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Optimizing Health Worker Performance and Productivity to Achieve the 95-95-95 Targets

A Toolkit



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A Toolkit

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Cover photo: An HIV/AIDS counselor tests a client for HIV at the Orile Agege General Hospital in Lagos, Nigeria. (2016, HRH2030)

DISCLAIMER

This toolkit is made possible by the generous support of the American people through the United States Agency for International Development (USAID) in partnership with The U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The contents are the responsibility of Chemonics International and do not necessarily reflect the views of PEPFAR, USAID, or the United States Government.

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Acronyms

AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral drug
CEE	core essential element
CHW	community health worker
DHMT	district health management team
HICD	human and institutional capacity development
HIV	human immunodeficiency virus
HIV/AIDS	human immunodeficiency virus and acquired immune deficiency syndrome
HRH	human resources for health
HRH2030	Human Resources for Health in 2030
HRM	human resource management
HTS	HIV testing services
HW	health worker
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PICT	provider-initiated counseling and testing
PMTCT	prevention of mother-to-child transmission of HIV
POCT	point-of-care testing
RHMT	regional health management team
SIMS	Site Improvement Monitoring System
SOP	standard operating procedure
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
WHO	World Health Organization
WISN	workload indicators of staffing need

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Finally, we would like to acknowledge the extensive technical input from USAID's Office of HIV/AIDS to develop the toolkit and training package.

Introduction

What is the purpose of the toolkit?

This toolkit has been developed to build capacity of technical assistance providers and managers at the service delivery level to use a suite of existing tools and resources to address site-level health workforce performance and productivity problems impacting HIV service delivery. This toolkit aligns with the United States Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) human resources for health (HRH) priorities to optimize the productivity and performance of countries' existing health workers supporting HIV service delivery.

Frequently, the perceived solution to HRH challenges is to wait, fill staffing gaps, or to suggest training needs. However, oftentimes workforce problems contributing to service delivery gaps can be improved with no or few additional resources or external support, even at sites with staffing gaps.

Why is this toolkit necessary?

To achieve 95-95-95 targets, facilities and other HIV service delivery points (e.g., communities) will need to provide efficient and effective services to ensure that people living with HIV know their status, receive and sustain antiretroviral therapy, and achieve viral suppression by 2030¹. A key resource in this process, among other system factors, is the health workforce. It is commonly recognized that health worker shortages, inadequate training, maldistribution, and ineffective skill mix have negatively impacted delivery of critical health care in low- and middle-income countries. Addressing these health workforce barriers through improving health worker performance and productivity is an important strategy toward achieving and sustaining 95-95-95 goals. While we recognize that many other factors beyond the health workforce influence access, availability, acceptability, and quality of HIV services, this toolkit will focus on the workforce influences, as they are often the least understood and addressed.

<p style="text-align: center;">UNAIDS Fast Track Initiative</p> <p style="text-align: center;">95-95-95 targets</p> <p style="text-align: center;">By 2030:</p> <ul style="list-style-type: none">• 95% of people living with HIV know their HIV status.• 95% of people who know their HIV status are receiving antiretroviral therapy.• 95% of people on treatment have a suppressed viral load.
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Who should use this toolkit?

This toolkit is designed for country-level service delivery technical assistance providers and managers at the district, facility, or community levels supporting HIV/AIDS service delivery points. It is to be used in their work with staff when they have identified HIV service delivery gaps.

What does the toolkit contain?

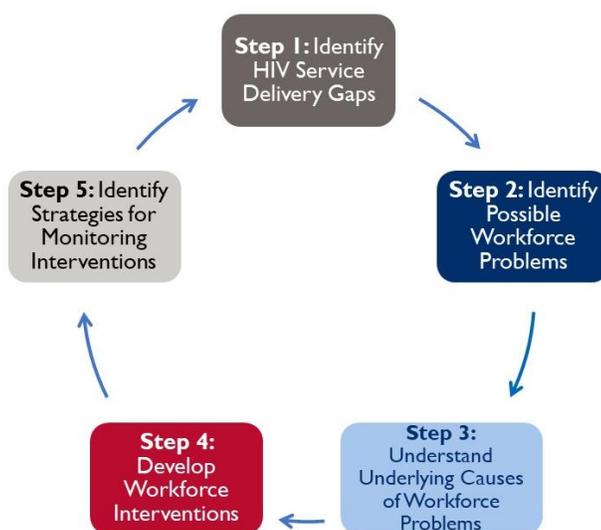
With the goal of improving HIV outcomes, this toolkit provides a rapid step-by-step process for addressing the workforce barriers at the site level that contribute to HIV service delivery gaps. It also

¹ UNAIDS. 2014. Fast Track: Ending the AIDS epidemic by 2030. Available at: http://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf

outlines relevant tools and resources that can be utilized across steps for further analysis and intervention determination.

The toolkit is organized according to the process steps for optimizing health worker performance and productivity to fill service delivery gaps and achieve 95-95-95 targets, shown in Figure 1 below. Each step is expanded upon throughout the rest of this toolkit, with tools and explanations for implementing each step outlined in each section.

Figure 1: Overview of process for optimizing health worker performance and productivity to achieve 95-95-95 targets



Step 1 entails reviewing existing HIV service statistics to identify gaps. The tools presented in Step 2 cover collecting workforce-specific data and general data analysis and use; the tools in Step 3 help to analyze the underlying causes of the most common workforce problems observed in HIV service delivery programs, including health worker competency gaps, low staff engagement, poor task allocation among staff, and inefficient work processes. The resources in Step 4 help to identify appropriate interventions to address the causes of workforce problems; and the tools in Step 5 support intervention monitoring. Case study examples highlight how the steps and tools can be applied throughout the toolkit.

How should this toolkit be used?

This toolkit is intended to be used as a reference guide to identify and implement the most appropriate interventions to address workforce-related productivity and performance gaps and strengthen HIV service delivery. The goal is to ensure that interventions address the underlying root causes of workforce problems and not just surface issues. The toolkit is designed so that each step stands on its own and can be used either independently or in a stepwise fashion.

Important note: For this toolkit, data review (Steps 1 and 2) and site visits (Step 3) should consider all points of service delivery across the continuum of HIV care, in both facilities and communities. Proposed workforce interventions (Step 4) should be considered to include all workers linked to that facility, including lay workers and those working in the community to link, track, or support patients.

Overview of the Process for Optimizing Health Worker Performance and Productivity

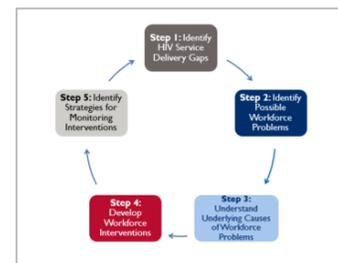
Key Terms

The concepts of workforce performance, productivity, and efficiency have been described in the literature in various ways, depending on the specific scope. For the purposes of this toolkit, we define these terms as follows:^{2,3}

- **Performance:** Performance refers to the quality of the health workers' work, the technical skills they use, the care they deliver, and the impact of their work on health outcomes. When health worker performance is optimal, they are providing client services reflective of their training and ability, regardless of location (e.g., facility or community).
- **Productivity:** Productivity is the ratio of the service delivery outputs produced (as measured by health services produced over a given period) over the human resources inputs used (as measured by health worker salary costs over a given period). Productivity is influenced by work assignment, management practices, modes of remuneration, health worker engagement, work organization, the regulation of the division of labor, and the availability of other labor and nonlabor resources.
- **Efficiency:** Efficiency is the ability to effectively use the allocated resources, including time, energy, and materials and supplies, to perform a task without waste; to maximize the use of existing resources; or to do more with less.

Process for Optimizing Health Worker Performance and Productivity

The process for optimizing health worker performance and productivity to achieve 95-95-95 targets is illustrated in Figure 1 on page 8 (repeated at the right). The goal of this step-by-step process is to identify and then address the underlying causes of workforce problems that contribute to identified HIV service delivery gaps at individual facilities, promoting a cycle of continuous review of data and adjusted actions for improvement.



The specific steps are as follows:

Step 1: Identify HIV service delivery gaps. Review routine service statistics to determine which areas on the continuum of care are not performing well. If service gaps are not identified (i.e., the facility is on track to achieve 95-95-95 targets), then you may consider skipping Steps 2 to 5. Continue monitoring routine data on a regular basis to ensure that any service delivery gaps are identified in a timely manner.

Step 2: Identify possible workforce problems. Review health workforce data at facility or point-of-service interventions to identify the potential workforce-related issues that could be preventing the achievement of PEPFAR targets. The goal of this step is to make use of existing data collected for HIV

² Global Health Workforce Alliance. Background Report: Improving Health Worker Productivity and Performance in the Context of Universal Health Coverage: The Roles of Standards, Quality Improvement, and Regulation. 2014. Available at: http://www.who.int/workforcealliance/media/news/2014/WG7_Productivityandperformance.pdf

³ The World Health Organization (WHO). The Labour Market for Human Resources for Health in Low- and Middle-Income Countries. 2012. Available at http://www.who.int/hrh/resources/Observer11_WEB.pdf

service delivery (e.g., numbers tested by modality and location in the facility, or numbers on initiated on treatment) and make an initial assessment of human resource–specific issues (number and type available at the service delivery point) to inform decision-making.

NOTE: Current recommendations for data review at the site level are for quarterly review, or monthly if possible. While site-level service delivery data are routinely gathered, HRH data may need to be collected, for which this toolkit provides recommended resources and tools.

Step 3: Understand underlying causes of workforce problems impacting service delivery gaps, as identified in the previous step, to arrive at the root of the problem. While we recognize that there may be many other factors beyond the health workforce that could influence HIV service delivery (e.g., availability of commodities, infrastructure, health financing), this toolkit focuses specifically on the contribution of the facility- and community-based health workforces, since HRH is an area that is often the least understood and addressed. Identifying workforce problems and their underlying causes is an iterative process, since there may be multiple root causes that require intervention to eliminate the workforce problems.

Step 4: Develop workforce interventions to address the underlying causes of workforce-specific problems. See Table 2 in the Step 4 section for an illustrative example of specific interventions that can be implemented to strengthen health workforce performance and productivity by pinpointing the underlying causes of common workforce problems contributing to HIV service delivery gaps, based on data of HRH gaps at the site level.

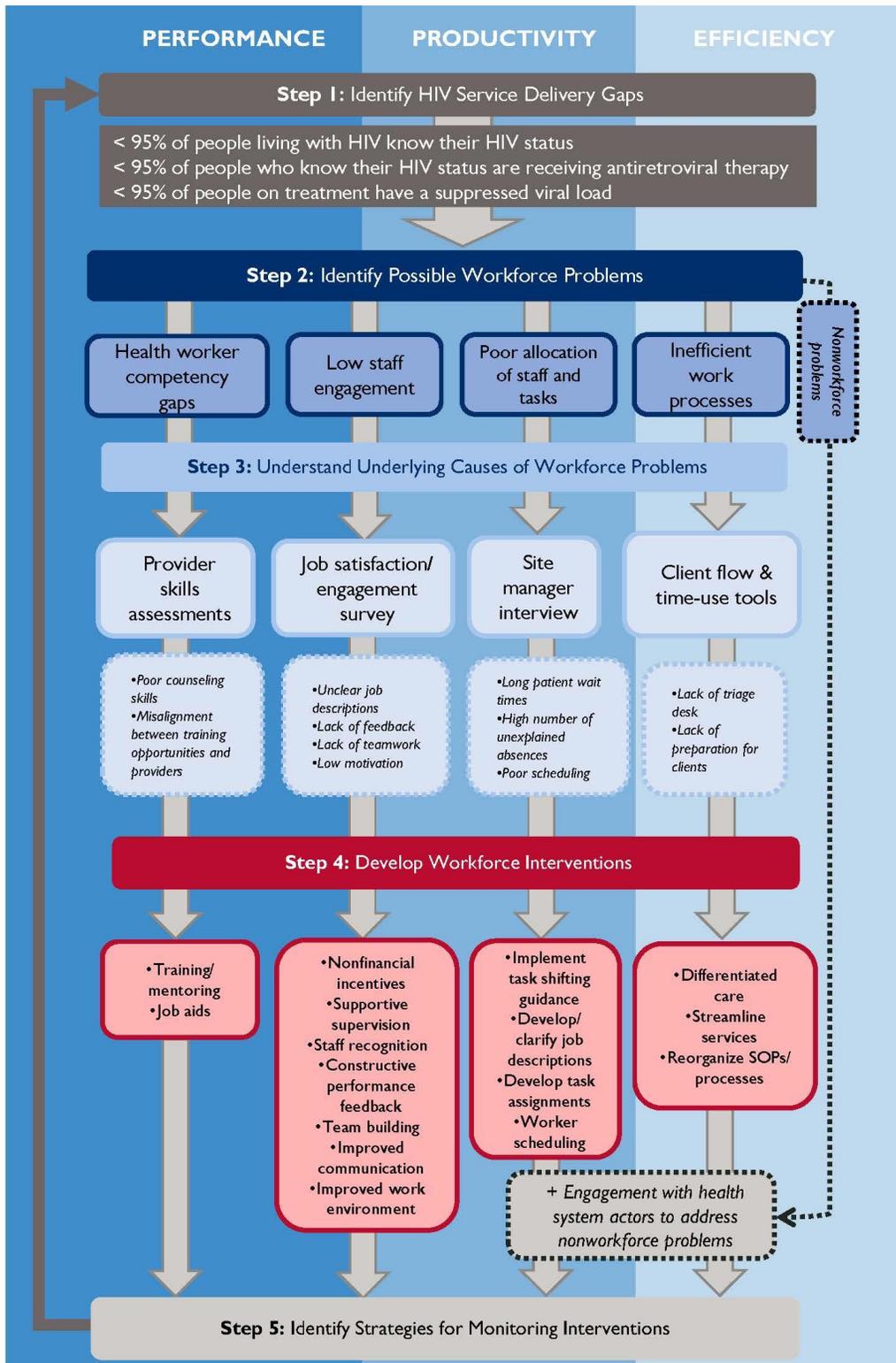
Step 5: Identify strategies for monitoring interventions to measure progress and systematically adjust the selected interventions to ultimately improve HIV service delivery outcomes. Implicit in monitoring the success and appropriateness of interventions is the effort to adapt them so that they effectively address the underlying causes of the workforce problems.

To determine and measure the effectiveness of which context-specific workforce-related interventions would be appropriate and effective to achieve 95-95-95 target, Steps 1 through 5 should all be undertaken. As this process is cyclical, after completing all steps, toolkit users should repeat it routinely (i.e., return to Step 1 to once again review service delivery gaps and possible health workforce problems and then understand underlying causes to develop workforce interventions and monitor their success).

A more detailed depiction of the five-step process for optimizing health worker performance and productivity to achieve 95-95-95 targets is shown in Figure 2.

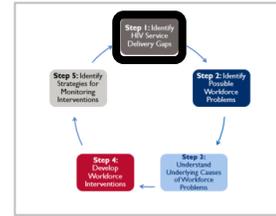
The following sections are labeled by their respective step, and include an overview, recommended tools and resources to complete the step, and a case study to show an illustrative example of how the step could be completed at a facility site.

Figure 2: Detailed process for optimizing health worker performance and productivity



Step 1: Identify HIV Service Delivery Gaps

Evidence-based decision-making for HRH interventions at the facility or point-of-service level requires the analysis of HIV service delivery statistics and health workforce data to identify underachievement of the 95-95-95 targets and workforce gaps. This will include looking at the service statistics related to the three target areas: HIV testing services (HTS), antiretroviral therapy (ART) initiation and continuation, and viral load suppression (see Figure 3 below).



First, review routine HIV service delivery data, such as monitoring, evaluation, and research data and cascade data to determine the gaps, if any, there may be with the continuum of HIV care. If there are service delivery gaps, you will want to proceed with identifying potential site-level health workforce gaps that are contributing to the underachievement of the 95-95-95 targets.

NOTE: If a review of monitoring, evaluation, and research data and cascade data does not identify any HIV service delivery gaps and your facility is on track to meet the 95-95-95 targets, then you may not wish to invest time and resources in completing these toolkit steps.

