global targets, however it provides priorities most relevant to Mycountry based on achievements and future challenges. Mycountry focuses on the following strategic approaches:

- sustaining and enhancing the DOTS to reach all TB patients, improve case detection and treatment success;
- establishing interventions to address TB/HIV and MDR-TB;
- forging partnerships to ensure equitable access to an essential standard of care to all TB patients;
- contributing to health systems strengthening.

Within each strategic approach, key expected result, broad activities, and key interventions are outlined.

c. HRD in NTP

ACTION

Briefly outline the strategic issues related to HRD in the NTP

For example:

Pursuing high-quality service delivery, including intervention for comprehensive TB control, depends on the availability of competent staff, sufficient working equipment, and facilities including working environment. An adequate number of competent staff / personnel at the right time and in the right place is a prerequisite for quality services. The performance of the program in delivering services and the planned activities depends on and is influenced by many factors, such as competence, motivation, working condition, policies, etc. All the factors should be taken into account when the TB program formulates, plans, implements, and evaluates HRD issues.

HRD for comprehensive TB control is one of the key issues in the overall health system. It sets a broader agenda including not only the organization of specific training courses, but also the overall management of training and other HRD activities. This includes the availability of enough staff of the categories of health workers involved in services at all levels – clinical and managerial – necessary to reach a specific long-term goal for professional competence. Hence, HRD for comprehensive TB control should be seen within the context of overall HRH development.

Describe how NTPs work on HRD is coordinated with and related to overall health workforce planning and management.

For example:

Until recently, the HRD activities of the NTP were not well coordinated with the HRH department. NTP activities were limited to initial training of staff for TB control. However, a paradigm shift has taken place and close collaboration has been initiated. The NTP is now represented on key task forces and working groups of the HRH department to ensure that the needs of the programme are taken into consideration in overall HRH strategic planning. The HRH department is represented on the NTP work group for HRD.

2. Vision and goal for HRD for implementation of the Stop TB Strategy

ACTION

State the vision and overall goal for HRD for implementation of the Stop TB Strategy. The vision should be a vivid idealized description of a desired outcome that inspires, energizes and helps create a mental picture of the target. It focuses on tomorrow and it is timeless. The goal should be a broad, guiding statement regarding purpose of HRD for comprehensive TB control in the NTP.

For example:

The vision for HRD for implementation of the Stop TB Strategy

Every person everywhere in Mycountry has access to a motivated and supported health worker who is skilled in TB control based on the Stop TB Strategy.

The goal for HRD for implementation of the Stop TB Strategy

- Health workers at different levels of the health system have the skills, knowledge, and attitudes (professional competence) necessary to successfully implement and sustain comprehensive TB control services based on the Stop TB Strategy.
- A sufficient number of health workers of all categories involved in comprehensive TB control are available at all levels of the health system with the support systems necessary to motivate staff to use their competencies to provide high-quality preventive and curative TB control services for the entire population according to their needs.

3. Key strategies and approaches

ACTION

Describe the strategies of the NTP to reach the goals for HRD for implementation of the Stop TB Strategy. The strategies should describe how the goal will be reached.

For example:

Mycounty's strategies to reach the goal for HRD for implementation of the Stop TB Strategy

1. Contribute to overall workforce planning and policy development.
 - Assess HR needs for implementation of the Stop TB Strategy.
 - Participate in HR policy revisions to enable implementation of the Stop TB Strategy.
2. Organize on-going in-service training (clinical, laboratory and managerial) for all health workers involved in implementation of the Stop TB Strategy; that is, promote and sustain lifelong learning including:
 - Initial training in all aspects of basic DOTS implementation for existing staff and new hires.
 - Initial training on TB-HIV and MDR-TB.
 - Retraining (for major performance problems), e.g., a formal training course.
 - On the job training (refresher: small performance problems that can be addressed during a supervisory visit).
 - Continued education (to gain more skills and knowledge).
 - Training/orientation of all public and private providers in TB control.
 - Advanced training on management aspects (e.g., such as health financing, leadership/governance, business planning, organizational development).
3. Strengthen pre-service training (basic training) for physicians, nurses, laboratory technicians and other health workers involved in implementation of the Stop TB Strategy.
4. Engage in strategic partnerships for health workforce development for comprehensive TB control with, for example:
 - Training divisions/institutions.
 - Other in-service training programmes, e.g., HIV/AIDS.
 - Ministry of Education and other relevant ministries.
 - Professional associations.
 - Private sector including NGOs.
 - Bilateral and international organizations.
5. Contribute to integrated personnel management system to foster adequate workforce planning, recruitment, hiring, deployment, and retention.
6. Monitor and supervise health worker performance:
 - to detect performance deficiencies;
 - to identify new staff in need of training, and
 - to identify additional staff needs for current interventions and for new interventions/strategies.

4. Country situational analysis

a. Overall health system structure

ACTION

Describe briefly the **overall health system structure** and the organization of health service delivery. Also describe the policy environment, financing, partnerships and leadership.

For example:

Health services in Mycountry are organized at five levels: central, provincial, district, sub-district and village. Various facilities are used in each level and the primary health-care concept is applied with the health centre as the main operational unit. The system is supported by a referral system consisting of district, provincial, and central hospitals that provide secondary and tertiary care.

General health service structure

Administrative level	Health service
Village	Sub-health centre; health post; and other community health activities
Sub-district	Health centres
District	District hospital, district health authority
Province	Referral hospital, provincial health authority
Central	Ministry of Health, national programme offices, Top referral hospital

In addition to legal aspects affecting the financing of the TB control programme, there are two important laws relevant for TB control, i.e., the law on medical practice and the law on disease outbreak management. The medical practice law specifically states the mandatory requirements of all medical practitioners to provide care according to service standards. The law on disease outbreak management requires all public and private health care facilities to notify priority communicable diseases to the respective authority.

The district level of health services can be regarded as the basic unit for TB control in Mycountry. District populations range from under 10,000 to over 2 million, with an average of between 50,000 to 150,000. Microscopy facilities for TB control are available at the district hospital, microscopy health centres, and independent health centres. Patients can present to any of these health facilities for diagnosis. Health centres have been categorized into three categories performing different tasks in the NTP structure:

- Microscopy health centres** have trained laboratory staff and perform smear diagnostics for a group of satellite health centres.
- Satellite health centres** do not have microscopy laboratory facilities. Sputum samples are collected from suspects and smears transported to microscopy centres for diagnosis. After a diagnosis is received from the microscopy centre, treatment is provided at the satellite health centre.
- Independent health centres** provide diagnostic and treatment services, for their own catchment area but do not collaborate with any satellite health centres.

Health expenditures comprised 3% of total government expenditures in 2006. Health care is mostly financed privately (63.4%), and only 15.2% of the population is covered by any form of insurance. The performance of the health system is measured by DALY, and the overall performances of the health-care system were ranked 90th out of 191 WHO Member States. Attempts to decentralize the healthcare system have been ongoing for the past 30 years. The current policy on decentralization of various authorities from central to provincial and district governments has had a direct impact on the health system through various levels.

- First is the impact of new financial responsibilities transferred from central to provincial and district governments directly. The new financial mechanism through a block grant system yields the authority for provincial and district governments to plan and manage most health care programs.
- Second, the emergence of wealthy and less wealthy provinces will affect the national health system. It is projected that there will be various local or regional health systems. The market-based health care system will have roles in the strong economy provinces.
- Third, the increased power of provincial and district parliaments for allocating resources for health may result in different ways of provincial and district government in regulating, financing, and delivering health service.

Various political views will influence local government. NTP has secured a sufficient budget from different sources. Although government contribution to TB is projected to be increasing in the future, much of the financial needs are currently being met through external sources.

The Stop TB Partnership is a cross-sector movement formed in 1999 to promote the acceleration of TB control measures through an integrated approach, involving hospitals, the private sector, academia, NGOs, funding agencies and other stakeholders.

