

## Workforce Performance Support Systems

### Background and Strategy

The Capacity Project aimed to achieve the following results for performance support over the life of the Project:

- Health worker job satisfaction and retention increased in intervention settings; lessons learned and approaches suggested for wider use
- Provider productivity improved; approaches documented and disseminated
- Supervision systems strengthened
- Plan implementation skills of HR managers and practitioners enhanced.

The Project carried out a range of activities to increase knowledge about key factors affecting health worker productivity and retention, and assisted countries to design and test interventions to influence policies and improve service delivery. These ranged from identifying current best practices in retention to implementing work climate improvement and supportive supervision initiatives to conducting studies assessing health worker job satisfaction and reasons for leaving posts.

### Results

#### *Productivity*

The most significant result of the Project's work in productivity and retention was the design and implementation of useful, operational studies that can be replicated in other areas of a country or other countries. These included studies of health worker satisfaction in Uganda and health worker productivity in Tanzania that generated data that can be used to design and implement country-appropriate strategies and policies to attract, recruit, retain and improve the performance of workers in high-need regions.

The Project worked with the Zanzibar MOHSW to improve health care service delivery, efficiency and system performance. Following a Project-led health worker time utilization study, which found that less than half of health workers' time was spent on direct patient care, and nearly a quarter was spent waiting for clients, in-country partners decided to focus on improving productivity at the primary health care level. The Project worked with key stakeholders on the agreed set of productivity improvement interventions, which included simple facility-driven interventions such as improved signage, posting of facility hours, completing daily work plans, instituting weekly meetings and completing community outreach forms to monitor the balance of health worker activities. Additional interventions were designed to strengthen the technical working groups at the MOHSW and facilitate ownership for the interventions implemented at the facility and district levels within the Zanzibar health system. An evaluation of the intervention's effectiveness found that although the actual time spent in direct patient care did not change, time spent waiting dropped to 11% and the ratio of overall patient care to wait time changed from 2.1:1 to 3.9:1.

#### *Retention*

Retention continues to be a serious challenge in the HRH crisis. There is increasingly widespread commitment to initiatives to attract and retain skilled workers, especially in rural areas. However, the factors influencing health workers' decisions to move

*"Capacity Project has helped to fund a number of studies. Case in point is the retention study, leavers study [on health workers who left their employment], assessments in staffing gaps and needs in districts, the study on services for reproductive health and HIV/AIDS—to mention but a few. This will help the Ministry to develop appropriate plans of action in scaling up proper service delivery."*

—Francis Ntalazi,  
assistant commissioner  
of HR management,  
Uganda MOH

*"There is an aspect of involving everyone responsible in an activity, so that people feel it is our thing. Sometimes we seem to slow down but the Capacity Project keeps pushing us to continue. We very much appreciate that."*

—Khamis Khamis, head  
of the HR Division,  
Zanzibar MOHSW

*“There were tall grasses which even snakes could hide in. The workers were not comfortable. When patients came here, they were not interested [in entering] because this hospital is like they have come to the bush. [Now] we have so many flowers; they say the compound is neat.”*

–Morris Kai, nurse,  
St. Luke’s Mission  
Hospital, Kilifi, Kenya

Read *Worker Retention in HRH: Catalyzing and Tracking Change and Retention of Health Care Workers in Low-Resource Settings* (available at [www.capacityproject.org](http://www.capacityproject.org)).

from impoverished rural areas to richer and better equipped urban settings and from low-income countries to those offering higher salaries are complex. Available evidence consistently shows that health workers are ready to leave their posts because of low compensation, lack of practical and educational opportunities, poor working and living environments and inadequate social amenities.

The Project created an ambitious health worker retention initiative that identified and documented promising practices in retention (Ghana, Malawi), supported the collection and use of workforce data to understand trends in worker turnover and movement (Uganda, Liberia), identified and developed a set of innovative retention practices and implemented and tested those practices. In addition, the Project served as a contributing member of the WHO global expert group on retention.