At PEPFAR-supported sites, staff generally collect HIV service delivery data on a routine basis, at least quarterly. Some specific PEPFAR indicators that facilities can consider include:

- Number of individuals who received HIV testing services and received their test results (HTS_TST) and are seropositive (HTS_TST_POS)
- Number of adults and children newly enrolled on ART (TX_NEW)
- Number of adults and children currently receiving ART (TX_CURR)
- Percentage of ART patients with a viral load result documented in the medical record and/or laboratory information systems within the past 12 months with a suppressed viral load (<1000 copies/ml) (TX_PVLS)

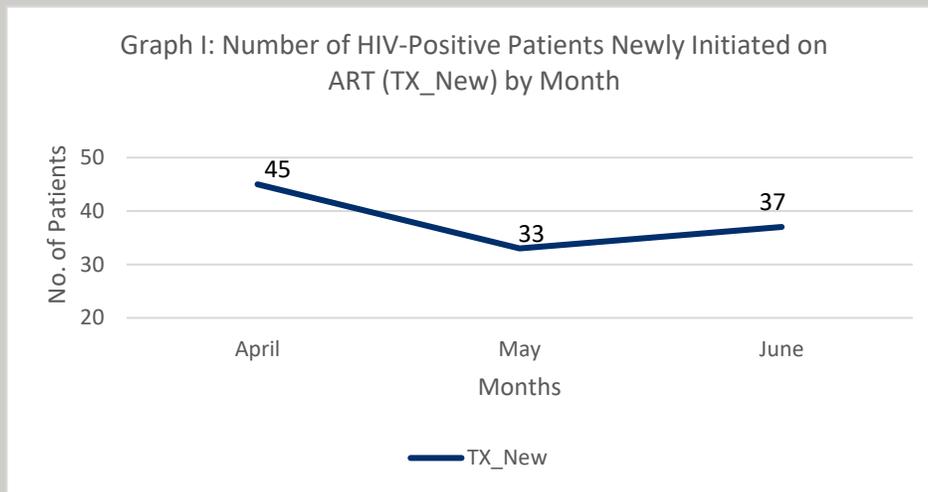
Figure 3. Step 1 of toolkit process



Step I Case Study: Identifying HIV Service Delivery Gaps

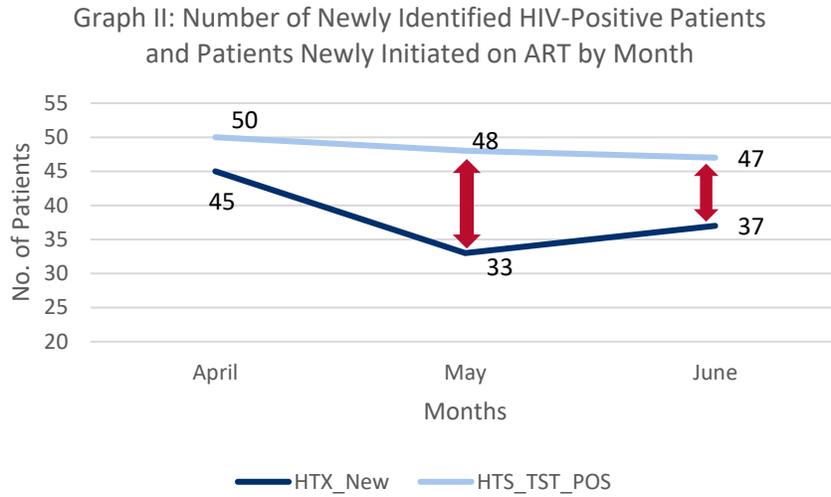
The Oche Baba Medical Center is a facility that provides HIV support and treatment services and links with community-based health workers. The facility staff, led by the manager, wanted to ensure that they were on track to achieve 95-95-95 targets.

First, they reviewed the facility's routine service statistics. On a Friday afternoon after service hours were completed, facility staff pulled data from the previous quarter on the number of newly identified HIV-positive patients initiated on ART (corresponding to PEPFAR TX_New indicators) and put it into a time series chart (i.e., a line chart tracking results month by month) to visualize their data over time and identify trends. When they looked at the number of individuals who had been initiated on ART after a positive HIV test result, the data revealed that it started at a high of 45 people in April, went down to 33 people in May, and back up to 37 people in June (as shown in Graph I below).



Because the team knew that initiating patients on ART was determined by identifying new positives, they also looked at the number of individuals who received HIV testing services and received positive test results (HTS_TST_POS) and saw that the number of newly identified positive individuals was relatively constant, with 50 identified in April, 48 in May, and 47 in June (as shown in Graph II below). The number of individuals identified as newly positive was relatively stable. The staff identified that there was a service delivery gap during the past quarter (especially in May and June), between the number of HIV-positive individuals identified and the number of HIV-positive individuals initiated on treatment (see red arrow in Graph II below).

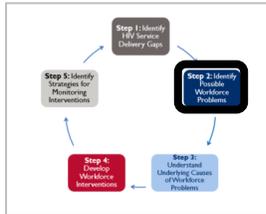
Step 1. Identify HIV Service Delivery Gaps



Based on the gaps in service shown in Graph 2, the Oche Baba Medical Center team determined that they should examine the potential health workforce–related challenges that may be negatively affecting how many newly identified patients were successfully linked to treatment.

Step 2: Identify Possible Workforce Problems

Overview of Step 2



Depending on the facility and whether previous assessments have been conducted, facilities may require additional assistance to collect data on workforce-related factors as well as support to interpret this information and identify bottlenecks. It is recommended that health workforce data be collected and reviewed continuously (e.g., monthly or quarterly), considering routine staffing changes made across facilities or other points of HIV service provision.

Basic facility workforce data include the types, number, skill mix, availability, and roles and responsibilities of specific cadres (both formal and informal, e.g., lay counselors) at the site level. They also entail understanding the levels of health worker productivity and performance, health worker capacity and preparation for providing quality services, and issues affecting workforce motivation and retention. These data can be compared against results of HIV service delivery indicators (above) on a frequent basis (e.g., quarterly) to ensure that available human resources are arrayed according to need and ability to provide services.

Further, as these data are often available for different areas within a facility, there is greater sensitivity to ensure that both professional and lay cadres are appropriately distributed within and across the facility or community under study (e.g., antenatal care clinic, tuberculosis clinic, ART clinic). Below are tools that can help provide a rapid overview of site-level workforce indicators as well as a more in-depth assessment of specific workforce elements (e.g., human resources management, job satisfaction, staff engagement).

If service delivery gaps are concentrated in one aspect of the cascade, then managers may choose to focus on the health worker types, or cadres, involved in that service area, as opposed to all HIV services on the continuum. Alternatively, if there is general underperformance across multiple interlinked service areas, or several cadres are implicated in multiple service areas, then tool users may choose to use Step 2 tools to assess the health workforce across the entirety of the HIV continuum of care.

Tools for Step 2

Collecting Workforce Data

HRH data are required to help identify workforce challenges impacting HIV service delivery. This may include information on the types, number, and availability of workers at the facility/community; issues affecting retention and productivity; current health worker cadre allocation per service point; health worker capacity and preparation; and workforce barriers. Many of these important workforce data points can be obtained through a review of facility-level HRH staffing inventories and human resource management (HRM) practices and processes. HRM is the “integrated use of systems, policies, and practices that will provide the range of functions needed to plan, produce, deploy, manage, train, support, and sustain the workforce. HRM focuses on people: how they fit and are utilized within a health system, and how they can be most effective.”⁴ An effective HRM system is central to health workforce performance and productivity.

The Step 2 tools described below can help facilities collect initial workforce data to help identify any workforce problems affecting HIV service delivery. As some tools may be perceived as time-consuming for some managers, it is possible to select parts of the tool. It is also possible to compile HRH data based on what is available or to focus only on data relating to the health workforce cadres performing the services where you observe the HIV service delivery gap.

The PEPFAR Rapid Site-Level Health Workforce Assessment Tool (Tool 2.a) contains recommended questions. It is possible to adapt the entire tool or to review it to select only the questions that would elicit valuable information.

At PEPFAR-supported sites, implementing partners are expected to assist facilities to review HIV service delivery data on at least a quarterly basis but will likely need to collect more workforce-specific data to compare with their facility- and community-level service delivery data. The [PEPFAR Rapid Site-Level Health Workforce Assessment Tool](#) (Tool 2.a) was specially developed to solicit relevant HRH data. In addition, PEPFAR Site Improvement Monitoring System (SIMS) HRH-related data may also be used (Tool 2.b). Relevant data include:

- Types, number, and availability of cadres at facility:
 - Cadre types: clinical, clinical support, managerial, social service, lay, other
 - Full-time and part-time staff
- Worker availability and reasons contributing to absenteeism, retention, and productivity
- Existing workforce performance management approaches
- Current health worker cadre allocation per service point:
 - Service point types: community outreach, community-facility linkages (e.g., patient referrals), client registration, triage, tuberculosis screening for HIV patients, patient consultations and clinical assessment, HIV/AIDS pre- and posttest counseling, lab testing, adherence counseling and psychosocial support, pill count, ART initiation, antiretroviral drug (ARV) refill, and dispensing ARVs
- Health worker capacity and preparation for providing quality HIV services by service point (as described in bullet above)
- Perceived HRH challenges pertaining to service delivery

⁴ Marsden P, Caffery M, McCaffery J. 2013. Human Resources Management Assessment Approach. Available at: <https://www.capacityplus.org/files/resources/hrm-assessment-approach.pdf>

Step 2. Identify Possible Workforce Problems

Tool 2.a: PEPFAR Rapid Site-Level Health Workforce Assessment Tool (Recommended)	
Hyperlink	www.hrh2030program.org/pepfar_tool
Description	This tool helps collect site-specific workforce data to inform program planning, optimize efficient utilization of health workers, and identify workforce barriers to quality HIV service delivery. Data collected include types, number, and availability of cadres at facility; reasons contributing to absenteeism, retention, and productivity; current health worker cadre allocation per service point; health worker capacity and preparation for providing quality HIV services; and workforce barriers pertaining to service delivery.
When to use the tool	This tool is recommended to be administered annually during the implementing partner's routine supportive supervision visit to a facility or during a specific visit to a facility as necessary to conduct the assessment and gather data. Completing the assessment during the fourth quarter of the fiscal year is advisable so that site-level workforce data are available to review with year-end monitoring, evaluation, and reporting data during PEPFAR's oversight accountability reporting and can be used for planning the next year's Country Operational Plan activities.
How to use the tool	<p>The tool is administered through a discussion with the in-charge or lead manager for HIV services at a facility followed by a walk-through of the key HIV service delivery departments. The assessment takes about 60 to 75 minutes to complete at each site.</p> <p>Quantifying the number and range of services and gaps in human resources at the site level will allow program managers to assess whether additional staff are required (if/where possible) or whether task shifting/sharing opportunities should be identified to ensure that expected services can be provided with the personnel available. These data collected in this tool should be juxtaposed with the service delivery data to help identify which services would benefit from revisions to the human resource workloads.</p>

Tool 2.b: PEPFAR Site Improvement Monitoring System (SIMS) Facility-Based Tool	
Hyperlink	https://www.pepfar.gov/documents/organization/276459.pdf (most recent guidance from PEPFAR on SIMS)
Description	PEPFAR's Site Improvement Monitoring System (SIMS) is a mandatory quality assurance mechanism to ensure high quality of HIV programs at the site, community, district, and national levels. Through systematized monitoring using standardized questions, the quality of key HIV program area elements is regularly assessed, documented, and needed improvement actions are identified.
When to use the tool	PEPFAR guidance on the frequency of site visits is subject to change on an annual basis and by typology of the facility (e.g., moderate or high volume). While the SIMS tool itself is not in the public domain, PEPFAR implementing partners have access to it. PEPFAR-supported sites can utilize the tool on a more frequent basis than described in the guidance if it will be of use to them, based on knowledge of what has changed in the operating environment.
How to use the tool	<p>The following selected core essential elements (CEEs) from the SIMS Facility Master Tool Version 3.0 can help provide relevant workforce data at the site level:</p> <ul style="list-style-type: none"> • CEE #: F_1.04: Q3. Are all staff trained, or given refresher training, at least annually on nondiscriminatory service provision? • CEE #: F_1.05: Q1. Do all facility staff involved in the delivery of HIV services have a job description (different from national scopes of work) or similar document that describes the staff roles and expectations (e.g., job aid, work flow charts that outline tasks for team members)?

Step 2. Identify Possible Workforce Problems

	<ul style="list-style-type: none"> • CEE #: F_1.05: Q2. Which mechanisms are in place that facilitate performance feedback between health workers, their supervisors, and the clients? • CEE #: F_1.05: Q3. Are measures in place to enhance the work environment to enable health worker performance (e.g., addressing safety concerns such as lack of equipment, protection from violence and/or harassment)? • CEE #: F_11.02: Q1. Is there documentation that all point-of-care testing (POCT) staff have received training on every test they are conducting? • CEE #: F_11.02: Q2. Is there documentation that all POCT staff have passed an initial competency assessment for every test they are conducting? • CEE #: F_11.02: Q3. Is there documentation that all POCT staff receive annual competency assessments with corrective action, if needed? <p>These data will help identify quality assurance shortfalls at the facility and can serve as an opportunity to focus quality improvement efforts in these areas.</p>
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Tool 2.c: Human and Institutional Capacity Development (HICD) Handbook Appendix 1.7: Sample Questions for Identifying Performance Gaps

Hyperlink	http://pdf.usaid.gov/pdf_docs/Pnadt442.pdf
Description	USAID's <i>Human and Institutional Capacity Development Handbook: A USAID Model for Sustainable Performance Improvement</i> was developed to guide partner organizations through a process to strengthen institutional capacity. The <i>HICD Handbook</i> includes tools to guide a comprehensive analysis of organizational performance to identify gaps and introduce solutions to close those gaps. <i>Appendix 1.7: Sample Questions for Identifying Performance Gaps</i> (page 45) of the <i>HICD Handbook</i> , available at the link above, provides a useful set of questions for leading a discussion to identify performance gaps related to information, resources, incentives, and skills and knowledge at facilities. This tool is more of an overall organizational development model and may or may not fit the specific needs at site level.
When to use the tool	Use this tool when leading or guiding a discussion with facility staff to identify performance gaps related to information, resources, incentives, and skills and knowledge at facilities.
How to use the tool	Use the questions included in <i>Appendix 1.7: Sample Questions for Identifying Performance Gaps</i> (page 45) of the <i>HICD Handbook</i> , available at the link above, to lead a discussion or conduct a survey with facility staff to identify performance gaps.

Tool 2.d: Health Facility Human Resources Management Scorecard

Hyperlink	https://www.capacityplus.org/files/resources/hrm-assessment-approach.pdf
Description	The health facility scorecard helps facilities examine the status of existing HRM systems and functionality. The tool is a self-assessment — staff rank their facility on several different components of HRM to better understand their HRM strengths and weaknesses.
When to use the tool	When a facility is trying to assess the strengths and weaknesses of the key components of HRM in their own facility.
How to use the tool	The overall approach to conducting assessments is described along with tools for use at the facility level.

Step 2. Identify Possible Workforce Problems

Tool 2.e: The Human Resource Management Rapid Assessment Tool for Health Organizations

Hyperlink	https://www.msh.org/sites/msh.org/files/hrm_tool_version_3_2012_final_webv.pdf
Description	This HRM rapid assessment tool offers a method for assessing an organization's HRM system and how well it functions. This tool helps users to develop strategies to improve the HRM system and make it as effective as possible. It is designed to be used in public and private health organizations.
When to use the tool	When trying to assess the functionality of different aspects of HRM at a facility and identify where improvements could be made.
How to use the tool	This tool assesses the overall organization and may need to be adapted to serve at a facility level to identify gaps or challenges with HIV service delivery.

Tool 2.f: Workload Indicators of Staffing Need (WISN)

Hyperlink	http://www.who.int/hrh/resources/WISN_Eng_UsersManual.pdf?ua=1
Description	The previous tools included in this toolkit were chosen for their simplicity and their ability to identify improvements that can be made utilizing the existing level of human resources. When a more in-depth assessment into workload pressure and staff allocation is necessary, consider using the Workload Indicators of Staffing Need (WISN) tool. The WISN tool was developed by the World Health Organization (WHO) to calculate optimal allocation and deployment of current staff nationally, regionally, and at district levels. The tool sets activity time standards for health workers, then makes calculations based on the work that is undertaken by health staff.
When to use the tool	Use this tool when a more rigorous, quantitative in-depth assessment into workload pressure and staff allocation is necessary. <u>In some cases, a WISN tool may have already been used, and WISN data could be reviewed.</u>
How to use the tool	The manual for implementing the WISN tool can be found at the link above. It requires downloading the WISN software and following the methodology as per the manual. <i>IMPORTANT: The WISN process is both time and resource intensive (in terms of cost and level of effort), but it may be a useful tool in regions or districts requiring comprehensive interventions.</i>

Interpreting Step 2 Data

PEPFAR implementing partners and other technical assistance providers work closely with facility managers and staff to gather, analyze, and interpret site-level HRH data and understand the context that result in the data points. Start by organizing data and results by category of health workforce problem, which are described in more detail below.