Health facilities related to TB control		
Admin. level	Unit	Number
Central	Ministry of Health	
	Disease Control Directorate	
	Direct Transmitted Diseases Control Directorate	
	Central Unit of the TB Sub Directorate (NTP)	
Province	Provincial Health Service	30
	Provincial Health Laboratory	27
District	District/Municipal Health Authority	410
Sub-district	Health Centres	7312
	Microscopy Health Centres (PPM and PRM*)	2612
	Satellite Health Centres	4700
Village	Sub-health centres, health posts	
	Community health efforts	
Hospitals and clinics		
Central	Lung Hospitals	7
Province	Lung Clinics	34
	Provincial General Hospital	30
District	District General Hospital	340
Different levels	Private General Hospitals	600

b. Organization, role and function of health system staff involved in providing TB control

1. Programme structure: description of the basic organization of the NTP.
2. NTP staff, type, and role, including:

Facility type (e.g., district hospital health centre or district health office), staff type (e.g., doctor, laboratory technician, nurse), and the job descriptions (include in an annex) of the staff involved in delivery of TB control services. If applicable, specify staff working full time on TB control.

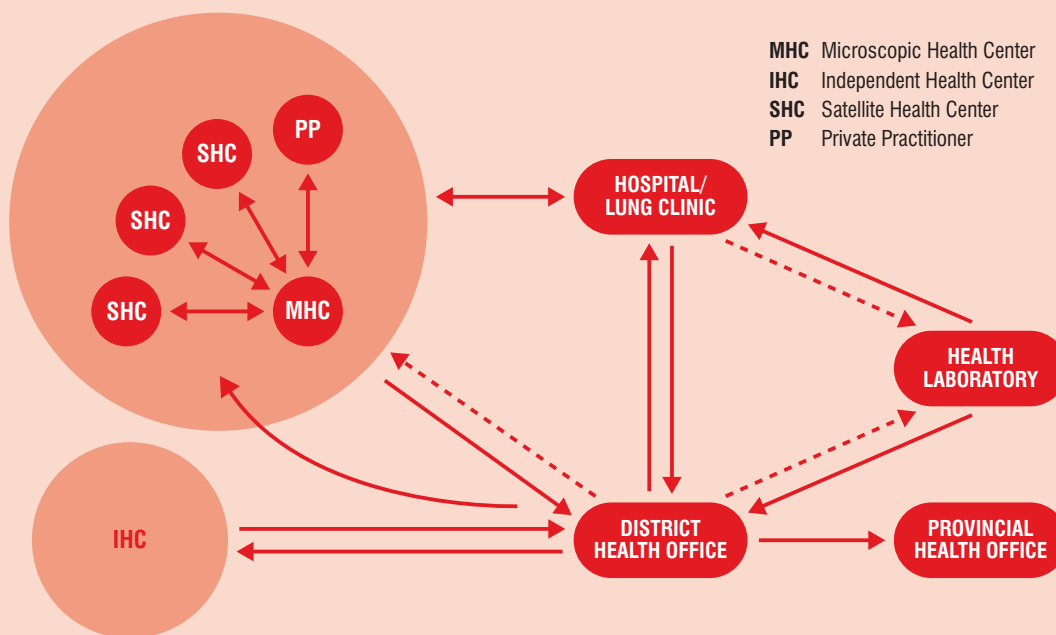
District, provincial, regional staff – include categories and their job descriptions.

Central level – include numbers, categories of staff and their job descriptions.

3. **Private providers, NGOs, community volunteers, etc.** – provide information on categories, tasks performed.
4. Include relevant health management and support workers in addition to the health service providers.

For example:

Organization and networking of TB services at the district level



For example:**Roles and responsibilities at various levels**

Facility/level	Staff	Main role/task
Provincial Health Office	District TB Supervisor and TB team	Supervise Health Service Unit Surveillance (Monitoring and Evaluation) Planning and Implementing the program
	Provincial HRD-TB Coordinator and training team	Planning and Implementing training (pre and in service) Supervision and Evaluation
	Technical Officer	Support the task/role of Supervisor and HRD coordinator
District Health Office	District TB Supervisor and TB team	Supervise HSU Surveillance (Monitoring and Evaluation) Planning and Implementing the program
District hospital and Health Centre (Microscopic Centre)	Doctor	Make diagnosis, prescribe treatment
	Clinic staff	Keep suspect register, fill out patient treatment card,
	Laboratory technician	Perform sputum smear exam
Satellite Health centre, Private Practitioner, Clinic	Doctor	Make diagnosis, prescribe treatment
	Clinic staff	Keep suspect register, fill out patient treatment card
	Laboratory technician	Send sputum smear to Microscopic centre
Community	Family members Volunteer, Health Worker	Drug administration under supervision, record keeping

There is no data available on health management and support workers involved in TB control.

The district level is responsible for the treatment register, TB networking, sufficient drug supply, laboratory quality assurance, and defaulter tracing. Directly observed therapy (DOT) is generally carried out by health volunteers or other community members supervised by health centre staff (weekly DOT). At the provincial level, a core DOTS team is established, consisting of a Provincial Project Officer (PPO), a Provincial Training Coordinator (PTC), and a Provincial Technical Officer (PTO).

c. Framework of HRD management within the NTP

ACTION

Describe how the HRD is structured within the NTP.

Please see Annex 3 for an example.

d. Strengths and weaknesses in HRD for implementation of the Stop TB Strategy (based on the action fields of the HRH Action Framework)

ACTION

Based on the **current goal, achievements and challenges** for HRD for implementation of the Stop TB Strategy, assess **each action field** of the HRH Action Framework. Within each action field, aim at separating issues that are under the direct responsibility of the NTP and issues where other departments/units have the overall responsibility (see Table 4). For each action field do a strengths, weaknesses, opportunities and threats (SWOT) analysis.

Strengths

For example:

1. Working Group for TB-HRD for coordination and collaboration has been established at central level.
2. Commitment from central level (NTP and HRH department), as well as funding to support some activities.
3. Adequate number of facilitator at national level, as well as in most provinces.
4. The Strategic plan and 5 years plan for HRD-TB 2002–2006 has been implemented.
5. Standardized training material with national training guideline, modules, and facilitator guide available for basic DOTS implementation.
6. Human resources (staff) having responsibilities in TB are mostly available at every level of service (health centre, hospital, district health office, provincial health office, central) - low level of vacancies.
7. HRD covering staffing, training and supervision is an integrated chapter (one chapter) in NTP Guideline.
8. Focal points (coordinators) have been appointed at national level and in most provinces.
9. Work on strengthening the teaching of TB control in basic training institutions has started (medical and nursing).
10. The NTP routine reporting system has been revised to include a simplified data collecting form for HRD activities.

Weaknesses

For example:

1. No information for TB HRD available.
2. No workload assessment for management of MDR-TB.
3. Objective training evaluation based on specific learning objectives not routinely conducted.
4. High turnover of trained staff, in particular in remote areas.
5. No designated HRD focal point.
6. No standardized training programme for TB-HIV collaborative activities.
7. Recruitment process slow and not responsive to priority needs.
8. Limited organizational structure and intensive training for DOTS expansion.
9. Workload due to expansion in the TB control program increases complexity of the problem further; training programs on TB case management have largely been focused on health centres and public hospitals, and are still limited for private health sectors.
10. Limited human resources availability coupled with increasing workload as a consequence of the expansion strategy remains an issue for all health programs, including TB.
11. Very limited training of hospital and private practitioners. (The number in need of training at hospitals is considerably higher than the available training resources available for this audience).
12. Very limited capacity for implementation of TB-HIV and MDR-TB interventions.

Opportunities

For example:

1. Potential increase in funds from partners.
2. Possible combining efforts with other programmes within the ministry of health.
3. Technical assistance from external consultant.
4. Additional workforce through collaboration with local NGOs and community based groups is an untapped resource in many areas.
5. Efforts to improve efficiency in resource utilization can be further optimized, such as through collaboration with other health programs and community members (horizontal collaboration), partnership with educational institutions (vertical collaboration), contracting-out mechanisms either for provision of services (case management) or part of control programs (e.g., advocacy to patient-community, training for private practitioners), and development of performance-based incentives.
6. Awareness of the fact that broader HRD issues have been neglected for many years is increasing.
7. Potential for additional funds from local governments.