The Project designed a retention study in Uganda to determine health worker job satisfaction and reasons for leaving health posts, and supported HRIS development to strengthen national-level retention planning. Data from the retention study were then analyzed to guide intervention development. Findings revealed that fewer than half of the 641 respondents reported being satisfied with their jobs. Satisfaction with salary was particularly low, and doctors were the least satisfied group. Working and living conditions were very poor, and workload was judged to be unmanageable. Working conditions were better in the private (nonprofit) sector than in the public sector, but compensation and job security were viewed as superior in the public sector. Although health workers had been in their jobs a long time (81% said they were still in their first jobs; average time with their employers was 13 years), about one in four would leave their jobs soon if they could, and more than half of doctors (57%) said they would like to leave their jobs. Most workers were employed where they were born or trained, suggesting implications for recruitment and retention. The important correlates of intent to stay or job satisfaction include the importance of salary (but not the satisfaction with salary, which is uniformly low), a good match between the job and the worker, active involvement in the facility, a manageable workload, supportive supervision, flexibility to manage the demands of work and home, job security and a job perceived as stimulating or fun.

Based on study findings, the Project assisted health ministry leaders in Uganda and Tanzania to pilot-test retention interventions to influence policies governing health worker retention. In Tanzania, the Project assisted the MOHSW to develop and begin implementation of an HRM briefing program for 19 districts participating in an emergency hiring initiative.

Tanzania’s Ulanga District, facing shortages of health workers at every service delivery level, implemented a workplace climate improvement initiative (WCI) with support from the Project, to improve morale and performance. The aspects targeted for improvement included management practices for facility managers and the work environment for health workers in frontline facilities. The year-long WCI, which began in April 2008, was implemented in 14 public sector facilities. Health workers confirmed that functioning of facilities improved in the 12 months of WCI implementation. There were increases in the proportion of health workers reporting availability of work plans (51% to 80%), constructive feedback (77% to 92%) and the provision of expanded scope of outreach services (55% to 96%). There was a dramatic

increase in client load, especially for PMTCT and ART services, following the intervention; the mean number of PMTCT clients increased threefold (50 to 150). Facilities revived community health boards to strengthen facility–community linkages. On average four meetings were held with the community board in the 12-month intervention period compared to one meeting in the year before the intervention. The proportion of clients reporting dissatisfaction with services received on the day of the baseline and endline visits dropped from 40% to 11%.

The Project also worked with the Kenya MOH to select and pilot simple, low-cost WCI interventions in ten rural facilities over 18 months. The initiative focused on four key areas: the patient/health worker relationship, the health worker/supervisor relationship, workplace environment and worker wellness. Facility-based teams assessed their own work climates and generated activity plans to test low-cost approaches for improvement. The initial survey found very low morale, and a vast majority of respondents were unhappy about the work climate. Facility-based teams assessed their own work climates and generated activity plans to test low-cost approaches. Interventions included improved signage, job descriptions, organizational vision and mission statements, departmental work plans, more equitable shifts, managed inventories, safe waste disposal, cleaner yards and facilities, more organized patient flow, infection prevention protocols, staff lounges with free tea, new resource centers, painting and refurbishment of facilities, new equipment and more frequent team meetings and sharing of information. In addition, the Project provided leadership training to members of WCI facility teams to support the initiative. In a follow-up survey, nearly all staff in the ten sites expressed high satisfaction with their environments and had no intention of leaving. All sites reported increases in service use. Examples of improvements cited by Project supervisory teams include better staff morale, improved patient–provider relations, safe waste disposal procedures followed, improved signage, organized patient flow procedures and cleaner facilities for staff and patients.

### ***Supporting Health Worker Performance with Effective Supervision***

Access to quality health services depends on the performance of skilled personnel. Consequently, improving the effectiveness and efficiency of health services requires continuous support for health workers to allow those in the frontline of service delivery to perform as expected. Supervision, therefore, is one of the most relevant tasks in health systems management. However, health managers commonly neglect supervision, and many supervisors lack the knowledge, skills and tools for effective supervision. To address these shortcomings, the Capacity Project worked with governments and partners in Uganda and Central America to test a performance support (PS) approach that implements performance improvement and supportive supervision in a complementary way.

In Belize, Costa Rica, El Salvador, Guatemala, Nicaragua and Panama, national health authorities decided to increase the number of hospitals providing HIV services to address barriers to access given the centralization of services, persistence of stigma and discrimination and lack of nutritional management. The Project applied the PS approach in 36 hospitals across the six countries. The approach includes five steps: 1) foster agreements and commitments among stakeholders, 2) determine the expected performance of local health teams, 3) assist local health teams to carry out performance improvement, 4) manage change and 5) celebrate progress.