Categories of Workforce Problems

This toolkit uses four main categories of health workforce problems affecting workforce performance, productivity, and efficiency, since these are the areas that are often the least understood and addressed. These four categories guiding analysis are 1) health worker competency gaps, 2) low staff engagement, 3) poor allocation of staff and tasks, and 4) inefficient work processes, as shown in Figure 4 below. It should be noted that these workforce problems are frequently focused on at the facility level; however, as many HIV and other health services are community based, consider if these problems exist at the community level. In addition, the framework recognizes that there are critical nonworkforce problems that may influence access, availability, acceptability, and quality of HIV services, such as inadequate infrastructure, drugs, supplies or equipment, or low service demand.

Figure 4. Step 2 of toolkit process



The four categories of health workforce problems are:

1. Health worker competency gaps

Providers need to have the necessary competencies, defined as the capability to apply relevant knowledge, skills, and attitudes, to perform their role with a high degree of quality. When there are gaps in competency, performance and productivity will suffer.

Do the health workers have the right skills?

2. Low staff engagement

Staff engagement describes a health worker's state of mind when he or she is not only satisfied with his or her job but is motivated to do the work, committed to doing it well, and feels valued for doing it. Increased staff engagement has been associated with better performance and

Step 2. Identify Possible Workforce Problems

productivity, higher retention, and improved clinical measures.⁵ Motivation and job satisfaction are key components of engagement.⁶

Are the health workers motivated?

3. Poor allocation of staff and tasks

We use the term allocation to describe the number and skill mix of human resources available at a given facility and task distribution within facilities. This may or may not be in line with the workload at that facility or community and disease burden or health needs of the population. For example, in facilities with low workloads, allocated health workers may be underutilized, while in high-workload facilities, there may not be enough health workers to meet client needs. In some facilities, clinical officers provide counseling when that task could be delivered instead by trained counselors, peers, or even experienced clients. Provider allocation of tasks among staff can impact performance and productivity. Similarly, with the growth of community-based workers, particularly for the identification of HIV-positive individuals or linked with ART adherence, the ratio of workers to patients may not be optimized.

Do we have enough of the right health workers performing the right kinds of tasks?

4. Inefficient work processes

Work processes include how services are organized and the resulting client flow through the health facility, as well as the use of appointment systems to manage client load throughout the working hours of the facility. Inefficient work processes have implications for both performance and productivity of facility-level health workers. Inefficient work processes can also result in inappropriate use of time by staff.⁷ For example, evidence has shown that clinicians in resource-poor settings frequently spend limited amounts of time at the clinic site, with a large portion of the clinic time taken up by tasks that do not require specialized patient care skills.⁸ Procedures should also be in place to mitigate any expected or unexpected absenteeism or tardiness.

Are health workers' tasks well organized?

Effective data collection and visualization helps build a shared and evidence-informed understanding of the challenge and its root causes, a deeper commitment to the possible solution, and a greater willingness to change. Most PEPFAR-supported facilities have a technical assistance or service delivery partner who can provide hands-on assistance to facilitate data collection, review, interpretation, and use.

With Step 2 tool results and secondary HRH data review, you may have a range of information to consider. To interpret this data, ask yourself:

⁵ Wellins RS, Bernthal P, and Phelps M. 2007. Employee Engagement: The key to realizing competitive advantage. Development Dimensions International, Inc. Available at www.ddiworld.com. Harter JK, Schmidt FL, and Hayes TL. 2002. Business-unit-level relationship between employee satisfaction, employee engagement, and business outcomes: A meta-analysis. *Journal of Applied Psychology*, 87(2), 268-279.

⁶ Ikram AN, Broughton E. 2012. Exploring the relationship between engagement, performance, and retention of health workers delivering HIV/AIDS services in Tanzania. Health Care Improvement Project. Available at https://www.usaidassist.org/sites/assist/files/tanzania_health_worker_engagement_study_protocol_5th_jan_2012_doc_-_urc_review.pdf.

⁷ Wagner G, Ryan G, Taylor S. Formative evaluation of antiretroviral therapy scale-up efficiency in Sub-Saharan Africa, *AIDS Patient Care STDs*, 2007, vol. 21 (pg. 871-87)

⁸ Were MC, Sutherland JM, Bwana M et al. Patterns of care in two HIV continuity clinics in Uganda, Africa: A time-motion study. *AIDS Care*. 2008 Jul;20(6):677-82

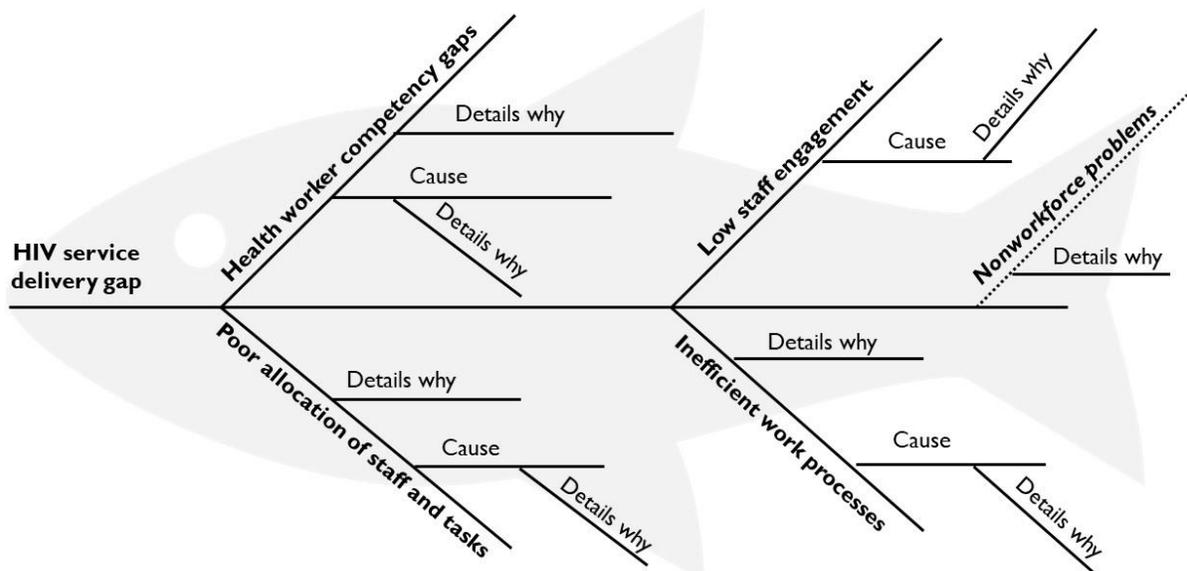
Step 2. Identify Possible Workforce Problems

How do workforce problems seem to be affecting HIV service delivery? Which problem(s)?

- Do the health workers have the right skills?
- Are the health workers motivated?
- Do we have enough of the right health workers performing the right kinds of tasks?
- Are health workers' tasks well organized?

List out all the workforce problems that you may have identified by using Step 2 tools. Then use the fishbone diagram (see Figure 5 and Tool 2.g description on the following page) to organize and categorize the problems to consider for further analysis (Step 3) and action (Step 4). The “Five Whys” (Tool 2.h) can further help to understand potential health workforce problems.

Figure 5. Fishbone diagram adapted for health workforce problem analysis



Tool 2.g: Fishbone Diagram	
Hyperlink	http://siteresources.worldbank.org/WBI/Resources/213798-1194538727144/9Final-Fishbone.pdf
Description	<p>The fishbone diagram is a team brainstorming tool used to identify potential (or actual) underlying or root causes to problems. In a typical fishbone diagram, site-level HIV service delivery gaps represent the “need” and is placed at the “fish head” (see Figure 5 above).</p> <p>The categories of problems are then laid out along the “bones” and classified into different themes along the branches. We recommend using the workforce categories of: health worker competency gaps; poor task allocation among staff; low staff engagement; and inefficient work processes. Additional categories can be added as well, including nonworkforce problems that affect HIV service delivery (see Figure 5 above).</p>
When to use the tool	Use this tool to identify <u>all possible</u> underlying causes for a problem when a visual mapping of the problem may be productive. It is most useful when you are trying to assess the scope or breadth of underlying causes.

Step 2. Identify Possible Workforce Problems

	<p>Specific to this toolkit user’s needs, the fishbone diagram is a useful tool to engage site-level stakeholders to identify the root causes of their workforce problem for a collective appreciation of the multiple and potentially diverse underlying factors that contribute to the problem. It may also be helpful to include the nonworkforce–related problems to appreciate their effect on workforce issues. During group work to elaborate the fishbone diagram, you may develop a greater understanding of the relative magnitude of the underlying factors, for example, an understanding of the extent to which health worker competency gaps versus lack of equipment or drugs affect performance.</p>
How to use the tool	<p>This tool can be used with the site managers and staff in a participatory manner. The proposed use of the fishbone diagram for this toolkit is described in the steps below:</p> <ul style="list-style-type: none"> • Generate a clear, concise statement of the need(s), such as a service delivery gap that inhibits the achievement of the 95-95-95 targets. Make sure that everyone in the group agrees with the need as it is stated. • Using a long sheet of paper, draw a line horizontally along the page. This line will be the "spine" of the fish. Write the need along the spine, on the left-hand side. • Draw four lines at a 45-degree angle along the spine of the fish. Label each "bone" one of the four health workforce problem categories (See Figure 5 above). • Discuss the HRH information generated by any of the Step 2 tools (i.e., tools 2.a through 2.f of this toolkit). Consider listing out all health workforce problems or gaps identified by stakeholders in a brainstorming session on a separate piece of paper first. Then, review all problems and map them on the fishbone diagram according to the category they fall under. Use additional lines building off the four main "bones" to describe the causes and details for the problems. • When the group has come to the consensus that the diagram contains an adequate amount of information, analyze the diagram. Look for causes that are appearing in more than one section of the diagram. • Circle anything that seems to be a root cause for the need. Prioritize the root causes and decide how to act. This action may involve further investigating the root causes.

Tool 2.h: The Five Whys

Hyperlink	https://www.piutek12.org/images/5_Whys_Worksheet.pdf
Description	<p>The "Five Whys" is another simple brainstorming tool that can help teams identify the root causes of a problem so that your solutions address the root problem. Once a general problem has been recognized by a group of relevant stakeholders, ask yourselves the question "Why?" to drill down to the underlying or root causes of the problem. Asking "Why?" five times successively allows teams to move beyond obvious answers and consider less obvious explanations or causes.</p>
When to use the tool	<p>Using the "Five Whys" can deepen your understanding of the underlying causes of a workforce problem. This will help to ensure that any workforce interventions undertaken (Step 4) are identified to address a priority problem and its root cause. Use this tool when you have identified which <u>one specific</u> priority workforce problem you would like to address.</p>
How to use the tool	<p>The process is simple: First, define the problem. Then ask 'Why?' five times when you are trying to understand a problem.</p> <ul style="list-style-type: none"> • There is nothing special about asking five times. The point is to keep asking until you are sure you have the real problem rather than simply being satisfied with the first answer. • Often, patients or families have the answers. If you want to know why patients are acting in a certain way, ask them. • Sometimes three questions are enough—and sometimes you need to ask more than five. You will know when you have reached your final "why" when it does not make sense to ask "Why?" again. • The following illustration shows how you can document the "Five Whys":

Step 2. Identify Possible Workforce Problems

Define the Problem:

Why is it happening?

1.

Why is that?

2.

Why is that?

3.

Why is that?

4.

Why is that?

5.

Identified Root Cause:

Reminder:
✓ You don't want to list 5 different reasons; you want to go deep on one reason.

Caution:
✓ If your last answer is something you can't control, go back up to the previous answer on one reason
✓ Final answer cannot be because of a person



Health workers and HRH2030 program staff analyze and discuss facility-level data at the Ngombe Dispensary in Iringa Region, Tanzania, in July 2017.

Step 2 Case Study: Reviewing Data to Identify Potential Health Workforce Problems

The Oche Baba Medical Center then discussed how workforce issues might be influencing patients’ timely initiation from testing positively to initiating ART. They discussed whether the number and range of HRH available could potentially be impacting their results:

- For “HTS_TST_POS” (number of individuals who received HIV testing services, received their test results, and are seropositive), achievement of this result requires health workers across the range of tasks: HIV testing services, laboratory services, and community-facility linkages. However, these services appear to be successfully delivered, according to the monthly data (Graphs I and II, Step I Case Study, pages 15-16).
- For “TX_NEW” (number of adults and children newly enrolled on ART), the achievement of this result requires health workers across a range of all the tasks noted above plus ART initiation. This is the service that demonstrated reduced ART initiation results in May, per Graph II, page 16.

Because multiple cadres are involved in testing, community-facility linkages, and ART initiation, the facility manager suggested that they map task allocation for all cadres. The facility staff worked to collect some additional HRH data using adapted content from the [PEPFAR Rapid Site-Level Health Workforce Assessment Tool](#).

The staff then reviewed staff availability by task allocation to determine if that might have been impacting their ability to link newly identified individuals to treatment. The tool results provided them with a tally of the number of staff by cadre that were available for each task along the continuum of care (as shown in Table I below) over the past quarter. By creating a table of tasks and personnel by cadre, the team noticed that they had roughly the same number of staff conducting different tasks along the HIV cascade. The team confirmed that the facility’s staff roster had remained constant throughout the entire quarter, without any changes or significant absences of these personnel.

Table I. Staff providing HIV clinical services, by cadre and service type

Cadre	Task Allocation					Total by cadre
	HIV testing services	ART initiation	ARV refill	Laboratory services	Community-facility linkages	
Adherence support volunteers	0	0	0	0	4	4
Clinical officers	0	1	0	0	0	1
Laboratory technicians	0	0	0	1	0	1
Lay counselors	2	0	0	0	0	2
Nurses	0	1	1	0	0	2
Pharmacy technicians/technologists	0	0	1	0	0	1
Psychological counselors	1	0	0	0	1	2
Other	0	0	0	1	0	1
Total by task	3	2	2	2	5	14

The Oche Baba Medical Center staff further reviewed the PEPFAR Rapid Site-Level Health Workforce Assessment Tool in its entirety to identify potential workforce problems and to review how the available staff contributed to community-facility linkages and ART initiation (i.e., the HIV service delivery gaps of concern). Additional sections of the tool noted the staff availability in terms of

Step 2. Identify Possible Workforce Problems

the average number of hours delivering HIV services and whether the services are delivered in the facility or community. In addition, it includes facility manager perceptions of workforce performance management and HRH barriers. Based on this information, it was not known which workforce problems specifically affect the health workers tasked with community-facility linkages and ART initiation.

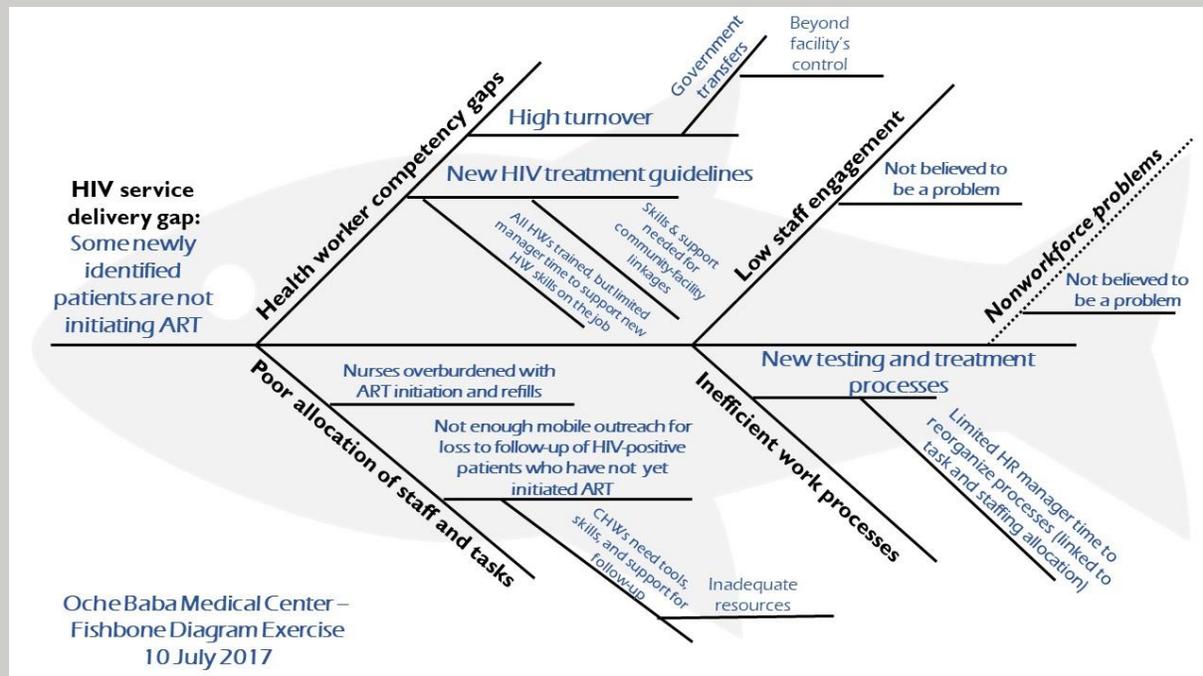
Interpreting Step 2 Data

The staff continued to explore the workforce problems for those health workers within those HIV service areas, discussing which category or categories of health workforce problems there may be. They asked themselves:

What workforce problem(s) may be contributing to the service delivery gap in ART initiation? Could the problem be classified as:

- Health workforce competency gaps? *Do the health workers have the right skills?*
- Low staff engagement? *Are the health workers motivated?*
- Poor task allocation among staff? *Do we have enough of the right health workers performing the right kinds of tasks?*
- Inefficient work processes? *Are health workers' tasks well organized?*
- Or a combination of these?
- Or other nonworkforce-related factors?

