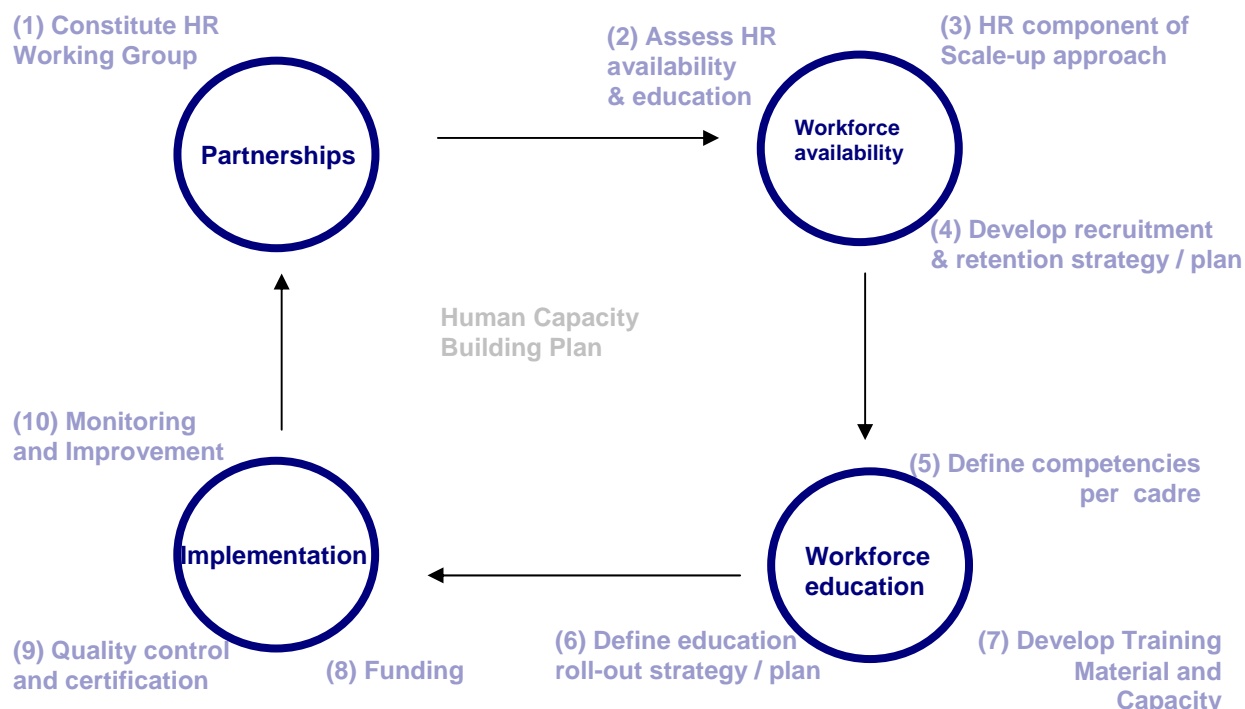


# **Planning human resources development to achieve priority health programme goals**

Human Resources for Health Development  
World Health Organization

This paper is a revised version of an earlier guideline developed by G. Weiler, N. Dreesch, and M. Dal Poz, WHO for the 3by5 Initiative. It was prepared by N. Dreesch, WHO.

## Planning human resources development to achieve priority health programme goals



### OPERATIONAL STEPS FOR DEVELOPING THE HUMAN RESOURCES DEVELOPMENT

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## **Operational steps for developing the human resources development component of scale up plans and funding proposals**

It is estimated that globally 4 million health workers are lacking (WHR, 2006). The GFATM and other funding agencies will address the health workforce shortages by accepting proposals which will help reduce it. People need to be trained for their contribution to achieving targets for the three diseases within strengthening of a Primary Health Care context. The challenge in this situation of dedicated disease funding lies in the identification of human resources development and training interventions which have both medium and long term impact on the disease while at the same time strengthening the underlying PHC health systems infrastructure.

Human resource aspects should hence be considered as an integral part of the overall development of the national service delivery strategy and scale-up plan.

One of the most important things to bear in mind when writing up a proposal for funding agencies with a clearly circumscribed mandate such as the GFATM is to clearly:

1. Identify what exactly constitutes the problem needing to be addressed in the specific disease area
2. Indicate how strengthening of the human resources problems will benefit the disease programme
3. Respond to the need to quantify the interventions needing to be undertaken
4. Cost the interventions over the coming years
5. Attach indicators for measuring implementation at regular intervals.

The funding agency guidelines often make this very clear, but proposals do not always conform with the request and risk getting rejected because of inattention to these issues. It should be borne in mind by those supporting the preparation of proposals that those reviewing proposals are not necessarily human resources specialists. Clarity of problem statement and simple links throughout the text how, for example, the proposal to start training medical assistants or clinical officers will address the size of an epidemic and reduce its impact. It should therefore be pointed out that this is a proven intervention, with less than half the training time for a medical doctor, and, in the absence of other alternatives a viable option to address the epidemic.