*“This is the first time in my career that I knew very clearly what the staff in the visited health center needed; it has been the first time that I was able to support them. The performance assessment tool allowed me to see beyond the appearance. Performance support is the key for making supervision supportive.”*

—District health officer, Uganda

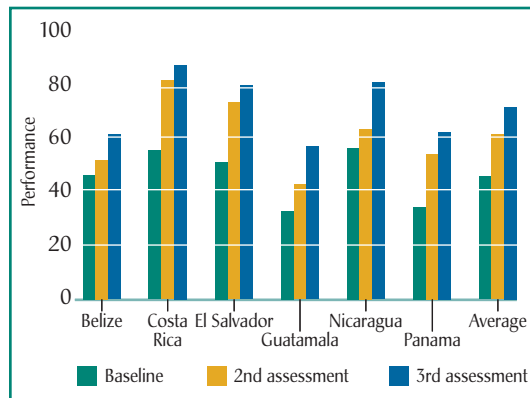


*“Multidisciplinary teams at HIV clinics are being empowered and are implementing a series of unprecedented change and improvement efforts. The teams are now able to identify specific needs that should be addressed by the central level. This is a very significant change, because it has helped us identify that [the] technical accompaniment of operational services by central-level programs has been weak. The performance support approach is allowing us to address this topic in a more systematic, sustainable and friendly manner.”*

–Dr. Gloria Terwes,  
national officer of the  
HIV Prevention and  
Control Unit, Costa  
Rican Social Security

The implementation of this approach allowed local teams to identify performance standards, study current performance and bridge identified performance gaps, including improving logistics systems, acquiring basic equipment, addressing stigma and discriminatory practices and improving infection prevention practices. National authorities also addressed systemic cross-cutting issues, such as improving nutritional care guidelines, strengthening infrastructure deficiencies and addressing HRH shortages.

The national and regional management teams adjusted their usual supervision approach, aligning their plans to respond to the actual hospital needs. In Guatemala, the MOH’s Hospital Management Unit incorporated PS into its plans and agendas. In Nicaragua, the general secretary of health led the PS implementation, adopting the performance standards for HIV treatment and care, including PMTCT, and expanding the use of PS beyond HIV services. Regional teams built partnerships with NGOs to implement PS in their private clinics. In Panama, the national HIV program incorporated PS into its supervision plan. Costa Rican Social Security used PS as the key intervention to facilitate the decentralization of HIV services, incorporating it into its management plans. El Salvador’s national HIV program incorporated PS as one of its management responsibilities and created a budget line item to support these activities; hospitals created PS teams to continue its implementation beyond the Project’s intervention. Follow-up assessments revealed an average improvement in HIV service standards performance of 26 percentage points from baseline (46%) to the third assessment (72%) across the six countries and strengthened supervision activities.



**Average Compliance with HIV Service Performance Standards, Central America**

## Lessons Learned

- Stronger HRM systems and better HR management will lead to improved work climate and more effective supervision, and this in turn can enhance health workers' performance by encouraging motivation, productivity and retention.
- Based on local conditions, countries should consider an appropriate mix of incentives that will be sustainable in the long term. Encouraging HR managers to use simple survey methods and tools to solicit health worker input will help to determine the best incentive mix for a particular context.
- Building a strong team and systems at all levels of health care delivery to lead HRH planning and management is one untapped practice that may yield good returns for addressing shortages and imbalances, including high turnover.
- A workplace climate initiative that accounts for a skills update in management practices combined with action planning, supportive supervision and infrastructure improvement has a good chance for success, up to the service delivery level.
- Health workers are not necessarily looking for costly incentives; they see value in taking smaller actions to improve their workplace or their living conditions (especially if placed in a rural, remote area).
- Districts that take the initiative to include HRH interventions will more likely take actions to improve recruitment, productivity and the climate in the workplace.
- Selecting only one service delivery or management issue helps to focus performance support efforts.
- Gender issues often play a key role in retention and productivity of health workers.

Read *Supporting Health Worker Performance with Effective Supervision* (available at [www.capacityproject.org](http://www.capacityproject.org)).