The staff listed out the problems as they were perceived. Then they organized them by category on the fishbone diagram, shown below:



Health workforce competency gaps? With the new national HIV guidelines released last year, multiple staff members had recently completed trainings at the district and national levels. However, several staff members who had been trained noted that since their on-site supervisor had not yet also

Step 2. Identify Possible Workforce Problems

been trained, it was hard for him to support their skills. How well were staff applying their newly acquired skills? The staff recognized that patients receiving their test results through mobile outreach may be the ones lost to follow up for ART initiation, so the capacity of the community-based cadres was important. What about the skills of the community-based adherence support volunteers?

Do the health workers have the right skills? – Not sure. They noted that “health workforce competency gaps” could be a possible workforce problem, but they still had questions and wanted to understand more.

Low staff engagement? Staff attested that many were really motivated to help their communities. They remembered what it used to be like when an HIV diagnosis equaled a death sentence. Many staff shared how empowered and confident they now felt, being able to witness patients on lifesaving treatment stabilize and continue productive healthy lives. They also all felt supported and encouraged by the community leaders within the facility catchment area to do their work. While staff turnover was higher than they would prefer, it was more related to government-mandated transfers beyond their control, not due to low motivation. Other absences noted in the survey — for the national trainings, workshops, maternity or annual leave — were to be expected.

Are the health workers motivated? – Yes. Staff felt that “low staff engagement” was not a health workforce problem that was contributing to the Oche Baba Medical Center’s HIV service delivery gap.

Poor allocation of staff and tasks? With more than one health worker per task within HIV services (per Table 1, the facility has a relatively even distribution across tasks in both the facility and community. However, specific to ART initiation (allocated to one clinical officer and one nurse), was this a problem? The current approach was not achieving desired results. What about for referrals and linkages to care? Did the task allocation respond to patient flow and demand? Possibly. There were four adherence support volunteers, one for each community within Oche Baba’s catchment area. The client flow between the community and the facility was unclear. What should they be doing better?

Do we have enough of the right health workers performing the right kinds of tasks? – Not sure, but it seemed that community linkages and ART initiation staffing and/or tasks might need improving. The staff agreed that “poor allocation of staff and tasks” could be a possible workforce problem.

Inefficient work processes?

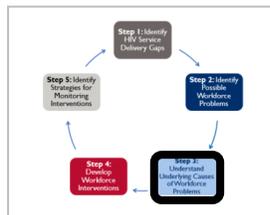
Staff discussed at length and concluded that there could be some inefficient work processes for specific tasks, especially from community testing to the facility because they were new protocols, but they could not pinpoint them. Managers were not sure what more they could be doing to improve efficiencies. As such, they agreed to dig deeper and try to see if/how current processes were affecting services.

Are health workers’ tasks well organized? - Partially. Staff agreed that “inefficient work processes” may be contributing to the HIV service delivery gap; however, they wanted to explore this more in Step 3.

Finally, the staff confirmed that there were not any nonworkforce, or systemic, challenges affecting ART initiation (e.g., drugs and supplies, community trust, or infrastructure issues). The staff concluded that they would proceed to identify underlying causes of the three potential health workforce problems through more in-depth review (Step 3).

Step 3: Understand Underlying Causes of Workforce Problems

Overview of Step 3



Once the service delivery and workforce data are collected in Step 2, they should be reviewed both independently and together to identify specific workforce problems that may be impacting the facility’s HIV service provision.

Building on Step 2 data and insights, the Step 3 tools are intended to help users understand the underlying causes of the workforce problems as well as to gather more robust data to enhance this understanding.

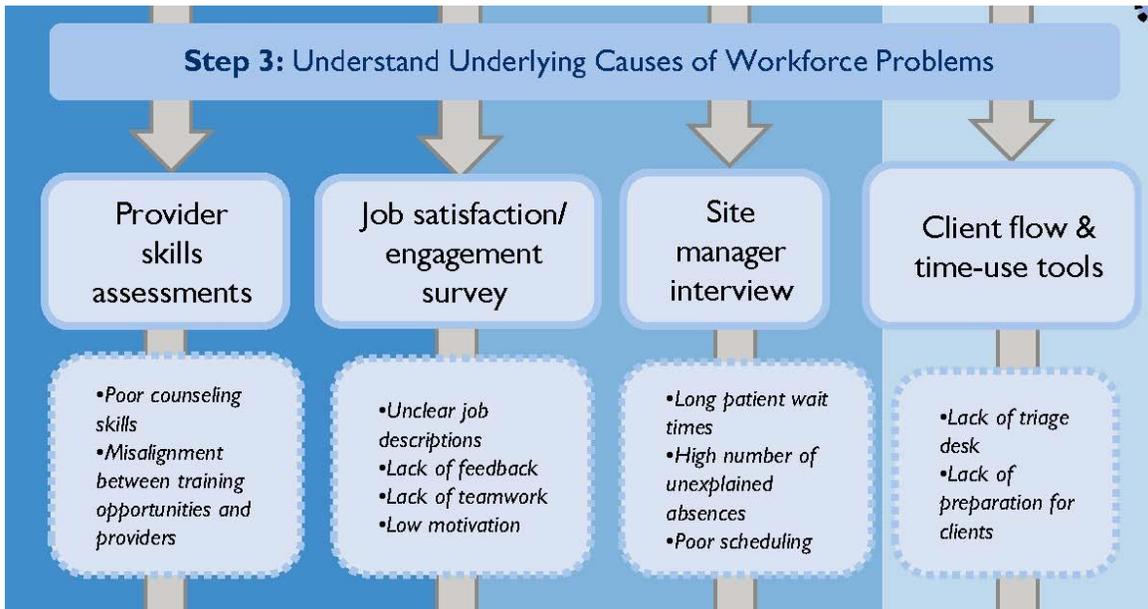
Workforce problems may include limited total numbers of individuals or specific cadres, health worker competency gaps, low staff engagement or morale, poor allocation of staff and tasks, and inefficient work processes or flows. The data collected in Step 2 help to provide a general idea of which of these workforce problems are contributing to HIV service delivery gaps. The data collected in Step 3 — which may include less quantitative data and more qualitative perceptions of why or why not activities are taking place — will further clarify the priority workforce problems and their underlying causes.

Identifying workforce problems and their underlying causes is frequently an iterative process. It is necessary to dig deeper than just the initial perception of the issues to understand the root of the problems or challenges, since there may be multiple root causes that require intervention. Identifying appropriate solutions to challenges/problems relies on knowing what the underlying causes are and not just addressing the symptoms.

As described in Step 2, a facility may face both workforce and nonworkforce problems, such as issues with client demand, inadequate supplies, equipment, and infrastructure. As noted earlier, this toolkit is intended to focus on health workforce issues, as other toolkits and materials provide detailed information on addressing other health system factors. Figure 6 also provides an illustrative example of some underlying causes that can contribute to workforce problems. Gathering additional workforce data using the tools referenced below will help determine which of the workforce problems are contributing to HIV service delivery gaps as well as the underlying causes. These information points will help to better inform development of appropriate interventions at the site level.

Step 3. Understand Underlying Causes of Workforce Problems

Figure 6. Step 3 of toolkit process; illustrative tools and potential underlying causes



Tools for Step 3

The tools included in this section can be used by site staff to better understand underlying causes for the workforce problems contributing to the HIV service delivery gaps at the facility. These tools can help gather more robust data that will provide a fuller picture of the specific root causes for the identified workforce problems. They are arranged by problem category (see Figure 6). You do not need to apply all the tools listed but rather use only the tools most relevant to the underlying causes of workforce problems identified through the fishbone diagram and/or the “Five Whys” (Step 2). Be sure to adapt and pretest any tools to your specific context.

Tools for Workforce Problem: Health Worker Competency Gaps

Health workers’ performance is contingent on their knowledge and skills to effectively perform their work. Frequently, there are gaps between what health care workers know and what they need to know to achieve high performance standards. Assessing health worker competence requires a clear understanding of the necessary skills, abilities, and knowledge that are needed by an individual health worker to perform his or her job. The following tools help to assess health worker competence to identify areas for targeted capacity building such as mentoring, training, continuing education, or other approaches.

Tool 3.a: Provider Skills and Competency Assessment	
Hyperlink	http://www.go2itech.org/HTML/CM08/toolkit/tools/tools_skills.html
Description	The tools at the link above were developed by I-TECH for use by clinical mentors to establish a baseline of a provider’s clinical skills and competencies in delivery of care and treatment services; identify gaps and areas in which additional training and support are needed; and track improvement in service delivery over time. The checklists should be adapted to fit the specific country and service delivery context in which they are used, since different cadres may have different job functions across countries.

Step 3. Understand Underlying Causes of Workforce Problems

When to use the tool	When inadequate health worker competency has been identified as a cause of existing service delivery gaps.
How to use the tool	The link above shows various assessment checklists available. Select the assessment checklist that best reflects the type of providers being assessed (e.g., physicians, nurses, pharmacists, etc.). These tools are more appropriate for use by personnel able to mentor facility staff.

Tool 3.b: Rapid Task Analysis Questionnaire

Hyperlink	https://www.hrh2030program.org/wp-content/uploads/2018/06/Rapid-Task-Analysis-Tool.pdf
Description	Alignment of competencies and skills ensures that health workers are prepared to work with clients on specific issues or topics of need, such as counseling for voluntary HIV testing and counseling. The rapid task analysis approach can help identify health worker competencies in HIV/AIDS services. The results can be used to inform in-service training policy initiatives and stimulate dialogue around how to ensure that clinical skills and provider-assigned tasks and responsibilities match population health needs.
When to use the tool	Use when you are unsure if health workers have sufficient knowledge and the applied skills to provide quality HIV services according to the standard of care. It could be used to assess priorities for training or additional on-the-job support.
How to use the tool	You may choose to administer the rapid task analysis for one health worker cadre, or the range of cadres supporting the low-performing HIV service(s) of concern. Once these parameters are defined, then adapt the tool by integrating the key tasks, so you have one tool, or form, for each health worker cadre in question. Some tasks performed by more multiple health worker cadres may be listed on each of their forms. It is recommended that you use tasks as outlined in existing documents, such as job descriptions, national guidelines, or standards of care. To keep the form “rapid”, limit the number of tasks per cadre to no more than 10. To learn more about how the rapid task analysis has been used in Madagascar and Cameroon, go to: https://www.hrh2030program.org/webinar-rapid-task-analysis/ For Madagascar report, go to: https://www.hrh2030program.org/rapid-task-analysis-in-madagascar/

Tools for Workforce Problem: Low Staff Engagement

If issues related to low health worker satisfaction, engagement, or motivation have been identified as the underlying causes of service delivery gaps in facilities you support, the tools below can provide additional data on how these problems are impacting HIV service provision. Based on the information gleaned from these tools, specific interventions to address the underlying causes can be developed.

Tool 3.c: Health Worker Engagement Questionnaires

Hyperlink	https://www.usaidassist.org/sites/assist/files/usaid_assist_health_worker_engagement_assessment_english.pdf See additional questionnaire template links under the “How to use the tool” section below.
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Step 3. Understand Underlying Causes of Workforce Problems

Description	These tools are used to examine underlying causes that affect a health worker's satisfaction, engagement, or motivation to inform activities to improve the work environment, management, and working conditions. ⁹
When to use the tool	When issues related to health worker satisfaction, engagement, and /or motivation have been identified as underlying causes of service delivery gaps.
How to use the tool	<p>The questionnaires can be used as is or adapted to collect additional data about the work environment, management, and working conditions of those providing HIV services.</p> <p>To collect additional data about the work environment, management, and working conditions of those providing HIV services, see this additional questionnaire on pages 51-53 (labeled in the document as F-1 through F-3). http://www.urchs.com/sites/default/files/TanzaniaBaselineAssessmentReport_Mar2011.pdf</p> <p>The draft tool in the link below was used as part of a baseline assessment to develop workforce interventions to improve health worker retention in Tanzania. It is brief, simple, and straightforward, allowing for application in a variety of settings to gain a deeper understanding of the levels and underlying causes of job satisfaction and engagement of health workers at a facility. http://pdf.usaid.gov/pdf_docs/PA00JZHN.pdf</p>

Tool 3.d: Satisfaction and Motivation Questionnaire Examples

Hyperlinks	<p>Health worker satisfaction survey (one page, see Figure 1 and Table 1): http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0079053</p> <p>Health worker satisfaction (French questionnaire): https://static-content.springer.com/esm/art%3A10.1186%2F1478-4491-11-30/MediaObjects/12960_2012_347_MOESM4_ESM.doc</p> <p>Found under <i>Electronic Supplementary Material</i> in the study entitled <i>Developing a tool to measure satisfaction among health professionals in sub-Saharan Africa</i>: http://human-resources-health.biomedcentral.com/articles/10.1186/1478-4491-11-30</p> <p>Health worker motivation (see Table 3): https://human-resources-health.biomedcentral.com/articles/10.1186/1478-4491-7-40</p>
Description	Several questionnaires on health care worker satisfaction/motivation that have been validated in low-income country settings are available in published literature. These questionnaires are not available as stand-alone tools, but the questions can be extracted from the articles linked above for adaptation and application in other settings.
When to use these examples	When developing questionnaires to gather more data related to health worker satisfaction and/or motivation.
How to adapt examples in your tools	Consider incorporating relevant questions from the questionnaire templates in the surveys above as you query the facility to better understand the underlying causes of employee satisfaction, motivation, and/or engagement.

⁹ For example, in collaboration with the Tanzania Ministry of Health and Social Welfare, the USAID Health Care Improvement Project (HCI) designed a baseline assessment of HIV/AIDS service providers to gather information on productivity and engagement.

Step 3. Understand Underlying Causes of Workforce Problems

Tools for Workforce Problem: Poor Allocation of Staff and Tasks

Allocation of health workers within a facility is an important workforce problem that can contribute to service delivery gaps. For example, if most health care workers are assigned to counseling new clients when there are fewer new clients than returning clients coming to care and treatment, there is an inappropriate allocation of health workers at that facility. The tools below can provide data on staff allocation.

Tool 3.e: Baseline Assessment of HIV Service Provider Productivity and Efficiency in Uganda - Appendix: Site Manager Interview	
Hyperlink	https://www.usaidassist.org/sites/assist/files/uganda_hiv_service_provider_productivity_efficiency_baseline_2010.pdf
Description	The site manager interview tool can be used to gather information on services provided, structure of services, staffing structures, HRM systems, and client load to better understand if staff allocation matches the need.
When to use the tool	When productivity has been identified as a cause of service delivery gaps at the facility.
How to use the tool	The Site Manager Interview can be found on pages 18-21 of the <i>Baseline Assessment of HIV Service Provider Productivity and Efficiency in Uganda Technical Report</i> at the link above.

Tool 3.f: Baseline Assessment of HIV Service Provider Productivity and Efficiency in Uganda - Appendix: Health Worker Productivity Interview	
Hyperlink	https://www.usaidassist.org/sites/assist/files/uganda_hiv_service_provider_productivity_efficiency_baseline_2010.pdf
Description	This tool allows the technical assistance provider to better understand the barriers to productivity for health care workers at a specific facility.
When to use the tool	When productivity has been identified as a cause of service delivery gaps at the facility
How to use the tool	Use the <i>Health Worker Productivity Interview</i> on pages 22-24 of the <i>Baseline Assessment of HIV Service Provider Productivity and Efficiency in Uganda Technical Report</i> at the link above.