The proposal should clearly indicate the phases implementation and the link between requested human resources strengthening measures, phased in arrival of supplies and equipment when these resources become available (no point raining someone and then having to wait for another project cycle to deliver the drugs to be used .....), or measures to upgrade training capacity or enrolment e.g. extensions of buildings, phased project support to the arrival of external additional teaching staff, etc.

### **The proposal development process**

The working group for the development of the proposal should include all national and international stakeholders relevant for developing a human resources scale up proposal. This includes ministry of finance, education, the public services commission and health and the usually required representatives of the local NGO community. Here it is also important that the local NGO representatives play an active role. In the case of HIV/AIDS, for example, one of the successful elements of the Malawi proposal was the inclusion of training of PLHA in the community health services as providers of care. The idea being that in addition to not just having some of them working as volunteers one would also use the power of wearing a white coat, delivering services as a respected member of a health team, and help to reduce stigma and make people come forward for treatment, prevention and care for HIV.

Depending on when the consultant support is requested, these meetings will already have established concept notes or papers which will form the background for feeding into the proposal. If support is

requested earlier, the consultancy services should also help drive the inclusion of national stakeholders in the process.

What is important, however, is to start the process of creating consensus around the development issues as early as possible and start building up the proposal document, in the format required and responding to the information needs. This may not always be easy to follow, but every effort should be made to respond in the requested way. The reason is simple; the GFATM Technical Review Panel will have to judge the proposals on the basis of a level playing field. Therefore the merits of each proposal must be presented in a more or less uniform way facilitating fair technical judgement.

Another challenge in this respect lies in the fact that multiple stakeholders will be involved in support HR development. It is important to provide a detailed picture of who is already supporting what, where the gaps lie, and how the proposal will fit into on going efforts. This will help the TRP see whether a well coordinated effort is underway between public and private contributors to HR development, and how the proposed measures will bring additional support to fill the gap.

### **The document**

Section 1 identifies essential stakeholder and partnership issues. Sections 2 to 4 address basic steps that lead to identifying and making available the human resources that are needed based on the national scale-up model. Sections 5 to 7 address efforts to equip health workers with the necessary knowledge and skills. These include a definition of the competencies for various cadres, the development of appropriate training material, and the design of pre- and in-service training plans. The final sections 8 to 10 of the document discuss issues related to the implementation of human resource and training plans, including the availability of adequate funding, certification and quality control, and monitoring and improving human resource development.

### **The human resources development and capacity building plan**

From a country perspective, major bottlenecks in successfully responding to human resource challenges in the health sector include 1) the absence of a concerted human resource development and training approach to recruiting, training and retaining the workforce; 2) multiple and sometimes conflicting training materials in use; 3) lack of training provider capacity; 4) insufficient quality control and certification systems in the training sector; and 5) insufficient financial resources for training, and many other relevant factors identified in the 2006 World Health Report.

The generic '*Human Resources Capacity-Building Plan*' below describes WHO and partner support to countries in overcoming barriers described above to ensure both the emergency expansion of the health workforce and long-term sustainability of human resources in the health sector (Table 1). Geared towards addressing the MDG priority diseases including HIV as a specific entity, it is firmly anchored in the concept of the three 'Ones' promoted by the UN for this area:

- One agreed HIV/AIDS Action Framework that drives alignment of all partners.
- One national AIDS authority, with a broad-based multisectoral mandate.
- One agreed country-level monitoring and evaluation system.

It should, however, be borne in mind that national coordination towards a unified approach to human resources development across the health sector does demand an agreed framework to which all partners agree. These are usually coordinated by SWAP mechanisms, or regular national country coordinating meetings between all partners.

Table 1 – Elements of WHO Human Capacity-Building Plan

	<b>Countries</b>	<b>Regional</b>	<b>Global</b>
<b>Human Resource Planning</b>	Support development of <b>ONE</b> country human resource and training plan	Technical Resource Networks and regional guidance for Human Resource Assessment and planning	Shared understanding of tools and guidelines for HR planning amongst key technical, donor and academic institutions; development of core guidance.
<b>Training Material Development</b>	Training material appropriate to national scale up approach for all key cadres involved in scaling up, or, in case of HIV, with a focus on facility level training based on Integrated Management of Adult Illness (IMAI) approach	Technical assistance to national training material development through regional technical resource networks and 'knowledge hubs', including IMAI technical networks	Partner consensus on training packages outline core competencies, curricula and annotated training material for different cadres of health workers, with a focus on facility based interventions.
<b>Training Provider Capacity</b>	Appropriate pre-and in-service training capacity with a focus on district and first level training	Provision of training of trainers (TOT) opportunities and in-country support to capacitate training providers based on training packages (including HIV IMAI based training). Through resource networks and 'knowledge hubs'.	Development of global partnerships in support of formation of technical resource networks at regional level.
<b>Certification and Quality Control</b>	National systems for certification of health workers involved in scaling up.	Technical assistance to establishment of certification systems through technical resource networks.	Recommendations and partner consensus on process, content and outcome verification criteria for development of national certification systems.
<b>Financial Resources</b>	Training and Human Resource needs appropriately reflected in national and international funding plans / proposals.	Regional backup to development of national funding plans and proposals.	Facilitation of access to global finance through guiding notes and assistance on a case by case.