Threats

For example:

1. Inability to sustain funding or partnerships.
2. Difference in priority between national and local programme (decentralization, health sector reform).
3. Weak implementation of regulations affecting the TB control program (such as regulations concerning disease outbreak and notification, essential drugs and pharmaceuticals, minimum service standards, insurance schemes, local government functions and financing, and medical practice), which create an unfavorable environment for TB control program management (such as in surveillance), case management, and DOTS expansion in general.
4. Quality and integration of information from different sources (such as health centres, hospitals, lung clinics, etc.) remains a challenge.
5. The HIV epidemic is a continuous threat to TB control in Mycountry.
6. Full implementation of the DOTS strategy alone is unlikely to be sufficient to control the looming TB-HIV epidemic.
7. Weak alliances and partnerships will not be sufficient to sustain funding and continuation of the program.
8. Difference view of the prioritization of the TB program at local level.
9. Inadequate numbers (shortage, imbalance) of TB staff at all levels.
10. Zero growth policy of civil servant recruitment.
11. Lack of incentives for health workers in geographically difficult placements.

5. Objectives

ACTION

Based on the goals, strategies, and situation analysis, develop specific, measurable, achievable, realistic, time-bound (SMART) objectives to be achieved in HRD for implementation of the Stop TB Strategy TB control. The objectives – and later on, the major activities – should demonstrate that once implemented, they would address issues raised in the situation analysis, as well as making progress towards goal. In addition, specific standards can be set with regard to the availability of competent staff.

For example:

Strategic objectives for 20xx:

- By the end of 20xx, at least 80% of health workers (medical doctors, nurses, and laboratory technicians) at health centre level are competent to perform assigned tasks for the implementation of the Stop TB Strategy; By the end of 20xx, all (100%) health workers (medical doctors, nurses, and laboratory technicians) at health centre level are competent to perform assigned tasks for implementation of the Stop TB Strategy; From 20xx and onwards: maintain the target for 20xx.
- By the end of 20xx, all (100%) district and provincial supervisors involved in TB control are competent to perform assigned tasks for implementation of the Stop TB Strategy; From 2008 and onwards: maintain the target for 2007.
- By the end of 20xx, medical schools, nursing schools, schools for the training of laboratory technicians, and other relevant schools have formally revised their curricula to reflect the Stop TB Strategy and prepared plans for faculty training, and update of training, reference material, and assessment procedures.
- By the end of 20xx, the annual staff turnover at the health facility level has been reduced from 30% (2007) to 10%.
- By the end of 20xx, vacancies among district and provincial TB coordinators have been reduced from 40% (2007) to 10%.
- By the end of 20xx, vacancies among health facility staff have been reduced from 40% (2007) to 10%.

For example:

To measure the success of the targets, the following are minimum standards for TB staffing for each facility:

- Standard for microscopic health centre: at least 1 medical doctor, 1 nurse, and 1 laboratory technician who are trained and competent in performing tasks for comprehensive TB control based on their job descriptions.
- Standard for satellite health centre: at least 1 medical doctor and 1 nurse who are trained and competent in performing tasks for comprehensive TB control based on their job descriptions.
- Standard for sub health centre: at least 1 nurse who is trained and competent in performing tasks for comprehensive TB control based on job description.
- Standard for district TB supervisor/coordinators who are trained and competent in performing tasks for comprehensive TB control: 1 TB supervisor / coordinator (full time equivalent) for about 20 health facilities in accessible areas and cities (municipalities) and about 10 health facilities for others areas. Health facilities included health centre and hospital.
- Standard for provincial TB supervisor/coordinators who are trained and competent in performing tasks for comprehensive TB control: 1 TB supervisor / coordinator (full time equivalent) for about 20 districts/municipalities for accessible areas and about 10 districts/municipalities for others areas.
- Training team at province: 1 HRD-TB coordinator and 5 training facilitators.

6. Major activities under each strategy to reach the goal for HRD for implementation of the Stop TB Strategy

ACTION

Based on the goals, strategies, situation analysis, and objectives, outline major activities under each of the key strategies for HRD for implementation of the Stop TB Strategy for the next five years. Maintaining and scaling up already ongoing positive activities needs to be included, as well.

For example:

STRATEGY 1: Contribute to overall workforce planning and policy development.

Major activities

An assessment of long term staffing needs for the implementation of the Stop TB Strategy will be conducted, including a review of how current personnel policies contribute to the shortage of staff. Staffing levels, and category of health workers currently involved in the implementation of the Stop TB strategy at each level, will be reviewed. Support will be given to the long term strengthening of the HRH division of the MOH to improve overall workforce policy development including setting up of a work group for regular review of needs for personnel policy updates.

The NTP will actively contribute to the debate on the financial reward (baseline and performance linked) of health workers, and application of a fair level of wages to the staff involved in TB control service delivery.

STRATEGY 2: Organize on-going in-service training (clinical and managerial) for all health workers involved in the implementation of the Stop TB Strategy, i.e., promote and sustain lifelong learning (linked to performance management in Strategy 5, HRM).

Major activities

In-service training programmes for different categories of health workers involved in the implementation of the Stop TB strategy will be revised and updated according to the respective functions. New training materials will be developed as needed based on needs assessments. Continuing education programmes, based on health service needs for TB control, will be competency based and follow NTP guidelines and International Standards of TB Care. Competency based evaluation systems will be developed and used for all training programmes.

Course facilitators for the different training programmes will be trained with particular attention to the technical and educational competencies of the future facilitators, as well as the ability to encourage course participants to develop skills in independent thinking and problem solving. Training courses will be prepared in close collaboration and coordination with other priority health programmes and interventions.

Existing training institutions will be involved in training activities organized by the NTP to strengthen educational quality. Continuous learning for all health workers involved in the implementation of the Stop TB strategy will be ensured. Supervisors will be trained to ensure better follow up after training.

Training needs assessment will be conducted using set standards for job performance and job descriptions (staff currently working), with results incorporated into ongoing training plans. Data from routine reporting will be analysed at all levels to determine key areas for improvement; action will be taken as necessary.

STRATEGY 3: Strengthen pre-service training (basic training) for physicians, nurses, and other health workers involved in the implementation of the Stop TB Strategy.

Major activities

The NTP will initiate and participate in reviews of pre-service training curricula to ensure that curricula are up-to date to reflect the competency needs for the implementation of the Stop TB Strategy. This will include updating of teacher training programmes, course material, assessment procedures, etc.

STRATEGY 4: Engage in strategic partnerships for health workforce development for comprehensive TB control

Major activities

The NTP will collaborate and coordinate with other disease control programmes, other departments and services in the Ministry of Health (MOH), and other units and services in the provincial/district health services to ensure synergy and consistency with overall local health sector plans and capacity-building frameworks.

Efforts will be made to increase participation of groups and departments concerned with education and other aspects of health workforce development. Partnerships with other public sector, private sector, and community networks with common linkages to TB (for example, HIV/AIDS national programmes, professional associations, faith-based organizations, and international and bilateral organizations) will be strengthened to ensure active participation in relevant activities for health workforce development.

STRATEGY 5: Contribute to integrated personnel management system to foster adequate workforce planning, recruitment, hiring, deployment and retention

Major activities

As part of personnel management, the NTP will assess staffing needs at all levels, including the central level, for the implementation of the Stop TB Strategy. The NTP will collaborate with overall HRH departments and contribute financial resources to staff retention strategies and incentive packages for rural postings managed by the overall HRH departments. Minimum data requirement for adequate HR management will be determined, and necessary action taken to revise NTP routine recording and reporting systems. The NTP will take action to ensure that all HRD activities by the programme will conform to overall HR management systems and policies currently in place. Staffing problems (e.g., vacant posts, severely understaffed health centres) identified during supervisor visits will be communicated to departments responsible for overall personnel management for the health sector.