Tools for Workforce Problem: Inefficient Work Processes

Wait times and client flow can have a significant impact on patient satisfaction and, therefore, retention in care. If patients must wait for long periods of time for services, they are less likely to return for regular visits. It is challenging to know how much time patients spend waiting for services without direct observation. The following tools collect information on how services are organized, how clients move from one service to another, how long they wait for services, how much time they spend with providers, as well as caseload per provider per day, all through direct observation. This information will help identify where to target appropriate interventions to organize work processes more efficiently.

Likewise, how workers at a given facility spend their time impacts appropriate allocation of tasks among staff. Increasing the productivity of health workers can be a cost-effective way to improve health system capacity and performance. While the definition of productivity is simple — the ratio of outputs to inputs — no widely accepted “gold standard” measure of health workforce productivity has been identified in

Step 3. Understand Underlying Causes of Workforce Problems

the literature. Health worker productivity has been measured in a variety of ways, including assessments of health facility absenteeism or observations of the proportion of time health workers spend providing clinical care services as compared with administrative or management activities. The time-use tools below provide detailed information on how workers at a given health facility spend their time, allowing technical assistance providers and facilities to develop targeted interventions to address productivity gaps and reorganize time and services as necessary.

Tool 3.g: Process Mapping/Workflow Analysis	
Hyperlink	https://www.usaidassist.org/sites/assist/files/tipstoolsimprovement_flowchart_may_30_ada.pdf
Description	Process mapping allows a team to visually represent key processes at their clinic as well as bottlenecks and areas where roles and responsibilities may be unclear. Based on your data review, choose one priority process to draw out with the facility team. It is essential that a multidisciplinary team take part in the process mapping exercise to adequately represent the entire process.
When to use the tool	Use this tool when identifying processes related to a priority problem and a visual mapping of the process may be productive. This tool is particularly useful to visualize redundancies and/or gaps in workflow processes at the facility level.
How to use the tool	Process mapping and workflow analysis are commonly used tools for problem identification and quality improvement, and there are many available descriptions and references. The link above is one of many descriptions of how to apply process mapping for problem identification.

Tool 3.h: Client Flow Assessment Examples	
Hyperlinks	<p>The <i>Client Flow Form</i> can be found on page 13 of the <i>Evaluation of the Costs and Benefits of an HIV Care Coverage Improvement Collaborative in Uganda Research and Evaluation Report</i> here: http://www.urc-chs.com/sites/default/files/Cost-benefitEvaluationoftheUgandaHIVCoverageCollaborative_June2011.pdf</p> <p>The <i>Client Flow Assessment Tool</i> can be found on page 54 (labeled in the document as G-1) of the <i>Baseline Assessment of HIV Service Provider Productivity and Efficiency in Tanzania Technical Report</i> here: http://www.urc-chs.com/sites/default/files/TanzaniaBaselineAssessmentReport_Mar2011.pdf</p>
Description	Client flow assessment tools document the amount of time one patient spends in different service areas during one visit as well as the amount of time the patient spends waiting for those services. Analysis of this information allows for identification of efficiency bottlenecks in the flow of clients through a facility.
When to use the tool	The impact of problems with client flow can manifest in long wait times or low efficiency/productivity of health care workers. If any of these have been identified as causes of service delivery gaps at facilities, using the client flow assessment tool will help identify the specific location of bottlenecks in client services to develop interventions to address them.
How to use the tools	Follow instructions of forms to track the times of service start and completion by task and health care provider.

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Tool 3.i: Time Utilization Observation Form	
Hyperlinks	See below for specific uses.
Description	These tools allow for observation of health care workers to document how they are spending their time. While most facilities may want to assess the time use of facility-based health staff, there may be situations where time-use studies may be useful with other cadres, such as community-based health providers or district health managers. Below are links to two examples of time-use tools for other cadres available from the published literature.
When to use the tool	When productivity has been identified as a cause of service delivery gaps at the facility and there is a need to understand how health care workers are spending their time to develop an appropriate intervention.
How to use the tool	<p>Use the <i>Time Utilization Observation Form</i> on page 48 (labeled in the document as E-1) of the <i>Baseline Assessment of HIV Service Provider Productivity and Efficiency in Tanzania Technical Report</i> at the link below to document how health care workers are spending their time in one-hour increments.</p> <p>http://www.urc-chs.com/sites/default/files/TanzaniaBaselineAssessmentReport_Mar2011.pdf</p> <p>The time-use tool for district health managers can be found by accessing the Time-Use Study at this link: http://journals.plos.org/plosone/article/file?type=supplementary&id=info:doi/10.1371/journal.pone.0130633.s001</p> <p>Additional context is provided in the article “What Do District Health Managers in Ghana Use Their Working Time for? A Case Study of Three Districts,” found at this link: http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0130633</p> <p>The time-use tool for health extension workers can be found by accessing the Self-Reported Diary and List of Activities at this link: https://static-content.springer.com/esm/art%3A10.1186%2F1478-4491-12-61/MediaObjects/12960_2014_453_MOESM1_ESM.docx</p> <p>Additional context is provided in the article “How do health extension workers in Ethiopia allocate their time?” at this link: http://human-resources-health.biomedcentral.com/articles/10.1186/1478-4491-12-61</p>

Step 3 Case Study: Understanding Underlying Causes of Workforce Problems

With Step 2 identifying the potential workforce problems of **health worker competency gaps, poor allocation of staff and tasks, and inefficient workforce processes**, the Oche Baba Medical Center staff focused on ways to better understand them. They decided to conduct a rapid task analysis for pre-ART/initiation and referrals (Tool 3.c) and client flow mapping (Tool 3.h).

Through the rapid task analysis, the team found that:

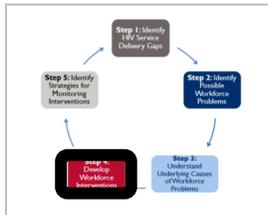
- Adherence support volunteers expressed some knowledge and confidence to conduct referrals for ART initiation in communities after mobile outreach, as they were already doing this informally. However, none had been trained on supporting referrals.
- Nurses have been formally trained and authorized to manage stable ART patients. While all three nurses at Oche Baba expressed confidence managing ARV refill recordkeeping duties, they were still relying on the clinical officer to conduct all ARV refill consultation for stable patients, which overburdened her.
- At present, the nurses were assigned to follow up on any patients lost after their HIV-positive test follow-up. However, as these nurses were also responsible for supporting ART initiation and refills, which were newly acquired tasks that they were mastering, they were becoming overburdened and did not have time to conduct follow-up in the community.

Through the client flow mapping, the team found that:

- Some newly identified HIV-positive clients were verbally referred to initiate treatment but were not escorted to the treatment clinic because nurses did not have time to walk with them. For community-based referrals, there were not staff or lay counselors identified or available to accompany referred patients to the treatment clinic. Currently, community-based staff did not capture the contact information of patients being tested at mobile clinics so facility-based staff could follow up with them as needed.
- ART initiation can only be done by the clinical officer, as she is the one with formal training in this. As such, new ART patients must wait a long time when the clinical officer is pulled to address an emergency. One patient observed waited three hours but did not stay to complete the consultation. (Upon learning this through the client flow mapping, facility staff did follow up with this patient to be sure ART initiation was completed.)
- Excess time was spent by clients waiting for ARV dispensation at the pharmacy.
- ARV dispensation was the first point of contact that a new patient had with the adherence support volunteers.

Step 4: Develop Workforce Interventions

Overview of Step 4



After the staff at a facility or point-of-service intervention have analyzed their data and identified the major workforce problem(s) and underlying causes contributing to service delivery gaps, the next step is to work together in developing the appropriate interventions that will address the cause of the workforce problems.

Frequently the perceived solutions to HRH challenges are to wait/fill staffing gaps or to suggest training needs, but many workforce problems contributing to service delivery gaps can be improved with no or few additional resources or external support even in sites that have staffing gaps.

The intervention development process should be collaborative and engage with staff at each step to maximize their buy-in and commitment to the interventions.

The figure below lists common facility-level workforce interventions that have shown promise in addressing key workforce problems affecting service delivery outcomes and that can also be used at other point-of-service interventions (e.g., community-based services). The intervention ideas listed below will need to be modified and adapted for the specific context of each situation, and staff involvement will be essential in identifying those modifications. Note that the interventions listed here are organized by the four main categories of workforce problems: 1) competency gaps, 2) low staff engagement, 3) poor allocation of staff and tasks, and 4) inefficient work processes.

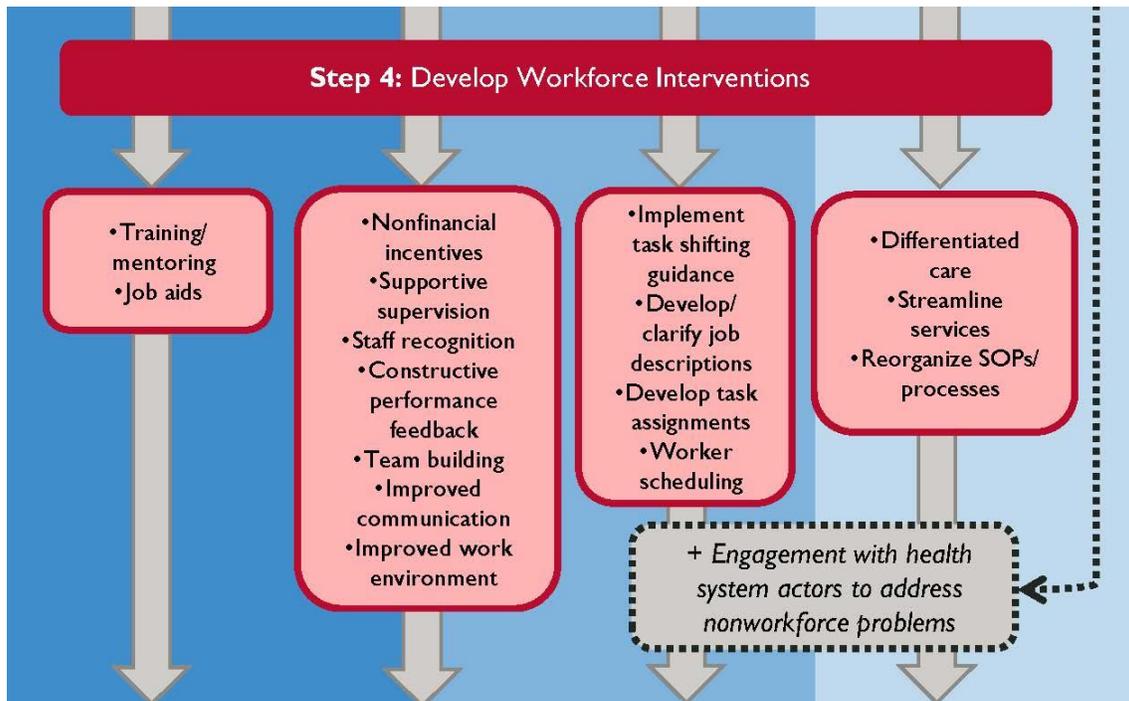
Tips for supporting facilities to select and adapt an intervention

- ✓ Interventions, when chosen by the facility staff themselves, have a much higher likelihood of being successfully implemented.
- ✓ Start with changes that can be made quickly in the facility or changes that do not require extensive new resources or permission from higher levels.
- ✓ Think creatively!

For PEPFAR-supported facilities, implementing partners can incorporate such engagement as part of routine technical assistance and support for quality improvement, supportive supervision, and clinical mentorship.

Step 4. Develop Workforce Interventions

Figure 7: Step 4 toolkit process: Illustrative interventions for workforce problem categories



Potential Interventions for Step 4

This section presents categories of potential interventions to consider, organized by the type of workforce problem to be addressed. Appropriate interventions need to be rooted in the reality of the context and will likely differ in every facility to which they are applied. When selecting appropriate interventions, recognize that a thorough analysis of the underlying causes, as described in Step 3, is essential to ensure you are solving the real root of the workforce problems. Consider the people the interventions will affect, the cost of implementing the intervention relative to the budget available, and the time it will take to show results. The proposed interventions have been selected as they require minimal resources.

IMPORTANT: Involve health workers and other stakeholders to identify which interventions could be overseen by the health worker team itself. When health workers participate in identifying problems and developing solutions, then the solutions are more likely to succeed and be sustained.

The CapacityPlus [Health Worker Productivity Analysis and Improvement Toolkit](#) includes resources on how to share results with health facility teams and solicit their feedback.

Many of these interventions are widely supported across PEPFAR programs. Additional examples and descriptions of recommended interventions can be found in the CapacityPlus Health Worker Productivity Analysis and Improvement Toolkit, [Stage 4, Step 2](#). Consider the importance of better supporting the appropriate and effective implementation of these interventions.

Step 4. Develop Workforce Interventions

Strengthening Health Worker Competency

When the underlying causes for service delivery gaps are related to health worker competency gaps, consider the interventions listed below.

Intervention 4.a: Competency-based In-service Training	
Description	While training is a common solution when competency gaps are identified, training is resource intensive and not always focused on improving and testing specific competencies. In-service trainings to improve skills and competencies are most effective when combined with interventions to facilitate and reinforce those skills in everyday work.
When to use the intervention	Use when skill and competency gaps exist, when a high-quality, competency-based training curriculum exists (or when a curriculum can be easily adapted), resources are available, and when other options have already been considered.
How to use the intervention	<p>Consider using the following examples of training:</p> <ul style="list-style-type: none"> • Select motivated health workers (i.e., trainees) to complete a training that is directly relevant to their work • Provide on-the-job or “just in time” refresher trainings on certain topics; on-the-job trainings also reduce health worker shortages due to off-site trainings • Provide “low dose, high frequency” training on topics that emerge as gaps • Identify highly skilled health care workers at a site to provide clinical mentoring to less skilled staff • Develop an on-boarding process for new staff to ensure that their skills and competencies are adequate to provide high-quality care • If appropriate to the skill/competency gap (see section below on job aids), develop job aids to support health care worker performance • Ensure that health care workers with an identified competency gap are prioritized for additional training in that area • Ensure tracking of training needs • Schedule required off-site training to mitigate time away from facility <p>Additional evidence-based references provided in Annex 1: 12, 17.</p>

Intervention 4.b: Improving Mentoring	
Description	<p>Mentoring, which involves engaging a collegial relationship between a mentor and mentee health workers, can have a positive effect to reinforce the skills and competencies of the mentee. The mentor is a champion of the skill/competency and can help to support the mentee address on-the-job challenges to improve performance.</p> <p>It is important to ensure a good match between mentor and mentee. A supervisor or district manager could initiate or recommend less structured or formal mentoring during supportive supervision. Longer-term mentoring programs may be more structured, with a signed agreement and specific mentoring goals.</p>
When to use the intervention	Use mentoring when there is the presence of a champion who has the knowledge and skills that respond to the facility’s unmet service delivery need. The availability and quality of the mentor is an essential element for successful mentoring.
How to use the intervention	Mentoring for Human Capacity Development: Implementation Principles and Guidance: https://www.mcsprogram.org/resource/mentoring-human-capacity-development-implementation-principles-guidance/

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	<p>The Clinical Mentoring Toolkit provides detailed guidelines and resources for conducting a basic three-day training to orient mentors on the following skills:</p> <ul style="list-style-type: none"> • Building relationships • Effective communication and feedback skills • Theories of learning; clinical teaching skills • Clinical diagnosis and decision-making skills • Addressing systems issues <p>https://www.go2itech.org/HTML/CM08/toolkit/training/index.html</p> <p>See the USAID Mentoring Guide as an example of a formal mentoring program: http://pdf.usaid.gov/pdf_docs/pbaab420.pdf</p> <p>For additional guidance on starting a mentoring program, go to: http://www.apsc.gov.au/publications-and-media/current-publications/gender-equality-strategy/implementation-strategy/toolkit/establishing-a-mentor-program</p>
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Intervention 4.c: Supporting More Supportive Supervision	
Description	<p>Supervision, if correctly done, is an effective strategy for providing professional development to health care workers to adhere to standards of care and quality for service delivery, as well as improving their job satisfaction and motivation. Supportive supervision, which is needs oriented, participatory, instructive, and provides direct and timely feedback, may be most effective at improving health care workers' performance by improving not only their knowledge and skills but also their motivation.</p> <p>Supervisors themselves may need support to learn how to provide appropriate supervision. It is also important to note that lay health care workers, such as peer counselors and community health educators, are frequently neglected in supervision systems. Be sure to include a mechanism for providing them with valuable supervision.</p>
When to use the intervention	<p>Use routinely to provide professional development and to address job satisfaction and motivation for all health care workers, especially when poor supervision is impacting staff motivation. <u>Supportive supervision can also be useful when “low staff engagement” is the health workforce problem.</u></p> <p>In addition, consider adding supervisor mentoring or peer-to-peer exchanges within your supportive supervision program.</p>
How to use the intervention	<p>Consider using the following examples of supportive supervision:</p> <ul style="list-style-type: none"> • Identify and train a few of the most senior members of the health facility staff to provide supportive supervision to lower-level health care workers • Discuss process of supervision with supervisors, ensure that feedback (positive and negative) is provided to health care workers during supportive supervision visits • Coworker mentoring support • Intersite supportive visits <p>Additional evidence-based references provided in Annex 1: 2, 7, 8, 13</p>