This document proposes a number of concrete steps for developing and implementing human resource and training plans at country level, and presents key resources available in support of the proposed activities. It is addressed at individuals and groups who are concerned with the development of the human resource component of priority disease scale-up efforts, such as capacity building working groups, national HIV/AIDS programmes and/or consultants working on human resource and training

issues. It should be noted, however, that the scale up process will have to be supported by changes and/or additions to existing service organisation. A systems approach to identification of all health human resources, whether public or privately operating, their skills and possible contribution must therefore guide the exercise in order to arrive at a most cost-effective and comprehensive solution on a national scale, bearing in mind PHC support to be effected through the interventions proposed.

## **1. Have partnerships for capacity building been established?**

**Issues:** Human resource development and capacity building are complex issues that necessitate input from a range of stakeholders at the national level, for planning, implementation and monitoring. This is best achieved by bringing together a group of dedicated individuals and organisations in regular meetings, e.g. in the context of a “Human Resources Capacity Building Working Group” or a Human Resources Observatory serving as a sub-group of the appropriate National Steering Committee. Such a group should target a wide range of stakeholders, including the relevant government bodies (often Ministries of Health /Education /Finance), NGOs, training providers (universities and training schools), professional associations, and service providers, donors and TA providers. In countries where such a group does not exist, the UN can facilitate such a group, for example in the context of the expanded UN Theme Group. WHO in-country staff should drive the establishment of such a group.

### **Possible project proposal**

During the national consultations for, for example, a GFATM proposal on scaling up human resources for target diseases within a PHC framework, the National AIDS Control Organisation (NACO) or other priority disease consultative body in country may have identified a need to revise the core curriculum for training teams on priority interventions e.g. HIV AIDS prevention, malaria or TB control. A meeting could be organized by WHO and UNICEF, including NACO, selected State AIDS Organisations, NGOs, and designated training centres. It is proposed to develop the group into a continued capacity building working group which provides inputs to funding proposals.

## **2. Is there a good understanding of the human resource situation?**

When devising scale up plans for priority disease programmes in the short term (e.g. as part of GFATM proposal preparation), it is not always possible to go through a process of detailed assessment and deliberations due to time constraints. The following points suggest a number of operational steps for the development of the capacity building element of an overall scale-up plan. They were developed as ad-hoc guidance in the context of the emergency scale up and the development of related ad-hoc operational scale-up plans - notwithstanding the need for initiation of a more comprehensive process. In effect, with human resources plans for the entire health sector not always present or up to date in some countries, it may well be important to include the creation of a long term human resources development plan in the project proposal to ensure a wider framework and workforce development as part of systems support to specific priority diseases. Carrying out the steps below will already provide elements and show the technical review panel the significance of the strengthening proposal in order to reach priority disease objectives on the basis of a strong and sustainable PHC system.

A thorough assessment of the national human resource situation in the health is seen to be a precondition for the development of a meaningful and realistic approach to human resource development for priority health programmes. A proposal for human resources development support should include this background information so that a clear picture emerges for the funding agency to understand the urgency of the support needed and the reality behind the request for human resources development. Issues that need to be addressed include the following:

**A) What is the HR current situation? What are the size, composition and deployment of the workforce? (And the population of the country?)**

- What is the existent institutional capacity to conduct HR development at national level (existence, composition and characteristics of the HR department in the MoH)
- How good are the health information systems – is it possible to say how many of each professional are working and where they are based?
- Is there any specific information on how many health workers are currently involved in care for AIDS, Malaria and TB?
- What are the major HR problems as seen by key informants?

- What is known about the private sector and who is working in it?
- What is the strength of the professional associations? Do they have records of qualification?
- What are the main skills available? This may be different from roles, and a 'skills' audit may have been done to ascertain the main skills levels.
- What are the constraints to changing roles and responsibilities in the system?
- What other organizations are working on human resources for health in the country?

**B) What is the overall state of the national labour market?**

- What is the unemployment rate?
- Are there many school leavers and university leavers from health programmes who cannot find jobs?

**C) What is the state of the health labour market?**

- What is the number of funded posts?
- How many funded vacant posts are there?
- How many trained health professionals are currently unemployed?
- How many health professional are migrating overseas?
- Is an annual attrition rate from the health workforce available?

**D) Production of HR:**

- Capacity of medical/nursing/other undergraduate programmes to take more students
- Current 'drop out rate'
- Number and education of lecturers
- Number and qualification of practice teachers
- How many physicians, nurses, dentists and pharmacists that are produced each year by the country are able to find jobs? How many technicians? What happens to the others?