As part of performance management, functions and tasks by level and by professional category will be reviewed periodically and revised as necessary to ensure that all the components of the Stop TB Strategy are covered. Work load assessments will be undertaken. Job descriptions for staff involved in TB control will be revised as necessary to correspond with current policies and recommendations for TB control, e.g., the introduction of MDR-TB case management. Capacity development (competence and staffing) for supportive supervision - for implementation of the Stop TB strategy - will be coordinated with other high priority programmes. The NTP will contribute expertise and resources to the development and implementation of strategies for staff motivation and retention (not only financial).

STRATEGY 6: Monitor and supervise health worker performance.

Major activities

Supervisory checklists for all levels will be periodically reviewed and revised as necessary. Training of supervisors in specific supervisory and management skills will be implemented.

Recording and reporting system will be kept up-to-date to reflect new staff categories involved in TB control and the full implementation of the Stop TB Strategy. Linkages between regular supervision and continued education will be strengthened. Efforts will be made to strengthen the system of identification of new staff in need of training and to ensure the timely training of those identified.

7. Budget

ACTION

Prepare the budget for implementation of the strategic plan (in broad categories) taking into consideration whether the budget is a central level budget or whether parts of the budgeting is decentralized. Indicate if there are assumptions such as that the provinces and districts would initially fund a small number of activities or that local contributions would remain low.

Specify the sources of funding, such as government regular budget and loans, Global Fund (GF), other donors. Indicate what funding is available and committed, and describe the remaining gaps. Indicate if funding for some activities comes from the other programmes/departments in the ministry of health. Describe coordination with the overall HRH plan for the country.

For example:

The NTP prepared a five-year plan for HRD in 2007 as part of the overall TB strategic planning. Overall financial requirements for the plan are about USD 5 Million annually. A detailed breakdown is available in the annexes to the strategic plan.

The budget needed for HRD-TB activities refer to Strategic Plan of NTP 2006 – 2010. As the HRD is a supporting activity, the budget is included in many activities already included in the Strategic Plan. Nearly all fields of activities include HRD activities, such as training, supervision, staffing, etc.

A key issue in the development of this plan was the impact of decentralization on the government budget. Under the new decentralization policy, the budget available at the central level has been drastically reduced in favor of local budgets available at the province and district levels. This in effect means that local governments have full authority over the use of funds. While some general guidelines for the allocation of funds at peripheral levels exist (e.g., that total spending for health should amount to 10-15% of the total budget), experience during the fiscal years 2005 and 2006 has shown that funding for the health sector has been low in many provinces and districts, and that available funds were rarely used for TB control. Salaries for staff at all levels are excluded.

The funds available at the provincial and district levels are generally large, so that the potential for substantive contributions to the financing of the national TB control program exists, including the HRD activities. The contribution of provincial and district budgets to financing of the HRD plan is expected to increase from 5% of the total budget in the first year to 67% in the year 2008, while donor contributions gradually decrease to less than 5% by the year 2010.

The proportion of government contribution (central, province, and district) steadily increases over five years, from 49.6% in 2006 to 69.3% in 2010. For the years 2006 and 2007, GFATM, USAID, and CIDA funding will be used to meet the financial needs. However, financial gaps in year 2008-2010 have not been covered. Therefore, with anticipated gradual increase of district governments' allocations during the five year period, it is expected that future phasing out of external funding will be implemented by local governments.

8. Monitoring and evaluation

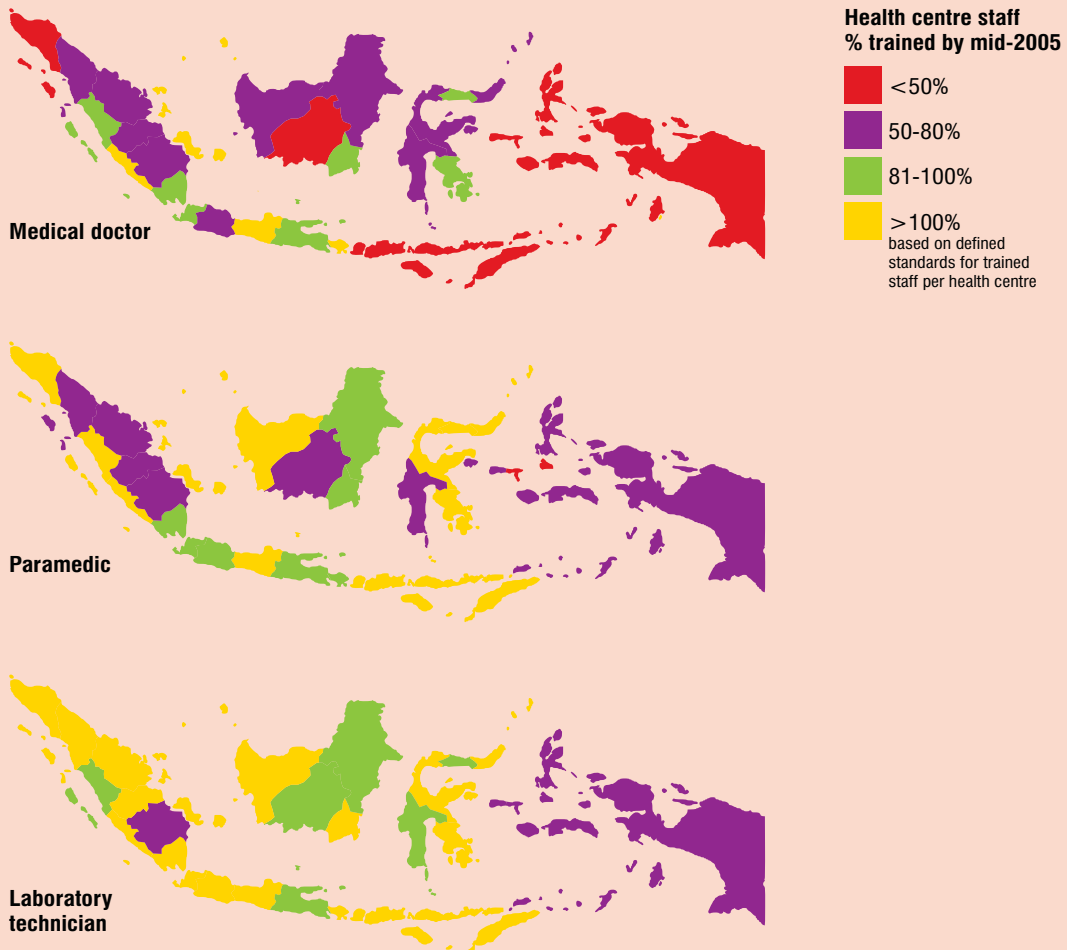
ACTION

Establish a routine monitoring process that will provide information on the progress being made in implementation of the plan. Monitor and evaluate progress on the content of the plan and provide data to make appropriate revisions. Develop broad process and output indicators to monitor progress towards the goal **based on the specific objectives** as listed in the plan.

Prepare a draft schedule for the preparation of annual implementation plans. Include a schedule for the preparation of the next strategic plan. This should start during the last year (or two) of implementation of the current plan.

For example:

Mapping of availability of trained staff at health centre level based on data collection in the routine monitoring system. This mapping is done on a yearly basis.



Analysis of the above illustrates the HR problems in the eastern part of the country.

9. Conclusion

ACTION

Elaborate on main assumptions/challenges for the success of the plan. Put emphasis on strengths and opportunities.

10. References

ACTION

List main documents used for reference during the development of the plan.

11. Annexes

ACTION

Consider issuing bulky annexes as separate documents or as a volume and part of the overall plan. The following are some of the documentation that could be part of the plan: relevant aspects of the NTP strategic plan; current HRH policy; statistical tables and other relevant data and information including data from the routine NTP monitoring system; the process followed in developing the plan; a list of main stakeholders involved and consulted.