Intervention 4.d: Reinforce Use of Job Aids (also known as SOPs)	
Description	<p>A job aid serves as a reference tool for the health care worker. Job aids are effective when they include correct and well-communicated information in a format useful to the health care worker and are available at the time and location the health care worker needs it. For teams seeking to implement new guidelines and clinical protocols, such as for HIV, job aids can help recently trained health workers more effectively apply their new knowledge. Although evidence on the</p>

Step 4. Develop Workforce Interventions

	effectiveness of job aids on health care worker performance and productivity is limited, they do serve as a useful and timely prompt that can streamline service delivery processes and potentially improve efficiency.
When to use the intervention	Use job aids to provide a quick and timely reference for information that is hard to remember but important to follow. Introduce a job aid during an in-service training, then continue to reference it post training. If a supervisor or manager identifies a challenge for health workers to apply a specific skill, then the job aid should focus on this skill, including strategies for addressing the barrier to skill application.
How to use the intervention	Consider using the following examples of job aids: <ul style="list-style-type: none"> • Wall charts with key counseling messages in the counseling room • Reminders in consultation room to ask clients about adherence <p>Additional evidence-based references provided in Annex I: 16.</p>

Intervention 4.e: Introduce “Low Dose, High Frequency” Learning Approaches

Description	The standard approach of extended one-time off-site trainings has documented limited effectiveness on provider performance post training. “Low dose, high frequency” learning is interactive, with case-based learning, hands-on practice, and immediate performance feedback.
When to use the intervention	Use this approach when introducing or reinforcing a new practical skill. This approach is most effective when combined with coaching, supportive supervision, quality improvement initiatives where tasks and related service delivery results are tracked.
How to use the intervention	To read more about how the approach has been applied in clinical settings, see: https://hms.jhpiego.org/wp-content/uploads/2016/08/LDHF_briefer.pdf To read about how to transition training content to “low dose, high frequency” learning approaches, see <i>Trends in Healthcare Learning: Clinical Thought Leadership Series 2017 Report on Industry Trends - eBook</i> https://www.healthstream.com/resources/ebooks/ebooks/2017/05/19/ebook-trends-in-healthcare-learning

Increasing Staff Engagement

When the underlying causes for service delivery gaps are related to low staff engagement, consider the intervention categories listed below.

Intervention 4.f: Nonfinancial Incentives

Description	The WHO defines incentives as “all the rewards and punishments that providers face because of the organizations in which they work, the institutions under which they operate and the specific interventions they provide.” Incentives have been shown to be an important tool to motivate health workers to improve performance. Financial incentives can be an effective motivation for staff but are often not feasible in resource-limited settings. Nonfinancial incentives, such as performance-based recognition or further training, can provide motivation for health workers to improve their performance and may be more effective. These nonfinancial incentives can be categorized into four types: reward, recognition, opportunity, and flexibility. Nonfinancial incentives can be provided to individuals or teams within health facilities; team incentives can be a strategy to improve team strength. Small-scale nonfinancial incentive strategies can be implemented within a facility by its own management.
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When to use the intervention	Use nonfinancial incentives in resource-limited settings to motivate staff when a lack of incentive structures is impacting staff motivation.
How to use the intervention	<p>Consider using the following examples of nonfinancial incentives:</p> <ul style="list-style-type: none"> • Performance-based nonfinancial awards • Employee of the month program • Chance to lead team or certain tasks • Ability to transfer least favorite task to someone else (if appropriate) • Balancing workload among staff and teamwork • Provide supervisors with training on providing supportive feedback <p>Additional evidence-based references provided in Annex 1: 1, 2, 3, 12, 16.</p>

Intervention 4.g Feedback or Performance Appraisal

Description	Performance appraisal, or audit and feedback, is a reliable tool with consistent effect upon health care worker performance. Appraisals should be based on the job description and on clear and specific criteria that the health care worker knows in advance. This kind of routine performance review, with meaningful feedback, can build the trust relationship between a health care worker and his or her supervisor, increasing the health care worker's motivation.
When to use the intervention	Use to routinely provide feedback and maintain health care worker's motivation or when staff are not receiving timely feedback.
How to use the intervention	<p>Consider using the following examples of feedback or performance appraisal:</p> <ul style="list-style-type: none"> • Provide supervisors with training on providing supportive feedback • Support strengthening of systems for routine performance appraisals based on job descriptions <p>Additional evidence-based references provided in Annex 1: 2, 9, 10, 12, 16.</p>

Intervention 4.h: Supporting More Supportive Supervision

Description	<p>Supervision, if correctly done, is an effective a strategy for providing professional development to health care workers to adhere to standards of care and quality for service delivery, as well as for improving their job satisfaction and motivation. Supportive supervision, which is needs oriented, participatory, instructive, and provides direct and timely feedback, may be the most effective at improving health care workers' performance by improving not only their knowledge and skills but also their motivation.</p> <p>Supervisors themselves may need support to learn how to provide appropriate supervision. It is also important to note that lay health care workers, such as peer counselors and community health educators, are frequently neglected in supervision systems. Be sure to include a mechanism for providing them with valuable supervision.</p>
When to use the intervention	<p>Use routinely to provide professional development and to address job satisfaction and motivation for all health care workers, especially when poor supervision is impacting staff motivation. <u>Supportive supervision can also be useful when “health worker competency gaps” is the health workforce problem.</u></p> <p>In addition, consider adding supervisor mentoring or peer-to-peer exchanges within your supportive supervision program.</p>
How to use the intervention	<p>Consider using the following examples of supportive supervision:</p> <ul style="list-style-type: none"> • Identify and train a few of the most senior members of the health facility staff to provide supportive supervision to lower-level health care workers

Step 4. Develop Workforce Interventions

	<ul style="list-style-type: none"> • Discuss process of supervision with supervisors; ensure that feedback (positive and negative) is provided to health care workers during supportive supervision visits • Coworker mentoring support • Intersite supportive visits <p>Additional evidence-based references provided in Annex 1: 2, 7, 8, 13</p>
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Intervention 4.i: Recognition

Description	Recognition from supervisors, employers, colleagues, and the community is often cited as one of the most motivating factors for health care workers. While this recognition can occur spontaneously, it is important to have built-in systems that encourage recognition from supervisors or from the community. Although recognition can also be considered a nonfinancial incentive, there is enough evidence on the relationship between recognition and staff motivation and performance to warrant a separate discussion.
When to use the intervention	Use regularly to increase motivation and improve performance.
How to use the intervention	<p>Consider using the following examples of recognition:</p> <ul style="list-style-type: none"> • Hold regular community meetings where health facility staff engage with community members • Discuss process of supervision with supervisors; ensure that feedback (positive and negative) is provided to health care workers during supportive supervision visits • Employee of the month program • Coworker mentoring support • Intersite supportive visits • Develop “letter of recognition” program, where district health management team or district supervisor writes a letter of recognition to health care workers nominated by their facility supervisor <p>Additional evidence-based references provided in Annex 1: 2, 9, 10, 11, 12, 16.</p>

Intervention 4.j Team Building

Description	Supportive and respectful workplace relationships and working as a team for a common goal can influence the motivation of health care workers. To strengthen these relationships, it is important to foster collegial recognition, supportive teamwork, respect, and good communication in the workplace. Implementation of quality improvement initiatives, which encourage facility teams to work together to solve problems, can strengthen team relationships.
When to use the intervention	Use periodically to strengthen team relationships, support teamwork, and foster effective communication, particularly during times of transition, conflict, startup, or whenever the lack of a team-based approach is impacting staff morale.
How to use the intervention	<p>Consider using the following examples of team building:</p> <ul style="list-style-type: none"> • Implementation of quality improvement initiatives • Increased staff participation in decision-making processes within the facility <p>Additional evidence-based references provided in Annex 1: 2, 7, 9, 14.</p>

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Intervention 4.k: Improved Communication	
Description	Intraorganizational communication, as well as communication and engagement with the community, may play a role in health care worker motivation. Within facilities, leaders can implement strategies to improve communication between management and providers as well as internal communication within management or provider groups. Communication with the surrounding community may improve health care worker motivation by providing opportunities for community recognition and appreciation, which has been noted as one of the strongest forms of motivation. Community engagement may also improve motivation by reducing health care worker misunderstandings about a perceived lack of compliance or lack of cooperation from patients.
When to use the intervention	Use when communication between management and providers needs improvement, when communities are not engaged directly with staff, or whenever poor communication is impacting staff morale.
How to use the intervention	<p>Consider using the following examples of improved communication:</p> <ul style="list-style-type: none"> • Staff recommendation box • Increased staff participation in decision-making processes within the facility • Customer comment box at facility <p>Additional evidence-based references provided in Annex 1: 2.</p>

Intervention 4.l: Improved Work Environment	
Description	Poor working conditions can contribute negatively to health care workers' motivation to perform their job; a positive work environment has been associated with improved health worker ratings on quality of care. Factors to be examined for improvement in the work environment include adequacy of supplies, sufficient and relevant training, providers feeling safe from physical harm, and good team morale.
When to use the intervention	Use when staff indicate that a poor work environment is impacting quality of care, including inadequate supplies, insufficient training, lack of safety, or low morale.
How to use the intervention	<p>Consider using the following examples of improved work environment:</p> <ul style="list-style-type: none"> • Review procurement procedures to improve consistent supply of necessary materials and commodities to ensure that staff can conduct appropriate work • Team building activities • Involvement of health care workers in decision-making about facility processes <p>Additional evidence-based references provided in Annex 1: 7.</p>

Improving Allocation of Staff and Tasks

When the underlying causes for service delivery gaps are related to poor task allocation among staff, consider the intervention categories listed below.

Intervention 4.m: Implementation of Task Sharing Guidance	
Description	Many sites often already have experience with task shifting, which is defined as delegating tasks to existing or new cadres with either less training or narrowly tailored training. In the context of HIV/AIDS, task shifting can improve access to care and treatment services, optimize the skills of the existing health worker team, and provide stronger linkages between communities and the health system. A review of how task shifting has been done and what improvements can be made is an important step toward maximizing productivity.

Step 4. Develop Workforce Interventions

	<p>Task shifting can be implemented at a facility, following national-level policy, but it is important that the "shifted" responsibilities are clear to all parties and that the persons taking on new responsibilities are trained, supervised, and provided with support to perform their new duties well. Tasks to be shifted do not have to be solely clinical. Efficient implementation of administrative tasks is also essential, and task shifting of administrative responsibilities can improve efficiency of reporting, documentation, and other administrative aspects.</p>
When to use the intervention	Use when skills and tasks of health workers are not aligned, leading to client bottlenecks, long wait times, and/or attrition.
How to use the intervention	<p>Consider using the following examples of task shifting:</p> <ul style="list-style-type: none"> • Peer counselors/educators • Community health workers providing health education/counseling/client tracing • Shift daily clerical or reporting tasks to facilitate monthly reporting work <p>WHO/UNAIDS guidance on task shifting can be found here: http://www.who.int/healthsystems/TTR-TaskShifting.pdf</p> <p>Additional evidence-based references provided in Annex I: 3, 4, 5, 19.</p>

Intervention 4.n Worker Scheduling

Description	Another way to improve task allocation is worker scheduling, which is a way to ensure the availability of staff when service workloads are the highest.
When to use the intervention	Worker scheduling can be effective when you have studied the client flow processes or conducted a time-motion study and identified specific workforce availability bottlenecks to service delivery. It is appropriate when the workers available for scheduling are all adequately skilled and competent to deliver the tasks in need of additional support.
How to use the intervention	<p>Within the service or services in need of additional workforce support, refer to your client flow and/or time-motion study results to schedule additional health workers. Ensure that the health workers are well engaged in the process of starting the scheduling system and that they are available at the times proposed to staff.</p> <p>There may be special considerations to scheduling of safety and security, especially for female staff. For example, working late hours, such as for processing high volumes of laboratory samples, may be a challenge for staff to travel to and/or from the clinic after dark.</p>

Intervention 4.o: Developing/Clarifying Job Descriptions

Description	Having a written job description aligned with the appropriate level of responsibility and including clear standards for performance for all staff is one of the basic components of good human resources management. It has also been associated with higher service quality. If a work flow analysis or task list review shows that there are redundancies in work flows, revision and/or realignment of job descriptions may be an appropriate intervention. In addition to simply having a job description, best practice is to have a process for periodic review and updating of the job description.
When to use the intervention	Use when there are redundancies in work flows or job descriptions for health workers do not exist.
How to use the intervention	<p>Consider using the following examples of job descriptions:</p> <ul style="list-style-type: none"> • Ensure that all staff have an up-to-date job description, including responsibilities, and an evaluation system

Step 4. Develop Workforce Interventions

	<ul style="list-style-type: none"> • Display key job responsibilities at the workplace <p>Additional evidence-based references provided in Annex I: 15, 10.</p>
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Intervention 4.p Consider Differentiated Service Delivery Models

Description	<p>Differentiated care is a client-centered approach that simplifies and adapts HIV services across the cascade to reflect the preferences and expectations of various groups of people living with HIV while reducing unnecessary burdens on the health system. By providing differentiated care, also called differentiated service delivery, HRH tasks can be reallocated to those most in need.</p> <p>Consider the four evidence-based categories:</p> <ul style="list-style-type: none"> • Health care worker–managed group models • Client-managed group models • Facility-based individual models • Out-of-facility individual models <p>http://www.differentiatedcare.org/Models/Overview</p>
When to use the intervention	<p>Use when there is an influx of stable HIV patients and the need to increase client volume over time, which is particularly relevant for the achievement of the second and third “95s” (i.e., getting 95% of people to know their status on ART and 95% of these virally suppressed).</p>
How to use the intervention	<p>The HRH2030 program has developed a tool that inputs HRH and HIV client volume data to consider differentiated care models. When inputting data into the model to review various scenarios, implementation feasibility must be considered.</p> <p>https://www.hrh2030program.org/method-for-standardized-use-of-site-level-hrh-data/</p>

Improving Work Processes

When the underlying causes for service delivery gaps are related to inefficient work processes, consider the intervention categories listed below.

Intervention 4.q: Clarify Staff Workflow Processes to Streamline Services

Description	<p>There is no “one size fits all” service delivery approach. Every clinic serves a different client population and has different resources available to them. To address this, facilities may review their work flow analyses and determine what adaptations can be made to better fit the needs of the client in a way that optimizes facility resources. For example, if there is a problem with enrolling newly identified HIV-positive clients in HIV care and treatment, as shown in the Oche Baba Medical Center case study included in this toolkit, one way of addressing workforce causes of testing gaps may be to reorganize staff to provide a new service (physical escort) or adapt services to be more responsive to the problems identified (immediate enrollment upon arrival). Streamlining services means combining existing services or making existing services more efficient.</p> <p>This approach can also boost client satisfaction when it addresses problems that were barriers to client engagement in services. This can in turn increase client volume.</p>
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Step 4. Develop Workforce Interventions

	<p>Options for adjusting service delivery models revolve around answering three key questions:¹⁰</p> <ul style="list-style-type: none"> • <i>Who</i> provides a service? <ul style="list-style-type: none"> ○ Is this person/cadre of staff the most appropriate to provide the service? Is it more efficient for someone else to provide the entire service or a portion of the service? • <i>Where</i> is the service provided? <ul style="list-style-type: none"> ○ Is a service provided in a consultation room or at the triage desk? At the facility vs in the community? Where could the service be provided most efficiently? • <i>How often</i> is the service provided? <ul style="list-style-type: none"> ○ Do all clients need to return every three months for a refill? Can this period be lengthened for clients who have been adherent for a year or more?
When to use the intervention	Facilities that have implemented workflow process review for service delivery adaptations already may wish to review those adaptations and consider new ones to maximize effective implementation and seek new efficiencies.
How to use the intervention	<p>Consider using the following examples of service delivery adaptation:</p> <ul style="list-style-type: none"> • Introduce outreach visits to reduce travel distance for clients • Provide group classes for clients who default from care • Introduce self-management classes • “Fast-track” refill-only patients at the clinic so they do not have to wait • Provide HIV counseling and testing at the same location as HIV care and treatment, or provide care and treatment within other clinics, e.g., the maternal and child health clinic • Provide adherence or other counseling while patients wait to see nurse/doctor • Organize services so patients can receive all services in one room rather than moving from one place in the clinic or to another for different services <p>Additional ideas for interventions can be found here: https://www.k4health.org/sites/default/files/Q%202.pdf Additional evidence-based references provided in Annex I: 3, 4, 6, 16.</p>

Strengthening HIV Service Delivery Through Effective Workforce Interventions

Table 2 presents an illustrative result from the application of Steps 1 through 4 as described in this toolkit, with the goal of identifying and implementing the most appropriate interventions to close workforce-related productivity and performance gaps and improve HIV service delivery. Categorized by the 95-95-95 targets, Table 2 also provides an illustrative example of specific interventions that can be implemented to strengthen health workforce performance and productivity by pinpointing the underlying causes of common workforce problems contributing to HIV service-delivery gaps based on data of HRH gaps at the site level.