**E) What is known about provider performance?**

- Is there any effort to set standards and monitor provider performance? By whom?
- What management and supervision systems are in place?
- What is the legislative and regulatory support for practice?
- What is known about motivation levels? Have there been surveys and if so, by whom?
- Are there any pay or non-pay incentive schemes in operation to induce health workers to practice in difficult locations, or with particular patient groups or health needs?

**F) What HR policies and practices are in place?**

- What is the pay structure? Is there a zero growth policy for health sector wages?
- What are working conditions like at all levels? Are other resources adequate?

**G) Has there been specific in-service training on AIDS, malaria or TB? How many staff have attended?**

- Who are the major funders of specific training programmes?

**Calculating the overall human resources gap**

The World Health Report 2006 concluded that a ratio of 2.3 health workers (doctors, nurses, midwives) per 1,000 population is the bare minimum for a health system to have effect on any of the MDG related health targets.

So calculating this ratio for the country in question will illuminate the size of problem the proposed interventions wish to address. For example:

Total population:	23,000,000
Minimum workforce needed	$23,000,000/2.3*1,000 = 52,900$
Total actual health workforce size	40,000
GAP	<b>12,900</b>

The answers to these questions and the gap calculation will show the ‘state of health’ of the workforce. High unemployment rates overall suggest that the economy is depressed and therefore there is likely to be high unemployment in the health sector too. This can account for people migrating either overseas or to the private sector. Asking about regulatory support is vital as new practices might need new enabling legislation or regulation. If surveys of motivation of health workers have been done it is useful to know by whom as this can inform you of who might be interested in leading incentive reform to improve motivation, which of course underpins recruitment and retention. (NB: such initiatives can be built into the proposal for HR development). **Establishing the gap between the actual workforce, the minimum required workforce and situating the amount of HR to be generated into this context as an approximation** will document **concretely** which contributions the HR strengthening efforts will make through the disease specific HR interventions proposed to reduce the overall gap and render the system more effective.

**Example:** In Botswana, a process of health systems and HIV Human Resource analysis led to the integration of HR options for scale up in the national HIV and ARV Operational Strategy. In addition, the exercise stimulated the acceleration of the production of the Human Resources for Health Development Plan for the entire health sector for the next five-year period. (Further information can be requested from [dreeschn@who.int](mailto:dreeschn@who.int))

**Resources:**

- (.) A brief summary of issues and key questions relevant to human resource are outlined in the draft table developed by WHO/HRH<sup>1</sup>
- (.) WHO/HRH has developed a Rapid Assessment Guide on Human Resources for Health<sup>2</sup>

### **3. Have the human resource needs of the scale-up model been identified?**

Human resource needs directly flow from the service delivery model that a country adopts. What type of service delivery model a country opts for depends on a number of factors, including the consideration of treatment targets, existing health systems and service infrastructure, the distribution of service tasks between public/private/NGO providers of care, and the operational, financial and human resource feasibility.

Usually, the basic service delivery model for scaling up for a priority health programme has been defined by the appropriate national coordination body, and the current and potential available of human resources should play an important role in the design process. It is critical to spell out clearly the human resource implications of the service delivery model, in order to confirm the overall feasibility of the opted model, and to prepare for the development of human resource and training plans.

WHO has developed a set of tools and guidelines that can inform the development of the national HIV/AIDS treatment and care model. In particular, WHO has developed operational guidelines for comprehensive, acute and chronic HIV/AIDS care at first and second level facilities based on the approach of "Integrated Management of Adult and Adolescent Illness (IMAI). These operational guidelines are based on the WHO ARV treatment guidelines and support a team approach to ART in which health care workers take on significant tasks, including the initiation of ART as appropriate.

It is equally important to examine carefully the totality of human resource needs related to scaling up, including programme management at various levels (including country 3 by 5 management teams), and community treatment support. Human resources can also be budgeted under the “Technical Assistance” component (e.g. WHO country support staff).

**Box: Providing a quick estimate of Human Resource Needs for Rapid Scale up for a priority disease needing clinical interventions. Example of increasing access to ART**

For each professional category:

1. Establish the time commitment of each service provider for a patient contact (for example: 30 minutes for a doctor/health officer patient encounter) or activity
2. Check national protocols or other available guidance material which prescribes the number of patient visits. In the absence, take as a first best 'guestimate' the number of annual visits per patient (there is hardly a standard that can be defined, in case of HIV ART recent case studies found 7 - 9 visits considered sufficient by several practitioners, others proposed seeing a patient once a month leading to 12 visits per year).
3. Establish how many patient encounter minutes per visit are necessary on average during the course of one year: This will reflect a higher frequency of visits during the first months (for example for HIV ART 4 visits during the first three months, the next visit at 6, 9, and 12 months, if stable ). It will also reflect longer initial time needing to be spent with a new patient and less time during follow-up visits, once stable. These reference values should be extracted from local, experienced providers. Their experience will best represent all local constraints, opportunities, facility staffing norms, and possibilities for skills sharing.