Chapter 10 - Developing HRD annual implementation plans

The HRD annual implementation plan should specify the activities that will be undertaken during the next year, working towards reaching the goals and targets set in the strategic plan. The planning process describes the next year's activities and budgets, usually before the end of the year, so that resources can be obtained and plans distributed for use when the next year begins. The outline below includes the following components:

- I. Title
- II. Table of contents
- III. Foreword
- IV. Acknowledgements
- V. Executive summary
- VI. Abbreviations
 1. Introduction
 2. Situation Analysis
 3. Annual Objectives
 4. Major activities for HRD for implementation of the Stop TB Strategy
 5. Budget
 6. Monitoring and evaluation
 7. Conclusion
 8. References
 9. Annexes

Title

Mycountry Annual Implementation Plan for HRD for implementation of the Stop TB Strategy: 20xx to 20xx.

Table of contents

Listing of sections and subheadings to aid in quick reference.

Forward

Brief description of why document was developed.

Acknowledgements

Acknowledge those who contributed to the development of the plan.

Executive summary

Highlighting the key elements for an overview of the plan.

Abbreviations

Abbreviations used in the document are explained.

1. Introduction

ACTION

Make a short summary of the rationale for development of the HRD strategic plan and annual plan for implementation of the Stop TB Strategy.

Describe the relationship between the Strategic Plan and the Annual Implementation Plan. Summarize the vision, goals, key strategies and implementation approaches, and major activities as described in the Strategic Plan.

2. Situation analysis

ACTION

Assess implementation of the plan for HRD for implementation of the Stop TB Strategy during the current year including linkages and consistency with the strategic plan for HRD for implementation of the Stop TB Strategy. Gather information on the NTP's achievements. Sources of information to include (but are not limited to the ones listed below):

- annual evaluation from the previous year;
- quarterly reports from first three quarters of the year;
- reports from training courses and institutions;
- information from monitoring of activities and supervision;
- identified problems;
- resources that were used;
- reports for collaborating partners; and
- any reports from external consultants.

Assess the extent of the achievements of the NTP in HRD during the current year. Make sure that activities in all action fields of the HRH Action framework are being assessed.

For example:

1. Determine numbers, locations, and types of staff with responsibility for TB control at each level; determine numbers of vacant staff posts at each level and reasons vacant posts are not filled.
2. Review existing training activities throughout the country (requires availability of training records):
 - who is being trained;
 - where they are being trained (distribution of trained staff);
 - how many health workers have been trained - based on which needs;
 - type of training programme (in-service, new staff, reassigned staff, basic training);
 - whether staff are trained regularly and progressively (e.g., initial training followed by continued training for updating and reinforcement);
 - training of private sector providers; and
 - training materials and methodologies used.
3. Compare HRD accomplishments with the activities planned in the annual plan.
4. Examine other issues affecting performance (supervision, motivation of staff, pay and working conditions, turnover, migration).
5. Review overall strategic directions and modify if necessary based on implementation of the annual plan.

3. Annual objectives

ACTION

Review priorities based on the Strategic Plan and results of the situation analysis. Establish annual objectives. Objectives should be SMART (Specific, Measurable, Appropriate, Realistic, Time bound).

For example:

- By the end of 20xx, a comprehensive assessment of staff needs for the implementation for the Stop TB strategy will have been made with short and long term projections.
- By the end of 20xx, a training course for TB-HIV co-management at health centre level will be available.
- By the end of May 20xx, job descriptions for MDR-TB management will be available
- By the end of June 20xx, all job descriptions for staff at health facility level involved in comprehensive TB control will be up to date.
- By the end of 20xx, ___% vacant posts at district level will be filled.
- By the end of 20xx, an incentive package for remote postings will be implemented.

4. Major HRD activities for implementation of the Stop TB Strategy

ACTION

Specify major activities in all key strategies for HRD for implementation of the Stop TB Strategy for the year to meet annual objectives and solve problems identified. Develop activities for each objective. Ensure that time frames for implementation are included and that responsibilities are assigned (see format on page 60).

For example:

1. Ensure that the responsibility for human resource development at the central level is assigned.
 - Appoint or reappoint a human resources (HR) coordinator.
 - Assign or renew a training coordination group with representatives from training institutions, field staff, professional organizations, and other disease control programmes, such as NAP and leprosy.
 - Review roles and functions for training management at sub-national levels.
2. Do or update (if needed) a systematic task analysis for different levels and types of staff involved in TB control, including tasks required of:
 - clinical (health related) staff at community, health facility, district, provincial, and central levels.
 - laboratory staff at Levels I, II, and III.
 - managerial staff at community, health facility, district, provincial, and central levels.
 - tasks done in the private or voluntary sector.
3. Develop or revise job descriptions to include necessary tasks for TB control.
4. Provide training as needed, for new staff, transferred staff, etc. (Plan number of courses or other training interventions for particular types of staff).
5. Provide training for staff involved in the implementation of new strategies (e.g., management of MDR-TB).
6. Contribute to addressing staff retention (e.g., by improving motivation and addressing issues such as career development, remuneration, working conditions, and migration in collaboration with overall HRH department).
7. Develop/revise training for different categories of health personnel involved in the TB programme based to the functions and needs assessment.
8. Develop/revise training material (specify).
9. Select and train course facilitators for the different training courses (paying particular attention to the technical and educational competencies of the future facilitators, as well as the ability to encourage course participants to develop skills in independent thinking and problem solving).
10. Train supervisors at district and provincial level on follow up on training.
11. Organize bi-monthly meetings for provincial HRD coordinators as part of ongoing monitoring and continuous learning.

5. Budget

ACTION

Prepare a budget for the annual plan. Determine costs and personnel needed to implement the plan, and compare with what is available; obtain (or make plans to obtain) additional resources as needed.

6. Monitoring and evaluation

ACTION

Review and/or specify indicators of human resource development to be monitored and evaluated; and plan how they will be measured.

7. Conclusion

ACTION

Elaborate main assumptions/challenges for the success of the plan. Put emphasis on strengths and opportunities.

8. References

ACTION

List main documents referenced during the development of the plan.

9. Annexes

ACTION

Consider issuing bulky annexes as separate documents or as a volume and part of the overall plan. The following are some of the documentation that could be part of the plan: relevant aspects of the NTP strategic plan; current HRH policy; statistical tables; other relevant data and information including data from the routine NTP monitoring system; the process followed in developing the plan; and a list of main stakeholders involved and consulted.

Conclusion and next steps

Health workers drive the performance of health systems and priority disease control programmes. A motivated and skilled workforce plays a critical role in controlling TB, HIV/AIDS, and malaria, and providing essential preventive, diagnostic, and curative services. Stated simply, there are no shortcuts to developing the health workforce for achieving the health-related MDGs.

The crisis in the health workforce will not fade away. Gross underproduction of health workers is apparent in many countries hardest hit by the HIV/AIDS epidemic. Even in well-endowed countries, escalating demand for skilled workers in aging populations means accelerating importation in an increasingly porous global labour market. Few countries, rich or poor, have strong HR planning and implementation capacity to correct ancient deficiencies. Not only is urgent action necessary, at least a decade of sustained investments will be necessary to build a robust human infrastructure for most national health systems.

The resources mobilized through global initiatives have been important in focussing international attention on major issues and accelerating progress towards the MDGs. There is now an urgent need to ensure that these resources effectively complement and build sustainable health systems that address the full range of the health needs of a population. Cooperative arrangements between global initiatives and national plans of action should be designed to complement and strengthen, rather than duplicate or compete with, health systems. The bulk of external funding should flow directly into countries in support of national plans for health systems and priority disease programmes. While not a panacea, effective HR management is essential for improving the efficiency and impact of those investments. Getting the right workers, in the right place, at the right time, doing the right things is absolutely fundamental to health results. The health workforce operates as the common “currency” in harmonizing health systems and priority disease programmes. Ultimately, the priority that countries accord to the training, deployment, and tasks assigned to workers is where health systems and global initiatives come together. This is true not only for overall health workforce development, but also for HRD within the context of a global health initiative such as TB control.