For a detailed table of the empirical evidence on health workforce interventions, see Annex I.

¹⁰ The Global Fund, *A Toolkit for Health Facilities: Differentiated Care for HIV and Tuberculosis*, Nov 2015. Geneva, Switzerland. Available at: https://www.theglobalfund.org/media/2569/core_differentiatedcare_toolkit_en.pdf

Step 4. Develop Workforce Interventions

Table 2: Illustrative interventions for identified service delivery gaps, their related workforce problems, and underlying causes

Identify HIV Service Delivery Gap [Step 1]	Identify Workforce Problem(s) [Step 2]	Understand Underlying Cause(s) of Workforce Problem(s) [Step 3]	Develop Workforce-Related Interventions to Close Service Delivery Gaps [Step 4]
First 95: 95% of all people living with HIV will know their HIV status.			
Indicator (example): Number of individuals who received HIV testing services (HTS) and received their test results and were reactive [HTS_TST_POS]			
Identification of new HIV-positive clients, particularly young males	<p>Poor allocation of existing personnel</p> <p>Knowledge gaps in key clinical service provisions (e.g., targeted PITC approaches for men)</p> <p>Time when services are provided does not coincide with when men can attend</p>	<p>Clinic and lay counselors not allocated to outpatient department on a timely/frequent basis to conduct targeted provider-initiated testing and counseling (PITC) approaches</p> <p>Counselors/nurses not trained in algorithm for targeted PITC for males</p> <p>Consider extended operational hours and/or weekend hours to cater to people who cannot attend the clinic during the day</p>	<p><i>Do health workers know their roles and responsibilities?</i> Clarify roles and responsibilities through revised supervision to ensure appropriate deployment of personnel. Conduct in-service training by the lab technicians to reinforce lay counselors' and nurses' capacity to provide HIV testing with immediate referral for ART initiation. Conduct in-service training on PITC to ensure that staff conducting HIV testing are aware of how best to target individuals.</p> <p><i>Are mechanisms in place to support health workers to apply newly acquired skills?</i> Engage lay counselors and nurses with in-service training (at site) to ensure clear understanding of the testing algorithm. Follow up with direct observation and, if necessary, provide additional on-the-job mentoring or coaching on one-on-one basis</p> <p><i>Are health workers available when there is client demand?</i> May need to consider shifting work or establishing other types of flexible schedules if resources for overtime are not available</p>

Step 4. Develop Workforce Interventions

Identify HIV Service Delivery Gap [Step 1]	Identify Workforce Problem(s) [Step 2]	Understand Underlying Cause(s) of Workforce Problem(s) [Step 3]	Develop Workforce-Related Interventions to Close Service Delivery Gaps [Step 4]
Second 95: 95% of all people with diagnosed HIV infection will receive sustained ART.			
Indicator (example): Number of adults and children newly enrolled on ART [TX_NEW]			
New patients are not being immediately initiated on treatment	<p>Low staff engagement</p> <p>Poor work processes</p>	<p>Overworked health facility staff with all clients coming in large numbers on the same days and during the same hours for care and refills</p> <p>Only doctors and head nurses authorized to prescribe ART</p>	<p>Are health workers appropriately tasked and motivated? Organize client visits per ART stage (refilling vs new start)</p> <p>Establish fast tracking for stable clients already on ART to enable more time for new/unstable clients</p> <p>Reconfigure patient flow for clients to move through clinic more quickly</p> <p>In-service training for assistant nurse to refill ARVs (assuming protocols allow)</p> <p>Establish lead patient to collect ART for a group of clients</p>
Third 95: 95% of all people receiving ART will achieve viral suppression.			
Indicator (example): Percentage of adults and children known to be on treatment 12 months after initiation of ART [TX_RET]			
The clinic met its quarterly targets for new enrollments, but current number on treatment is much lower than expected	<p>Poor work processes</p> <p>Low staff engagement</p>	<p>Lack of accountability to track clients enrolled on ART</p> <p>No incentive for health workers to go above and beyond to track down clients defaulting from treatment follow-up</p>	<p>Establish clear process, including roles and responsibilities, for checking the appointment book and following up with clients</p> <p>Include care results in the staff performance review process</p> <p>Establish a recognition of system based on patient outcome in care; use “mop up” exercises as an opportunity for staff to travel outside of the facility</p>

Step 4 Case Study: Developing Effective Interventions

In the previous steps, the staff at the Oche Baba Medical Center decided to prioritize referral linkages and ART initiation as the gaps to address in their facility. The facility staff worked together to identify appropriate interventions based on their in-depth task and client flow analysis, as well as through additional discussions with staff, to consider what interventions would be the most feasible. They focused on interventions within their control to implement that responded to the identified workforce problems and underlying causes and that did not require significant additional resources.

The interventions are interrelated, and seek to respond to HIV service delivery gaps:

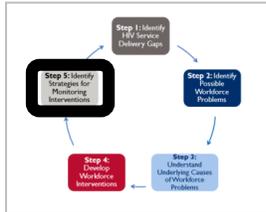
- **Implementing task shifting guidance:**
 - To relieve the clinical officer from her heavy workload managing all new and stable patients, the facility manager decided to implement the national task shifting guidelines, assigning all stable patients to the nurses.
 - To relieve nurses from their community linkages role and support their time on higher-skilled tasks for which they were qualified (including managing all stable patients), the staff recommended that adherence support volunteers be tasked with all pre-ART initiation loss to follow up and to manage all new patients identified through mobile outreach.
- **Improving mentoring and supportive supervision:**
 - To give nurses greater confidence managing ARV refills, for which they had been trained but for which they still relied on the clinical officer, the facility manager reached out to the Ngong Medical Center, a high-performing facility within their same district, where nurses demonstrated expertise in ART management. After a few visits of the head nurse to Oche Baba to coach their nurses, it was anticipated that they would feel more confident.
 - For adherence support volunteers to conduct pre-ART loss to follow up, they could be mentored by a lay counselor to improve community-facility linkages. Staff envisioned this would help patients identified through mobile testing to have a point of contact at the facility, even prior to ART initiation. Mentoring strategies between community volunteers and nursing staff (who manage the ART initiation recordkeeping) were devised to improve communication and ensure that they all had similar skills and competencies for referral linkages. They communicated on a WhatsApp group, with the nurse texting the adherence support volunteers at least once a week.
- **Improving communication:** By collecting and managing a simple chart of all adherence support counselors' telephone numbers, the Oche Baba Medical Center supervisor could easily follow up with the counselors in the community as needed to ensure the mentoring program was helping them.
- **Improving upon existing job aids** to reinforce the new allocation of defined tasks and to show how patient data could be confidentially shared with community-based workers for conducting follow-up for patients to initiate ART.
- **Improving work processes:** Based on the client flow assessment tool that showed that staff were not escorting HIV-positive patients to care and treatment, they decided to:
 - Identify other options for a physical escort between services. By placing one HIV-positive expert client at registration each day, when an HIV-positive client was identified, the expert client would be available to physically escort the client to ART

initiation and dispensation. This expert client was empathetic to the client and could help link them to the adherence support volunteer.

- Shift the registration responsibilities for ART initiation from the provider to the waiting room, so that clients would not be so easily lost to follow-up. The two lay counselors had enough time available to add client registration to their duties. They decided to mentor the two lay counselors and provide ongoing support from the nurses, and a desk was set up in the waiting room for confidential registration.
- With emerging evidence on differentiated service delivery models, the staff decided to review the load of stable patients and further investigate potential options for differentiated care for the future. While they first wanted to examine the performance of adherence support counselors with their additional role for referrals, the staff envisioned that they may be able to coordinate groups of patients for community-based clinical consultations (led by nurses) someday.

Step 5: Identify Strategies for Monitoring Workforce Interventions

Overview of Step 5



Monitoring the implementation of interventions is a process that aims to provide facility staff and others with early indications of progress toward closing service delivery gaps. This allows for timely decision-making. Health workforce interventions selected should be monitored to assess impact and to adjust accordingly. Monitoring of interventions should be done in conjunction with continuous review of HIV service delivery data.

After determining the interventions, but before implementing them, the facility team should develop a monitoring plan. To successfully monitor the workforce interventions chosen for implementation, appropriate indicators need to be selected and tracked over time. The first step is to identify the appropriate indicators for tracking the intervention; both process and outcome measures should be included. Process indicators will allow staff to monitor whether the intervention is being implemented in the way it was planned, while outcome indicators will allow staff to assess whether the intervention is having the desired effect.

Indicators may or may not be directly workforce related but should be related to the intervention selected to address the underlying causes of the workforce problems that are contributing to the identified service delivery gaps.

The monitoring plan should include the following for each indicator:

1. Title of the measure
2. Type of measure (outcome, process)
3. Operational definition of the measure
4. Data collection and sampling method
5. Plans for data display
6. Availability of baseline data
7. Goal(s) or target(s)
8. Data source

At PEPFAR-supported facilities, implementing partners can incorporate this monitoring as part of their routine support and monitoring of facility-level HIV service delivery data.

In addition, what will be measured, how often it will be measured, who will be responsible for measurement, and how the measurements will be shared with the team, leadership, and the organization are important questions to answer. See Step 5 tools for a Monitoring Plan Template.

It is essential to keep measures simple. If measures require extensive additional data collection, they are less likely to be successful. Where possible, use indicators that you know will already be collected, as in many of the service level indicators from Step 2; time and resources can then be safeguarded. Additionally, sampling can help reduce the amount of time needed to collect other indicators. For example, if “percentage of patients receiving adherence counseling” is selected as an indicator, examining all patient files would be resource intensive. Instead, select a set percentage (for example, 10%) of that week’s patients to review their files and then calculate the indicator based on that sample.

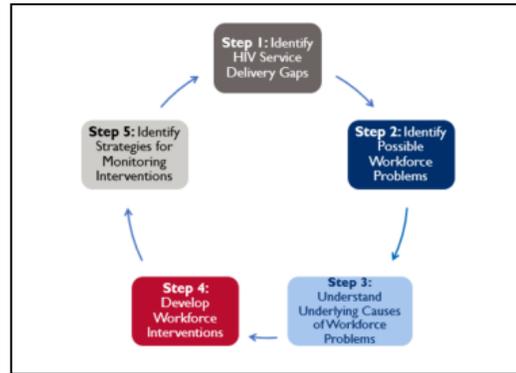
Step 5. Identify Strategies for Monitoring Workforce Interventions

The monitoring plan should be reviewed regularly with the team to verify that it is working and to ensure clarity in team objectives by measuring their progress. Also, consider posting the monitoring data at the health facility, with the appropriate data dashboard, so that the process is transparent and to increase buy-in. If staff see that an intervention is helping to improve service delivery indicators, they are more likely to continue to implement it well.

If the intervention is not being implemented as planned or is not achieving the desired effect, the team should reassess the root causes of the workforce problems contributing to the service delivery gaps and adapt the intervention or identify and implement a different intervention. It is recommended to return and repeat Steps 1 through 4 to promote continuous improvement of workforce performance and productivity.

Note that the steps in the toolkit process form a loop (see Figure 1, repeated at right). Information gained during the monitoring step should lead to additional reviews of data to determine if service gaps are being addressed, which in turn highlight additional problems and underlying causes to resolve, which will need different interventions, and so on.

Some improvements may be seen almost immediately, while the impact of others may take some time (weeks to months potentially) to be seen. Staff should proceed through the steps with a critical eye toward what are likely “quick wins” (mentoring, for example) and what will take a longer-term investment and prepare themselves appropriately.



Tools for Step 5

Tool 5.a: Monitoring Plan Template	
Description	As described in the narrative above, all workforce interventions should be monitored.
When to use the tool	When monitoring any health workforce intervention.
How to use the tool	Work as a team among facility and supervisory staff to complete the template below.

Monitoring Plan Template

Title of the measure	
Type of measure (outcome, process)	
Operational definition of the measure (i.e., what does it mean?)	
Data collection and sampling method	
Plans for data display	
Availability of baseline data	

Step 5. Identify Strategies for Monitoring Workforce Interventions

Goal(s) or target(s)	
Data source	
How will it be measured?	
Frequency of measurement (i.e., how often?)	
Who will measure it?	
How will measurements be shared with stakeholders?	

Tool 5.b: Resources for Selecting and Defining Indicators	
Hyperlinks	<p>HRH Indicator Compendium: http://www.who.int/workforcealliance/knowledge/toolkit/23_1.pdf</p> <p>HIV Data Sources: https://data.pepfar.net/dataSources</p> <p>Overview of health systems indicators at various levels (e.g., input, process, output, outcome): https://www.k4health.org/toolkits/measuring-success/indicators</p> <p>Quality measures (for service delivery): http://www.ahrq.gov/professionals/quality-patient-safety/talkingquality/create/types.html</p>
Description	<p>While there is no one tool to dictate exact indicators to use for a given intervention, the resources linked above describe different kinds of indicators, when they are appropriate, and the characteristics of good indicators. Above all, it will be important to define how to measure the improvement that you are seeking to make and track any changes over time. Engage relevant stakeholders to discuss what would be most appropriate to use to measure success of an intervention.</p>
When to use the tool	<p>Use when discussing the appropriate indicators to use to monitor an intervention.</p>
How to use the tool	<p>Review indicators in focus. Ensure that the indicator is “SMART” to increase the likelihood that you and your team will be able to monitor it routinely over time. Five characteristics define SMART Indicators:</p> <ul style="list-style-type: none"> • Specific - focused and clear • Measurable - quantifiable and reflecting change • Attainable - reasonable in scope and achievable within set time frame • Relevant - pertinent to the review of performance • Timebound/Trackable - progress can be charted chronologically

Tool 5.c: Time Series Chart for Tracking Data Variations	
Hyperlink	<p>https://www.usaidassist.org/sites/assist/files/tipstoolsimprovement_measurementtimeseries_may30_ada.pdf</p>
Description	<p>Described earlier in this toolkit, a time series chart is a graphical display of data that can be used to track any indicator over regular time intervals.</p>
When to use the tool	<p>Use at facilities to show and track trends and variation in indicators over time related to the intervention.</p>
How to use the tool	<p>Follow the step-by-step instructions within the tool.</p>