ART example for a service provider (doctor, medical assistant, nurse)  
Establish the number of visits per year and their average length

For example: 7 visits \* 30 minutes per averaged patient encounter = 3.5 hours per patient per year

Establish the ART coverage goal e.g.: 15,000 patients

Calculate the total number of patient encounter hours per year:  
 $15,000 \text{ patients} * 3.5 \text{ hours each} = 52,500 \text{ patient encounter hours}$

Establish the annual working hours available for a service provider in country  
E.g. annual working hours:  $200 \text{ working days} * 8 = 1,600 \text{ working hours}$

Calculate the number of Full Time Equivalent (FTE) Human Resource need  
E. g.  $52,500 \text{ patient encounter hours} / 1,600 \text{ working hours} = 33 \text{ FTE service providers in clinical contact}$

Calculate re-current costs for human resources (including salaries and recruitment costs, excluding training costs)

NOTE: The total HR requirement arrived at may not necessarily be the total of new staff to be trained. An assessment of tasks which staff currently perform which could be transferred to someone else (e.g. nurses' cleaning tasks given to trained cleaners, thus freeing nurses' time for clinical work), provision of incentives for motivation, introduction of premiums, etc. may need to be discussed prior to decision-making. In any case, the HR need will develop towards the total as a function of a phased roll out, a review of tasks and functions of each service provider, and possible downward adjustments of patient encounter time needs as staff become experienced with treating ART patients and encounter time gets reduced within a stable patient community.

**Resources:**

- (.) Integrated Management of Adult and Adolescent Illness (IMAI) Guidelines and training material<sup>3</sup>
- (.) HIV Universal Access Guidelines<sup>1</sup>
- (.) Scaling up HIV/AIDS care: service delivery and human resources perspectives, WHO/HRH, Geneva 2005<sup>4</sup>
- (.) WHO costing tool for human resources and training of health workers for scaling up ART in hospitals and health centres

**4. Human resource recruitment and retention**

The calculation of the absolute numbers of individuals needed for delivering on the proposed scale-up should be double checked against the national human resource situation as assessed earlier on – with the lead question being whether the target staff numbers are at all feasible without negatively impacting on other parts of the health sector. If deemed unfeasible, the basic service delivery model might have to be changed (e.g. through devolvement of tasks from medical officers to nurses to multipurpose health care workers).

The feasibility of the proposed human resource targets should be demonstrated by outlining a strategy on how to recruit and retain personnel in their positions. Major elements to be considered include: recruiting health personnel currently not employed back into the health sector; increasing actual work time of health personnel in health services; recruitment of retired health staff; revision of the recruitment policy in the country (responsibility, norms for staffing distribution); review freeze recruitment policies and retention policies in under-served areas; employment of staff from countries with surplus of health workers; increase output of medical training schools; increase productivity through improving working conditions; provide professional development opportunities (CME); provide financial and non-financial incentives. These and other strategies, be it at individual, organizational, social or institutional level, need to be evaluated and tested within the country and regional context.

The proposal working group needs to involve various stakeholders, in particular those from the public services commissions and ministries of finance. These are particularly necessary if scale up strategies include payment incentives aimed at increasing retention. They must be designed with approval of the Min Finance, and they must be done in such a way that other members of the public function will share the perception of the need of the health sector to receive particular income supplementation or allowances. Otherwise resistance or calls from other public sector workers are likely to occur.

**Resources:**

- (.) "Guidelines for Human Resources for Health Policy and Plan Development at Country Level" (Draft), WHO AFRO 2004<sup>5</sup>
- (.) Human Resource Management Assessment Tool for HIV/AIDS Environments. Management Sciences for Health, Feb 2002
- (.) The Division of Health Systems and Service Development, WHO AFRO, has developed draft "Guidelines for Human Resources for Health - Policy and Plan Development at Country Level", Brazzaville 2004<sup>6</sup>
- (.) Scaling up HIV/AIDS care: service delivery and human resources perspectives, WHO/HRH, Geneva 2005

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<sup>1</sup> Guidelines can be found on the following website: <http://www.who.int/hiv/universalaccess2010/en/>

## **5. Competencies and curricula for groups involved in priority disease services**

Usually, the decision for a specific service delivery model is based on an understanding of basic tasks that need to be performed by the various groups involved in service implementation, as discussed in section 3.

The first step in developing a human resources development and capacity building training approach focuses on the identification of core competencies that groups need to have in order to be able to fulfil the assigned tasks (e.g. for HIV treatment, the task: prescribe first line ART; competencies: ability to perform staging; ability to do evaluate eligibility for treatment, etc.). The core competencies flow directly from the defined tasks of the care cadres, and once they are spelled out they will form the backbone of training curricula development. A comparison of required core competencies with pre-existing competencies of staff to be recruitment leads directly to the identification of training curricula. For TB, malaria or other priority disease interventions, similar exercises need to be undertaken. If this cannot be done in the time available, the project proposal should identify this need and include the task review in the activity list over the coming years of scale up.