Strategic planning within global health initiatives and country programmes, in close cooperation and coordination with the overall management of the national health workforce, is essential to the creation of sustainable health services. We need to learn from experience and build on it, go beyond the health sector to search for solutions, seize the political and social opportunities to raise awareness, advocacy and commitment for addressing the health workforce issues. Applying the principles as outlined in this document will contribute to the improvement.

The development of strategic plans takes time. The main objective of this handbook is to share ideas on how to develop basic plans for HRD for implementation of the Stop TB Strategy, and to encourage their successful implementation and monitoring. The document is not intended as a textbook on HRD, but as a practical guide with flexibility for adaptation to suit individual countries.

This handbook will continue to evolve as other HRD management issues arise and experience accumulates. Suggestions for improvement are welcome and can be submitted to the Stop TB Department, World Health Organization, 1211 Geneva 27, Switzerland.

Annex 1: Glossary

The definitions given apply to the terms as used in this handbook. They may have different meanings in other contexts.

balanced distribution

Appropriate allocation of health personnel, geographically and among levels of care and types of services, to ensure equitable provision of high-quality health services to all.

brain drain

Outflow of health professionals to other countries, or from the public to the private sector within a country, or out of the health sector, usually in search of more employment opportunities, and better working and living conditions.

capacity building

Continuing process of strengthening existing capacities and introducing more efficient technologies and systems in order to address a problem in a more effective manner. The United Nations Development Programme defines capacity building as the process by which individuals, groups, organizations, institutions, and societies increase their ability to (i) perform core functions, solve problems, define and achieve objectives, and (ii) understand and deal with their development needs in a broad context and in a sustainable manner.

career

Movement of individuals from one job or position to another job or position that has different (usually higher) levels of authority, income, and/or skills and requirements.

career structure

A planned set of differentiated steps, posts, or jobs through which one can progress professionally within a specific position or across positions along a period of time to ensure the continued effectiveness of an organization.

career management

Process of setting goals and identifying specific skills, capabilities, and interests for the purpose of implementing a career plan. Providing career management assistance is one of the strategies employed to retain health professionals (see retention of staff).

competences

Knowledge, skills, and attitudes that an individual possesses. Competencies are accumulated and developed through education, training, and experience.

continuing professional development

Process of systematic learning that allows health professionals to continue to meet the needs of the population being served by updating and enhancing their skills, as well as achieving individual career and educational aspirations.

coping strategies

Approaches employed by health personnel to overcome unsatisfactory remuneration or working conditions in order to fulfill professional and material expectations. Examples of coping strategies include: (i) undertaking extra duties to supplement income (see fragmentation of work); (ii) migrating to private practice or out of the health sector (see brain drain); and (iii) being on a payroll without providing services (see ghost work).

deployment

Process of allocating personnel among types and levels of services, and among regions and subregions of a country.

discipline

Generic term covering the process and methods in an organization through which the conduct/behaviour of the workforce is managed.

education; basic, specialization, continuing

Education – development of competencies, or the process by which the appropriate number of each category of providers is produced and equipped with the knowledge, skills and attitudes needed to produce the kind of performance necessary to achieve health services objectives.

Basic – acquisition of fundamental professional competencies by new personnel. Provision of basic education is usually under the responsibility of professional schools and universities.

Specialization – process of acquiring specific competencies in addition to basic education.

Continuing education – all educational experiences, activities and resources engaged by a health professional after completion of professional training.

employment status: full-time, part-time, temporary, permanent

Full-time (whole-time) – employment or working for the amount of time considered customary or standard.

Part-time – employment or working for less than the amount of time considered customary or standard. The trend towards part-time or temporary employment with lower salaries is attributed to attempts by employers to develop more flexible employment practices, but can also be used positively as a way of retaining workers who wish to work reduced hours.

Permanent – employment contracted for an indeterminate period.

Fixed-term – employment contract for a fixed period of time.

Temporary – short-term contracts or “casual” work, either for a definite period or for a specific activity.

flexibility

Flexibility in the use of labour can be of two types: time-based, to match staffing to workload (use of different shift patterns, working hours etc.); or contract-based, for organizational flexibility (use of temporary staff and fixed-term contract staff, and even contracting-out whole sections of the service). Flexibility can also cover pay flexibility and skill flexibility.

ghost worker

Personnel formally on the payroll, but providing no service (See coping strategies).

grievance

A generic term covering the processes and methods through which members of the workforce may express disagreement with the conditions of employment.

human capital

The stock of accumulated skills, experiences, and personnel that make workers more productive. Or – human skills and capabilities generated by investments in education and health.

human resource development

Functions involved in planning, managing, and supporting the professional development of the health workforce within a health system, both at the strategic and policy levels. HRD aims at getting the right people, with the right skills and motivation, in the right place at the right time. It is a systematic effort, within the limits of what a country is prepared to spend, to maximize the effective utilization of the workforce in the health sector.

human resource management

Process of creating an adequate organizational environment and ensuring that the personnel perform adequately; the process uses strategies to identify and achieve the optimal number, mix, and distribution of personnel in a cost-effective manner.

human resource planning

Process of estimating potential requirements for human resources in health and designing ways to fulfill those requirements (see workforce planning).

human resource policies

Guidelines and directions that regulate the utilization of workforce, both within the health sector and within the wider context (socio/political/economic).

imbalances: regional, service, occupational, gender

An imbalance occurs when there is shortage or surplus of health personnel as a result of unequal demand and supply for labour. In the health sector, imbalances can be of the following types: (i) profession/specialty imbalances, related to a disparity in various health professions, such as doctors or nurses, as well within professions, for example, a shortage of one type of specialist; (ii) geographical imbalances, which refer to disparities of health personnel in urban–rural and poor–rich regions; (iii) institutional and services imbalances, related to differences between health-care facilities, as well as between services; (iv) public–private imbalances, associated with differences in allocation of human resources between the public and private health-care system; and (v) gender imbalances, which refer to disparities in the representation of females to males in the health workforce.

job analysis

Process of identifying requirements and defining roles to provide specific tasks.

job equivalence

The weighted values of the skill requirements and work conditions of a particular job that allow comparison to other jobs in an organization; most often used to determine career development and pay.

labour legislation

Policies and guidelines regulating the labour market. Laws and regulations that govern the functioning of the labour market.

labour markets

Institutions and processes through which employment and wages are determined, affecting the supply and demand for labour. Labour markets can be divided into regional, occupational, or skill segments. The health labour market is the segment concerned with human resources in the health sector. Factors affecting the health labour market are imbalances, mobility, and migration.

management of change, change management

The concept of change management encompasses three basic definitions: (i) the task of managing change, referring to (a) making changes in an organization in a planned and systematic way, or (b) responding to changes over which the organization exercises little or no control, such as legislation, social, and political upheaval; changing economic situations, etc; (ii) an area of professional practice, referring to experts or firms engaged in planning and managing change for their clients; and (iii) a body of knowledge, consisting of models, methods and techniques, tools, skills, and other forms of knowledge that go into making up any practice.

migration

Process of movement of people from one country, region, or place to settle in another. In the health sector, when related to movement of health workers, this process is also referred to as brain drain.

mismatches

A bad match, a discrepancy, or a lack of correspondence between the competencies of a person and the requirements of a job; or an imbalance between required numbers or skills of staff and staff available.

mobility

The capacity or facility of movement of personnel between positions, organizations, and regions. Mobility of health-care personnel is an important issue in the allocation of personnel within a health-care system (see deployment and brain drain).

motivation, satisfaction

Motivation – individuals' degree of willingness to sustain efforts towards achieving certain goals. (See *system of incentives*)

Satisfaction – contented state of mind that affects or motivates behaviour. (See *systems of incentives*)

outsourcing, contracting-out

To obtain goods or services (sometimes already provided by the staff of the organization, thus implying a process of transfer) by contract from a source outside an organization.

performance management, evaluation

Performance management – process of optimizing productivity and quality of work of the workforce. This includes designing or adapting performance management and performance appraisal systems.