Step 5 Case Study: Monitoring Workforce Interventions

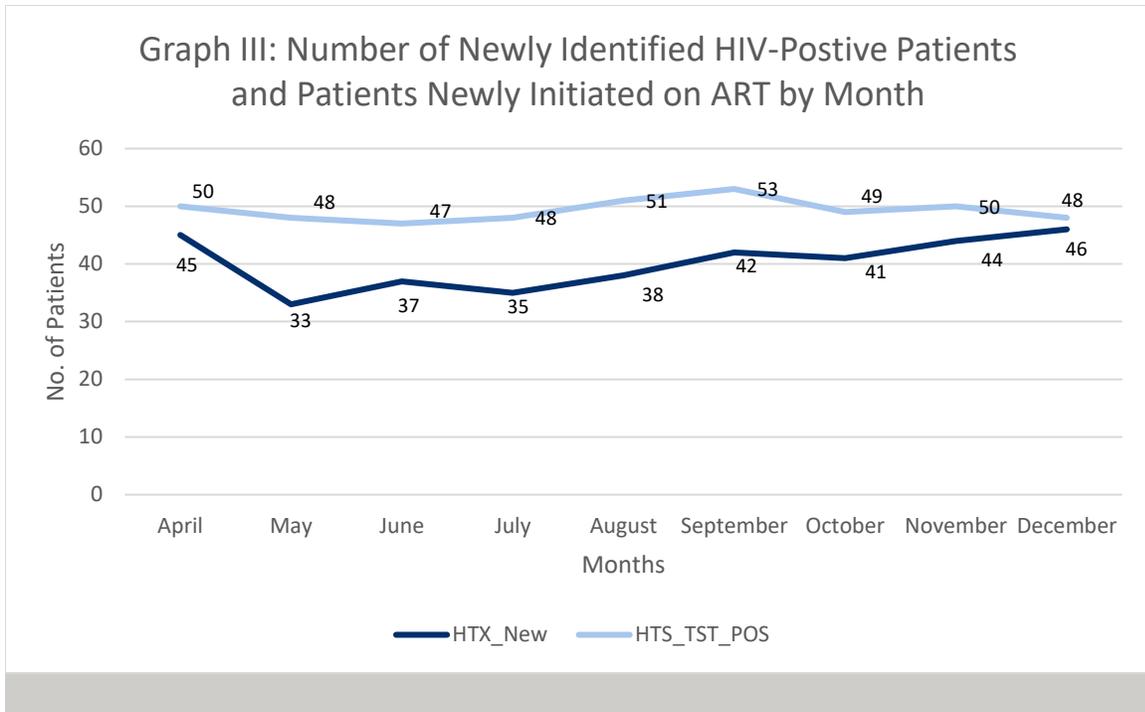
During the planning of their health workforce interventions, the Oche Baba Medical Center staff knew they would need a way to know if the interventions they selected were contributing to improved ART initiation rates. To track these changes over time, the staff decided to collect data on the following process indicators that corresponded to the respective outcomes:

- Process indicators
 - Percentage of newly identified HIV-positive HTS clients who were physically escorted to the care and treatment clinic
 - Average wait time (arrival to registration) for clients at the care and treatment clinic
 - Percentage of stable ART patient cases managed by a nurse
- Outcome indicators (from Step 1)
 - Number of newly identified HIV positive patients (corresponds to PEPFAR HTS_TST_POS indicator)
 - Number of patients newly initiated on ART (corresponds to PEPFAR TX_NEW indicator)

The process indicators require some additional data collection. To capture the process indicator, the HIV testing services staff will add a tick box to their register to indicate whether newly identified HIV-positive clients were physically escorted to the care and treatment clinic. Average client wait times are tracked by an expert patient through a mobile phone app and a mobile phone app automatically generates a report to the facility manager. At the end of each month, the nurses reviewed medical records to tally the proportion of stable patients that they managed.

The outcome indicators are the same data that are regularly collected at PEPFAR-supported facilities. Tracking these two indicators together will allow Oche Baba Medical Center staff to know if the changes to client flow and staff utilization are having the desired effects.

Each month, the Oche Baba Medical Center tracked and reviewed the indicators. Using a quality improvement approach, they sought to address intervention implementation challenges with each data review. Within the first month of implementing the changes, ART initiation rates started to improve. After one quarter, the improvements stabilized and continued to increase. Within nine months, enrollment rates more than doubled at Oche Baba Medical Center, as shown below (Graph III). The team could attribute these results to the evidence-informed health workforce interventions that addressed health worker competency gaps, task allocation, and work processes.



Additional Step 5 Tools (District Management and Technical Assistance Providers)

Planning and Documenting Your Site Visit

Once you have designed an intervention plan and identified a monitoring strategy, it is time for the team to apply their chosen intervention(s). The template below can help the technical assistance provider or staff at the facility or point-of-service intervention in the planning, execution, and monitoring of their workforce intervention(s).

The template below was developed specifically for this toolkit and the processes described within the toolkit. It may be useful when planning how to support a facility moving through each step. When planning a site visit, implementing partners should consider integrating this planning into existing site visit processes.

Regardless, supervisors and implementing partners should always undertake a brief and basic assessment of HRH issues at each visit. When conducting SIMS visits or other routine supervision, it is useful to ask oneself

Key workforce-related questions to consider at routine site visits:

How do workforce problems seem to be affecting HIV service delivery? Which problem(s)?

- Do the health workers have the right skills?
- Are the health workers motivated?
- Do we have enough of the right health workers performing the right kinds of tasks?
- Are health workers' tasks well organized?

Step 5. Identify Strategies for Monitoring Workforce Interventions

if any health workforce problems seem to persist.

Tool 5.d: Facility Workforce Improvement Plan Template	
Description	When working through the human resources improvement process with a health facility, it is useful to outline the results of each step of the process, particularly the details of the intervention and the measures to be used to monitor the intervention. The improvement plan template helps document the discussions with a facility related to each step and serves as a monitoring tool.
When to use the tool	When working through a human resources improvement process with a facility.
How to use the tool	Work among stakeholders to discuss and answer the questions to complete the template below.

Facility Workforce Improvement Plan Template

Facility Name					
Date of discussion					
Priority service delivery gap identified <i>What is the current service delivery gap that you want to improve?</i>					
Workforce problems identified					
Underlying causes related to workforce problems					
Intervention selected to address underlying causes					
Indicators selected to monitor intervention <i>How will you know that your intervention is working?</i> <i>Be sure to plan for collecting baseline data before you initiate the intervention and consider if you want to establish a goal for your measure.</i>					
Measure	Type	Indicator	Frequency	Data source	Who will collect
Date of follow-up visit to assess intervention					



Health workers and HRH2030 program staff analyze and discuss facility-level data at the Ngombe Dispensary in Iringa Region, Tanzania, in July 2017.

Raising Awareness of Workforce Problems with Stakeholders

This toolkit has focused on developing interventions at the facility or point-of-service delivery to improve health worker performance and productivity. However, as you work through this process with facilities, problems may emerge that cannot be addressed solely at the facility level. Some of the underlying workforce problems that facilities will identify are likely to be problems that can only be addressed at higher levels of the Ministry of Health, such as the district or regional health management team (DHMT/RHMT). To effect change at these higher levels, raising their awareness of current workforce problems is necessary.

Experts have identified a few key steps in the awareness raising process that will help you to effectively communicate workforce problems to DHMT/RHMTs. These steps include:

- **Define the problem:** Pick one problem and think through what you would like to ask from the DHMT/RHMT to help mitigate the problem. An example might be the problem of insufficient staff at the facility level. What sort of assistance would you seek from the DHMT/RHMT? Would you ask for additional funding to hire new staff; reallocation of existing staff positions (e.g., swapping out a lab assistant for a nursing assistant); reconsideration of policies governing task assignment?
- **Gather evidence:** Data are essential when raising awareness of stakeholders. The information the facilities gather during the problem identification process, particularly the workforce information, will be the most appropriate kind of data to use here. Check that the data being collected relate to the defined problem. For example, if the problem is a service delivery gap and its underlying cause may seem to be insufficient staff or poor task allocation, then consider gathering data on numbers of staff, patient-to-staff ratios, and staff workload by service.

Step 5. Identify Strategies for Monitoring Workforce Interventions

- **Build partnerships:** If there are multiple technical assistance providers in the district or region and you all face the same workforce challenges, work together to raise DHMT/RHMT awareness.
- **Identify and analyze stakeholder targets:** Know the appropriate personnel in the DHMT/RHMT with whom to raise workforce problems. While it may be useful to raise the awareness of the entire DHMT or RHMT on workforce problems, if there are only one or two key people who make decisions about health worker management, then it is important that the message reaches them.
- **Develop and deliver messages:** Messages should be based on the information gathered and should be communicated simply and clearly. The data presentation tools included in Step 2 of this toolkit can be useful for displaying quantitative data you have collected.

When raising issues to the DHMT or RHMT, it is helpful to be solution oriented. Using the gathered data to define your problem allows you to formulate your request. Open-ended requests without any supporting data are more difficult to be turned into useful actions.

Conclusion

You have now reviewed all the steps in the toolkit for optimizing health worker performance and productivity, with the end goal of achieving the PEPFAR 95-95-95 targets. Undertake these steps to determine and measure the effectiveness of which context-specific workforce-related interventions would be appropriate and effective to address HIV service delivery gaps.

As this process is cyclical, after completing all steps, toolkit users should routinely ask themselves key questions (repeated in the text box at right) to consider if health workforce problems are potentially affecting services (i.e., return to review service delivery gaps, identify possible health workforce problems, understand underlying causes to develop workforce interventions, and monitor their success). This will support a process of continual improvement of HIV service delivery at PEPFAR sites to accelerate HIV/AIDS epidemic control.

At routine visits, ask yourself:

**How do workforce problems seem to be affecting HIV service delivery?
Which problem(s)?**

- *Do the health workers have the right skills?*
- *Are the health workers motivated?*
- *Do we have enough of the right health workers performing the right kinds of tasks?*
- *Are health workers' tasks well organized?*

Annex I: Evidence on Workforce Improvement Interventions (Step 4)

Type of Intervention	Outcome	Country	Citation	Number
Nonmonetary incentives	PMTCT effectiveness	Multicountry	Toure H, Audibert M, Dabis, F. To what extent could performance-based schemes increase the effectiveness of prevention of mother-to-child transmission of HIV (PMTCT) programs in resource-limited settings? A summary of published evidence. BMC Public Health. 2010, 10:702.	1
Nonmonetary incentives	Health care worker motivation	Benin; Kenya	Mathauer I, Imhoff I. Health worker motivation in Africa: the role of non-financial incentives and human resource management tools. Human Resources for Health 2006, 4:24.	2
Expert clients (people living with HIV) providing certain nonclinical services (e.g., counseling) to patients	ART adherence	Tanzania	Layer EH, Kennedy CE, Beckham SW, Mbwambo JK, Likindikoki S, Davis WW, et al. (2014) Multi-Level Factors Affecting Entry into and Engagement in the HIV Continuum of Care in Iringa, Tanzania. PLoS ONE 9(8): e104961. doi:10.1371/journal.pone.0104961	3
Colocated HIV testing and counseling and care and treatment clinic services	Linkage	Tanzania	Layer EH, Kennedy CE, Beckham SW, Mbwambo JK, Likindikoki S, Davis WW, et al. (2014) Multi-Level Factors Affecting Entry into and Engagement in the HIV Continuum of Care in Iringa, Tanzania. PLoS ONE 9(8): e104961. doi:10.1371/journal.pone.0104962	3
Incentives	Health care worker motivation	Tanzania	Layer EH, Kennedy CE, Beckham SW, Mbwambo JK, Likindikoki S, Davis WW, et al. (2014) Multi-Level Factors Affecting Entry into and Engagement in the HIV Continuum of Care in Iringa, Tanzania. PLoS ONE 9(8): e104961. doi:10.1371/journal.pone.0104963	3
Patient navigation	Linkage, retention	Multicountry	Govindasamy, D., et al. Interventions to improve or facilitate linkage to or retention in pre-ART (HIV) care and initiation of ART in low- and middle-income settings - a systematic review. JIAS 2014; 17(1): 19032.	4
Integration of care	Linkage, retention	Multicountry	Govindasamy, D., et al. Interventions to improve or facilitate linkage to or retention in pre-ART (HIV) care and initiation of ART in low- and middle-income settings - a systematic review. JIAS 2014; 17(1): 19032.	4
Streamlining services to minimize patient visits	Enrollment in HIV care	Multicountry	Govindasamy, D., et al. Interventions to improve or facilitate linkage to or retention in pre-ART (HIV) care and initiation of ART in low- and middle-income settings - a systematic review. JIAS 2014; 17(1): 19032.	4

Type of Intervention	Outcome	Country	Citation	Number
Community health workers provide certain nonclinical services to patients	Adherence levels, virologic outcomes, patient retention	Multicountry	Wouters, E., et al. Impact of community-based support services on antiretroviral treatment programme delivery and outcomes in resource-limited countries: a synthetic review. BMC Health Services Research 12 (194) (2012)	5
Integrate ART into maternal health clinic		Tanzania	Improving Human Resource for Health (workforce) productivity and engagement through collaborative Quality Improvement (QI) Methods; Experience from Tandahimba District, Mtwara Region (Health Care Improvement project)	6
Supportive supervision		Zambia	Bazant, E., et al. Effects of a performance and quality improvement intervention on the work environment in HIV-related care: a quasi-experimental evaluation in Zambia. Human Resources for Health 2014; 12(73).	7
Supportive supervision	Job satisfaction, health care worker motivation	Multicountry	Bailey, C., A systematic review of supportive supervision as a strategy to improve primary healthcare services in Sub-Saharan Africa. Intl J of Gyn & Obs 2016; 132(1).	8
Recognition	Health care worker motivation and performance	Multicountry	Okello, DR, Gilson, L. Exploring the influence of trust relationships on motivation in the health sector: a systematic review. Hum Res Health 2015; 13(16).	9
Feedback	Health care worker motivation and performance	Multicountry	Okello, DR, Gilson, L. Exploring the influence of trust relationships on motivation in the health sector: a systematic review. Hum Res Health 2015; 13(16).	9
Communication	Health care worker motivation and performance	Multicountry	Okello, DR, Gilson, L. Exploring the influence of trust relationships on motivation in the health sector: a systematic review. Hum Res Health 2015; 13(16).	9

Type of Intervention	Outcome	Country	Citation	Number
Job descriptions, nonfinancial incentives, performance feedback, recognition, training in clinic tools, sufficient equipment	Health worker performance, quality of care	Armenia	Fort, AL, Votero L. Factors affecting the performance of maternal health care providers in Armenia, <i>Human Resources for Health</i> , 2014 June 22; 2(1): 8.	10
Recognition	Health care worker motivation	Multicountry	Willis-Shattuck, M, et al. Motivation and retention of health workers in developing countries: a systematic review. <i>BMC Health Serv Res</i> . 2008; 8; 247.	11
Performance feedback	Performance	Multicountry	Dieleman, M, Gerretsen B, van er Wilt G. Human resource management interventions to improve health workers' performance in low and middle-income countries: a realist review. <i>Health Research Policy and Systems</i> . 2009 7:7	12
Increased knowledge and skills	Performance	Multicountry	Dieleman, M, Gerretsen B, van er Wilt G. Human resource management interventions to improve health workers' performance in low and middle-income countries: a realist review. <i>Health Research Policy and Systems</i> . 2009 7:7	12
Incentives	Performance	Multicountry	Dieleman, M, Gerretsen B, van er Wilt G. Human resource management interventions to improve health workers' performance in low and middle-income countries: a realist review. <i>Health Research Policy and Systems</i> . 2009 7:7	12
Supportive supervision	Productivity	Ghana	Frimpong, J, HELLERINGER, S, Awoonor-Williams, J, et al. Does supportive supervision improve health worker productivity? Evidence from the Upper East Region of Ghana. <i>Tropical Medicine and International Health</i> . 2011. 16(10).	13
Linkages with community	Productivity	Botswana	Forchheh, N, Fako, T, Determinants of effective productivity among service workers: the case of nurses in Botswana. <i>African Journal of Business Management</i> . 2007. 1(5).	14
Peer support	Productivity	Botswana	Forchheh, N, Fako, T, Determinants of effective productivity among service workers: the case of nurses in Botswana. <i>African Journal of Business Management</i> . 2007. 1(5).	14
Written job description	Quality of care	Kenya	Thatte, N, and Choi, Y. Does human resource management improve family planning service quality? Analysis from the Kenya Service Provision Assessment 2010. <i>Health Policy Plan</i> . (2015) 30 (3): 356-367	15
Supervision, increased knowledge and skills, job aids	Performance	Multicountry	Rowe, A et al. How can we achieve and maintain high-quality performance of health workers in low-resource settings? <i>Lancet</i> . (2005) 366: 1026-35.	16

Type of Intervention	Outcome	Country	Citation	Number
Performance	Competence	Multicountry	Bluestone J, Johnson P, Fullerton J, et al. Effective in-service training design and delivery: evidence from an integrative literature review. <i>Human Resources for Health</i> . (2013) 11:51.	17
Increased knowledge and skills	Performance, quality of care	Multicountry	Marquez, L. 2001. Helping healthcare providers perform according to standards. <i>Operations Research Issue Paper 2(3)</i> . Bethesda, MD: Published for the U.S. Agency for International Development (USAID) by the Quality Assurance Project	18
Task shifting	Efficiency	Multicountry	Seidman, G, and Atun, R. Does task shifting yield cost savings and improve efficiency for health systems? A systematic review of evidence from low-income and middle-income countries. <i>Human Resources for Health</i> . (2017) 15:29.	19

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