### **Resources:**

(.) For HIV ART Basic recommendations on the task distribution among various groups involved were made in the Zambia Meeting<sup>7</sup> ([www.who.int/3by5/publications/documents/zambia/](http://www.who.int/3by5/publications/documents/zambia/)).

## **6. Appropriate training material and trained trainers**

The availability of simple training material is seen to be key for facilitating rapid training roll-out by a number of training providers whilst supporting adherence to national treatment guidelines and procedures. In many countries, a range of institutions have already gathered significant experience in training on various aspects of priority disease programmes such as the ones to the HIV/AIDS response, including treatment and care, and often training material has already been developed. The training material development process should hence focus on building on existing expertise and rapid upgrading along national and international standards.

Simplified and standardised training material facilitates training-roll out by a number of different training providers and adherence to nationally agreed training standards. Training material is hence best developed in collaboration between those leading the design and implementation of the PHC model with emphasis on priority diseases, and those with pre-existing training experience and adult education expertise. Often, training material is developed through a combination of consultative meetings and focused input by consultants who can support the adaptation / development of national training material (in many cases international).

Specific training material should be available for each of the core groups involved in scaling up, and include facilitators guides, participants guides job aids etc. Existing training material should be revised on the basis of national and international guidelines, and can take advantage of training packages published by WHO.

In particular, WHO has developed training packages for health workers at first and second level facilities based on the approach of "Integrated Management of Adult and Adolescent Illness (IMAI)" (see Box). WHO provides technical assistance in the adaptation of available training material to country context and the initial training of national facilitators. WHO is also maintaining contact with a number of training institutions that have prepared training material for a range of other health professionals and can provide references.

**Box: Example of preparing front-line workers: a WHO antiretroviral therapy training package for health workers at first-level facilities**

Recognizing the urgency of integrating HIV/AIDS treatment into health services at first- and second-level facilities, WHO and partners have developed a clinical HIV care training package based on the WHO Integrated Management of Adult and Adolescent Illness approach. The package is based on several simplified, operational guidelines covering *Acute care*, *Chronic HIV care with antiretroviral therapy*, *General principles of good chronic care* and *Palliative care* (<http://www.who.int/3by5/publications/documents/imai/en>, accessed 25 June 2004). These guidelines will support the shift of key tasks from physicians to nurses and health care workers and encourage the involvement of lay providers and the community. The WHO Integrated Management of Adult and Adolescent Illness guidelines have been translated into several readily adaptable training courses for health workers in first level facilities.

- *Basic antiretroviral therapy clinical training course.* This course prepares nurses, clinical officers or medical assistants to perform a clinical review, undertake clinical staging, provide prophylaxis, prepare patients for adherence, initiate a fixed-dose first-line antiretroviral regimen among people without complications under supervision, consult or refer to district medical officers, respond to side effects, monitor and support adherence, collect data based on a simple treatment card and effectively integrate HIV care and prevention. This course requires 4.5 days of training.
- *Antiretroviral therapy aide training course.* This course addresses HIV basics, including the continuum of care and progression of disease; available treatments; patient education and support; adherence preparation, monitoring and support; communication skills; group education and support; and reception and triage. This course also requires 4.5 days. It can be used with lay providers or staff with limited clinical background.
- *Short course on opportunistic infection management.* This course focuses on the emergency quick check, cough or difficult breathing (pneumonia, TB, and other causes of severe illness), mouth and skin problems, headache and meningitis and peripheral neuropathy. Emphasis is placed on when to suspect HIV infection or TB disease and how to manage less severe opportunistic infections, allowing many people with WHO Stage III and IV HIV disease to be treated prior to antiretroviral therapy without referral to the district.

All materials based on the WHO Integrated Management of Adult and Adolescent Illness approach were developed over time through expert consultation and field application. Effective, rapid processes of country adaptation are recognized to be key for their relevance to countries. For example, Uganda's Ministry of Health has adapted guidelines and training materials based on the WHO Integrated Management of Adult and Adolescent Illness approach. WHO helped to train a national core group of 40 facilitators and 30 expert-patient trainers who are now rolling out training based on the WHO Integrated Management of Adult and Adolescent Illness approach at the district level. WHO regional offices and headquarters are now setting up regional pools of experts who can provide support to countries in developing and rolling out antiretroviral therapy training all the way to first-level facilities. WHO will continue to learn from in-country application and improve and expand the range of tools available to implementers. WHO has already developed patient education flipcharts and patient treatment cards for each first-line regimen and is developing additional training aids such as videos. Additional materials, such as training courses based on the WHO Integrated Management of Adult and Adolescent Illness approach for district medical officers, are in production.