Evaluation – assessment process that provides feedback to workers on their performance, and ensures the quality and effectiveness of services provided.

personnel information system

National and/or local information system that provides analyses, evaluation, and distribution of information needed to support decision-making and health personnel management and practices.

productivity

Refers to outputs extracted from given inputs, such as patients seen per doctor, number of procedures per provider, etc.

recruitment

Process of searching for personnel to enter a particular job or position; process to strengthen or increase the supply of personnel to perform services.

regulation of practice: certification, licensing, accreditation, professional discipline monitoring and dealing with professional errors

Regulation of practice – formal recognition granted by a representative body (usually at national level) to an individual or group to verify that certain predetermined educational requirements and/or professional standards have been met. Such mechanisms are implemented to ensure maintenance of standards and the quality of health-care services provided. In some systems, there will be a requirement to re-certify or re-accredit at specified time intervals.

Accreditation – approval of an educational programme or an institution by a governmental or voluntary body.

Certification – process by which a nongovernmental agency grants recognition to an individual who has met certain qualifications.

Licensing (of health personnel) – governmental authorization of a person to engage in a health profession occupation.

Registration – official recording of the names of persons who have certain qualifications to practice a profession or occupation (such as health personnel).

remuneration

Payment of an equivalent to a person for a service or expense.

retention of staff

Maintenance of health personnel by offering adequate opportunities for re-training and career management assistance (see career management).

skills mix

Refers to the mix of posts in the organization, the mix of employees in a post, the combination of skills available at a specific time, or the combinations of activities that comprise each role, rather than the combination of different job titles. Skills mix is a strategy used to ensure the most cost-effective combination of roles and staff.

staffing

Process of recruiting, allocating, and retaining staff or personnel, in terms of mix and number of personnel (the right combination of categories of personnel and adequate numbers per category) and their deployment; this includes distribution of staff by region (including internal migration pattern), by level of care, by type of establishments, and by gender in order to meet the service objectives.

stock

Quantity of accumulated productive assets. In workforce planning, “stock” refers to the current composition of the workforce. In budgetary terms, it can refer to mobile clinics or fixed assets as part of the capital stock of the health-care system.

substitution

Process of delegating tasks to less qualified personnel with the goal of improving cost-effectiveness.

systems of incentives

Sets of rewards and sanctions to improve staff performance and motivation by providing financial and non-financial benefits such as flexible working schedules and training, education, and career development opportunities.

teamwork

Work done by a group formed by associates with different skills and backgrounds, with each doing a part, but all subordinating personal prominence to the efficiency of the whole (see skills mix).

training: in-service

Training – maintenance and adaptation of the competencies of existing personnel within the context of their current position.

unemployment, underemployment

Unemployment – the condition in which personnel available for work in a labour market are not employed.

Underemployment – the condition in which personnel available for full-time work in a labour market are (i) employed at less than full-time or regular jobs, or (ii) in jobs where their full skills are not utilized, or are inadequate to meet economic needs.

work organization

Process of defining arrangements of work in an organization, coordinating tasks, and assigning responsibilities. Coordination of clinical departments in hospitals, which brings together professionals from different disciplines, is one example of work organization. (See teamwork)

workforce dynamics

The way the stock changes through movement into (entry of newly trained individuals, immigration, re-entry) and out (retirement, death, emigration, exit of the occupation) of the workforce.

workload

The amount of work expected from or assigned to a specific position or to one person (can also be a technical term related to “measures” of activity by individuals or teams).

workforce planning: needs, supply and demand, surpluses, shortages

Comprehensive process to provide a framework for staffing decision-making based on an organization’s mission, strategic plan, budgetary resources, and a set of desired workforce competencies. It incorporates an analysis of the current workforce to identify competencies needed in the future and possible gaps and surpluses, preparation of plans for building the workforce (see capacity building) and an evaluation process to ensure objectives are being met. (See performance management and human resource planning).

working conditions, terms of employment, benefits

Working conditions – characteristics of the environment in which a person is expected to work. Includes terms of employment, benefits, physical and social climate.

Terms of employment – conditions that regulate and define employment contracts (see *job analysis*).

Benefits – advantages that a person is entitled to, such as maternity leave and health insurance (see *systems of incentives*).

Annex 2:

Resources

HRD-related documents from the WHO Stop TB Department

Assessment of human resources and time needed to implement the DOTS strategy for TB control in health facilities – survey instrument and guide to implementation. Geneva, World Health Organization, 2008 (WHO/HTM/TB/2008.395).

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Management of tuberculosis – training for district level coordinators: B. Faba District. Geneva, World Health Organization, 2005 (WHO/HTM/TB/2005.347b).

Management of tuberculosis – training for district level coordinators: C. Conduct supervisory visits for TB control. Geneva, World Health Organization, 2005 (WHO/HTM/TB/2005.347c).

Management of tuberculosis – training for district level coordinators: D. Provide training for TB control. Geneva, World Health Organization, 2005 (WHO/HTM/TB/2005.347d).

Management of tuberculosis – training for district level coordinators: E. Manage drugs and supplies for TB control. Geneva, World Health Organization, 2005 (WHO/HTM/TB/2005.347e).

Management of tuberculosis – training for district level coordinators: F. Ensure laboratory support for TB control. Geneva, World Health Organization, 2005 (WHO/HTM/TB/2005.347f).

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Useful web links

Africa health workforce observatory: <http://www.afro.who.int/hrh-observatory>

European Observatory on health systems and policies: www.euro.who.int/observatory

Global atlas of the health workforce: <http://www.who.int/globalatlas/default.asp>

Health systems: www.who.int/healthsystems

Health Evidence Network: <http://www.euro.who.int/HEN>

HRH Global Resource Centre: <http://www.hrhresourcecentre.org/>

Human Resources for Health online journal: <http://www.human-resources-health.com/>

Knowledge management for public health: <http://www.who.int/km4ph>

Latin America and Caribbean Observatory of Human Resources:
<http://www.observatoriorh.org/eng/index.html>

Management for Health Services Delivery (MAKER): <http://www.who.int/management/en>

World Health Statistics: <http://www.who.int/healthinfo/statistics>

WHO Eastern Mediterranean Regional Health System Observatory:
<http://gis.emro.who.int/HealthSystemObservatory/Main/Forms/Main.aspx>

The Asia Pacific Action Alliance on Human Resources for Health (AAAH):
www.aaahrh.org/aaah.php

The health academy: <http://www.who.int/healthacademy>

The global health library: <http://www.who.int/ghl>

The Global Health Workforce Alliance: www.who.int/workforcealliance/en/

The HRH Action Framework website was developed as an initiative of the Global Health Workforce Alliance. It represents a collaborative effort between the United States Agency for International Development and WHO. The Capacity Project is the web site administrator.

The WHO web site on the health workforce: www.who.int/topics/health_workforce/en/

Tools and guidelines for human resources for health: www.who.int/hrh/tools/en/

WHO HRH resource centre: www.who.int/hrh/resources/en/

TB education and training resources web site: www.findtbresources.org

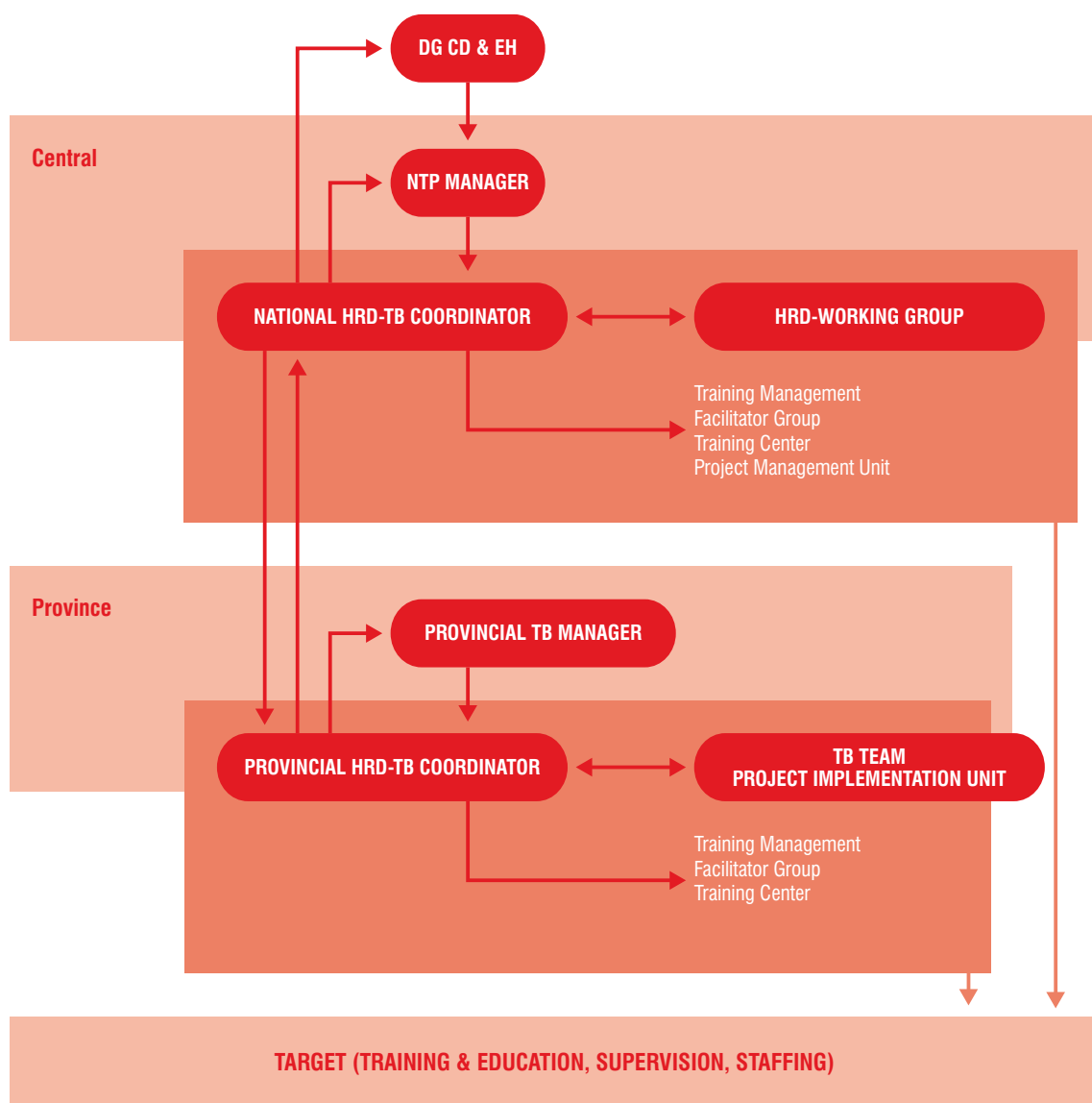
Human Resources for Health (HRH) Action Framework web site:
<http://capacityproject.org/framework/index.php>

Annex 3:

Sample HRD structure in the NTP

Since the Stop TB Partnership was established, HRD has been a priority in programme development. The organization of HRD-TB was initiated with the appointment of a coordinator for HRD-TB at central level and subsequently also at provincial level. In order to ensure more effective and efficient coordination and collaboration with key stakeholders, a working group of HRD has established at central level. In addition, a group master trainer and a training facilitator have been established at central and provincial levels (Figure 1.1.)

Figure 1.1.
Organization of HRD-TB in the national TB control programme



Capacity building (training) implementation use a cascade strategy, placing group master trainers at national level, collaborating with regional training centres (RTC) and responsible for training groups of facilitators in each province and supervisors at district and provincial levels.

In the province the group of facilitators are under the coordination of the provincial HRD coordinator. They are responsible for training TB staff at health service unit. Province and district TB supervisors are responsible for conducting post training evaluation through supervising the TB staff. See figure 1.2. and 1.3.

The roles and tasks of the districts NTP is technically and managerially supported and monitored by Provincial and Central Unit (sub directorate TB). For these purposes at the provincial level a DOTS team is established which consists of Provincial TB supervisor, Provincial project Officer (PPO), Provincial HRD-TB Coordinator (P-HRD-C), Provincial Technical Officer-at high burden provinces (PTO), as shown in the figure 1.4.

Figure 1.2.
Training cascade and its organization

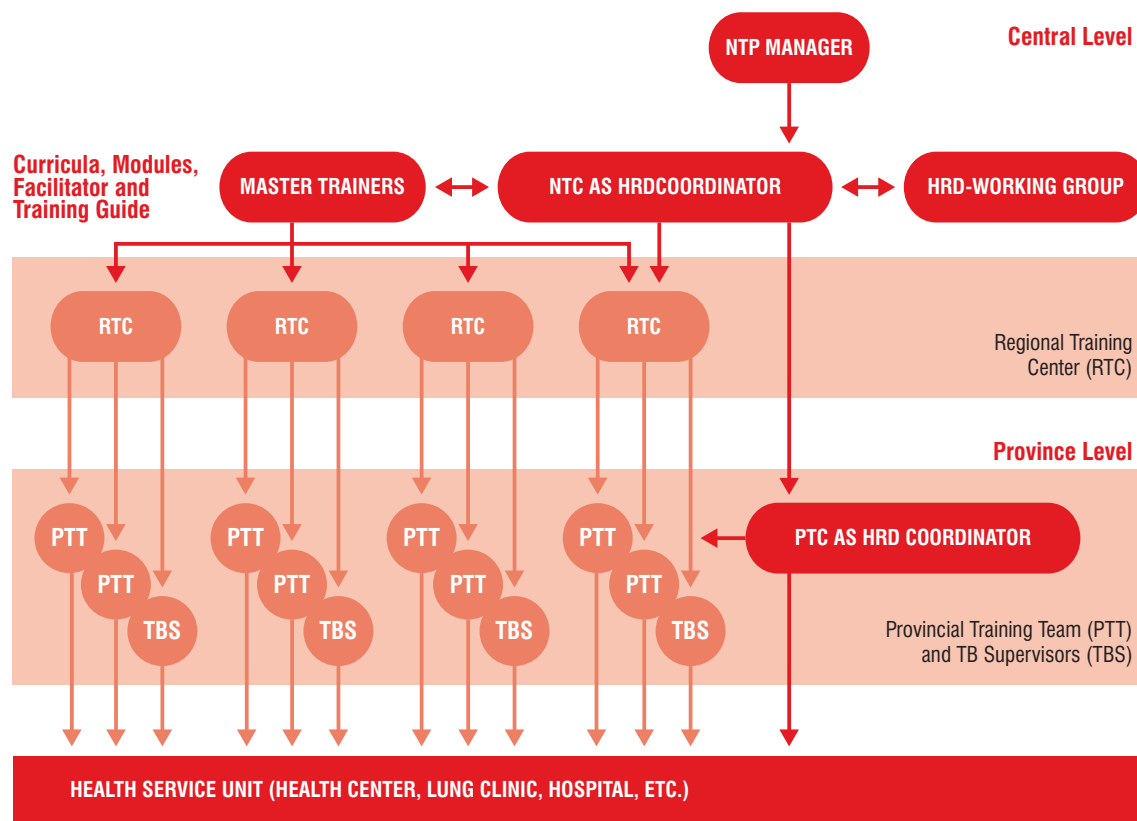


Figure 1.3.
Overview of TB-Training

PRE SERVICE	IN SERVICE (Clinical & Management)	
Medical School Nurse School PH School Health academia /diploma etc	Basic / Initial training • Supervisor • Health service unit staff Retraining • On the job training	Advance course • ACDA • TB Leadership
	New skill • TB-HIV • DOTS plus • Logistic	

Figure 1.4.
Provincial DOTS team.