Training packages based on the WHO Integrated Management of Adult and Adolescent Illness approach are complemented by simplified patient monitoring guidelines that were agreed upon during an international meeting in March 2004. These are based on agreed minimal or essential data elements to be collected during clinical chronic HIV care and antiretroviral therapy to support direct care needs and drug supply monitoring at the facility level and to meet the reporting needs of district and national programmes in accordance with the overall WHO/UNAIDS recommendations.

**Resources:**

- (.) WHO in itself is developing training material for multipurpose health care workers, based on the ‘Integrated Management of Adult Illness (IMAI)’ approach, and specifically tailored to meet training needs for ART scale up at 1<sup>st</sup> level facilities<sup>8</sup>. For further information and support contact [goves@who.int](mailto:goves@who.int).
- (.) WHO has convened an international consensus meeting on training material development, in which many organisations shared material and activities that they have developed.

**7. Plan / strategy for in- and pre-service training**

The training system seeks to upgrade and maintain competence for various groups to be able to fulfil designated tasks in the scaling up process. In the short term, the training process focuses on reaching all staff in time for taking up their functions, usually following closely the roll-out model. This is best done in the form of short, standardised induction courses. In the mid-term, the training plans also addresses how staff will be able to maintain their competencies, and how training can be integrated into pre-service education.

The absolute number of individuals in need of training to be based on the number of full time equivalents needed, the time that staff will dedicate to the specific intervention, the planned phasing-in (e.g. 6 monthly increase in ART service staff), and the anticipated retention of staff (need to re-recruit and train). The most appropriate in-service training approach should be developed on the basis of considering the following points:

- Rapid training is usually rolled out in ‘waves’, where one institution trains 5-10 other institutions that themselves tutor more training providers. These ‘waves’ can either flow from the centre to the periphery (vertical roll-out: from 3<sup>rd</sup> level facility to 2<sup>nd</sup> level facilities to 1<sup>st</sup> level facilities), or all levels of service provision are involved from the start and train their “peer” institutions (horizontal roll-out: 3<sup>rd</sup> and 2<sup>nd</sup> and 1<sup>st</sup> level train a number of 3<sup>rd</sup> and 2<sup>nd</sup> and 1<sup>st</sup> level facilities) – or a combination of both.
- Training can happen in training centres, or be provided by mobile training teams that travel to designated facilities.
- Many trainings take a team approach in which all members of the team are trained together, whilst some trainings are specifically targeted towards specific groups – some training combine both approaches.
- Induction training is an important initial step to upgrading competencies, but needs to be complemented by ongoing support mechanisms (such as “helplines”, coaching approaches).
- Consider training for groups that are not directly involved in service provision, such as community treatment supporters, health officials and higher level managers. Also consider mechanisms for patient education.

Pre-service training is a critical contribution to a sustainable production of human resources in support of the scale-up plan, and should be included in fund proposals and scale up plan as such. Usually, operational steps and costs involved in introducing HIV/AIDS training in existing curricula are best determined by the educational institutions.

The implementation of training necessitates the identification of appropriate training providers that are able to offer the services defined in the training approach, and based on the national treatment guidelines and training material. Even though in many countries a range of institutions do already have significant experience related to training, such institutions might still need start-up technical and financial support to prepare for implementing training. Such support usually includes the training of trainers, and might also include upgrading existing infrastructure. Capacitating the training providers is an important step in the planning process and in grant request preparation.

In writing up a project proposal, the team should consider which type of training will be best suited to ensure short, medium and long term impact. Each of the approaches above need to be costed for the period envisioned, with estimates of participants etc. provided to the best possible detail.

## **8. Funding for human resource development and training**

Training activities are often concentrated in the initial phases for scaling up. In general, all major funding processes now encourage the inclusion of significant training budgets, and it is important that all funding proposal do include human resource development and training as a cross-cutting issue. For example, the earlier guidelines for GFATM proposals mention: “Particular focus should be paid to demonstrating how adequate human resources capacity will be developed (either through the proposal or by other means) in both public and private sectors to ensure successful implementation of the proposal. This is important for all proposals, but especially critical if current staffing levels (or distribution) are insufficient to handle the expansion of services covered in the proposal.”

In cases where funding available for training is insufficient, funders also provide an opportunity to re-programme the proposals accordingly. Finally, a number of bi-lateral organisations and donors are accepting requests for ad-hoc, smaller scale funding related to capacity building (e.g. GTZ BACKUP Initiative: [www.gtz.de/backup-initiative](http://www.gtz.de/backup-initiative)). These need to be taken account of when preparing a proposal to properly document the entire support in this area and avoid overlap.

WHO has developed a costing tool that can be used to calculate the total costs for salaries and for training of health workers at health centres and at hospitals (including nurses, counsellors, medical officers, manager, lab technicians and pharmacists). The calculation of total salary and training costs are made based on a guided provision of information related to (a) the specific coverage goal, (b) the time commitment of each service provider per patient contact, (c) the annual working hours available per service provider, (d) the number of hospitals and health centres, (e) the training requirements, and (f) the costs of training material and trainers.

### **Resources:**

(.) WHO costing tool for human resources and training of health workers for scaling up ART in hospitals and health centres<sup>9</sup>

## **9. Authorization to practice and certification**

Adequate staff training is seen as a prerequisite for the provision of quality services, and depending on the kind of knowledge to be acquired many countries require the demonstration of training certificates for accrediting services. Certifying trainees for the successful acquisition of competence through the training activity is in itself seen as an element of quality control for training providers, as they have to demonstrate that the training adheres to certain national standards.

Countries that decide to build in a certification component for trainees, do so on the basis of nationally defined standards and procedure that regulate (a) on what basis trainees will be awarded certification (including training content, training process, and outcome verification procedures), and (b) what processes can be put in place to enable training provider issues such certificates (e.g. accreditation of training providers). Both the development of such standards and the implementation of certification processes need to be defined and budget for in a scaling up plan / funding proposal. WHO has developed a draft concept paper that discusses certification concepts and proposed concrete steps towards the establishment of national certification systems.

Proposals which emphasize training need to build in the strengthening of certification processes at all levels.

**Resources:**

(.) See for example, concept Note on Certification of HIV/AIDS Health Workers<sup>10</sup>

**10. Continuous monitoring of human resources building efforts**

Even when great care has been taken to think through human capacity building issues related to scaling up access to priority diseases, changes in the human resource context might occur rapidly and affect the human resource component significantly. The implementation of the human resource component of a priority disease scale up plan needs hence constant and vigilant monitoring and improvement. These elements should be built into the design of the scale –up plan and/or funding proposals. Examples of activities include the continuation of a capacity building working group (see step 1) and the establishment of a system to collect core information related to human resources.

**Resources:**

(.) With the collaboration of WHO/HRH “Guidelines for introducing human resource indicators to monitor health service performance” have been produced by by Peter Hornby and Paul Forte, Keele University, England 2002 (please contact [dalpozm@who.int](mailto:dalpozm@who.int))

## ***Tools and guidelines***

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<sup>1</sup> A brief summary of issues and key questions relevant to human resources are outlined in the draft table developed by WHO/HRH, available on resource CD and or through [dreeschn@who.int](mailto:dreeschn@who.int)

<sup>2</sup> Rapid Assessment of Human Resources for Health, WHO/HRH, Geneva 2005, [http://www.who.int/hrh/tools/en/Rapid\\_Assessment\\_guide.pdf](http://www.who.int/hrh/tools/en/Rapid_Assessment_guide.pdf)

<sup>3</sup> Integrated Management of Adult and Adolescent Illness (IMAI): WHO Geneva 2004, Guidelines and training material; available at: <http://www.who.int/3by5/publications/documents/imai/en/>

<sup>4</sup> Scaling up HIV/AIDS care: service delivery and human resources perspectives, WHO Headquarters, EIP, [http://www.who.int/hrh/documents/en/HRH\\_ART\\_paper.pdf](http://www.who.int/hrh/documents/en/HRH_ART_paper.pdf)

<sup>5</sup> World Health Organisation. Regional Office for Africa. Guidelines for Human Resources for Health Policy and Plan Development at Country Level (Draft). Brazzaville, 2004. Available on resource CD or through [nyonij@afro.who.int](mailto:nyonij@afro.who.int) .

<sup>6</sup> Guidelines for Human Resources for Health - Policy and Plan Development at Country Level, Division of Health Systems and Services Development, Human Resource for Health Development Programme, WHO AFRO, Brazzaville 2004 (available on Resource CD)

<sup>7</sup> "Emergency scale-up of antiretroviral therapy in resource-limited settings: Technical and operational recommendations to achieve 3 by 5 - Report from the WHO/UNAIDS Zambia consultation, November 18-21, 2003, Lusaka, Zambia", WHO Geneva 2004 (<http://www.who.int/3by5/publications/documents/en/zambiaen.pdf>)

<sup>8</sup> "Integrated Management of Adult and Adolescent Illness" (IMAI) based HIV/AIDS guidelines and training documents are available online at <http://www.who.int/3by5/publications/documents/imai/en>. For most recent versions and TA please contact [goves@who.int](mailto:goves@who.int)

<sup>9</sup> Estimating training costs for the WHO "3 by 5" initiative using the (a) "Training" Excel workbook and (b) User's guide. Draft Document, WHO Geneva 2004. Available on Resource CD and through [tantorrest@who.int](mailto:tantorrest@who.int)

<sup>10</sup> Concept Note on Certification of HIV/AIDS Health Workers, Draft Concept Note, June 2004, WHO Geneva, Department of HIV/AIDS, available on CD-ROM and through [weilerg@who.int](mailto:weilerg@who.int)

**For Planning of HIV/AIDS and other priority health services see:**

**<http://www.who.int/hrh/tools/planning/en/index.html>**