Aligning HRH Competencies with Local Health Needs – Piloting the Rapid Task Analysis in Madagascar

HRH2030: Human Resources for Health in 2030

March 13, 2018

This publication was produced for review by the United States Agency for International Development. It was prepared by members of the HRH2030 consortium.
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HRH2030: Human Resources for Health in 2030

Cooperative Agreement No. AID-OAA-A-15-00046

Cover photo: Basic Health Centre or Centre Santé de Bases (CSBs) managers in Madagascar’s Andramasina District meet on August 30, 2017 with the Ministry of Health Director of Training to learn how to administer the HRH2030 Rapid Task Analysis tool. These sessions were key to piloting the rapid task analysis and provided insight into future training needs. (Credit: Landy Andriaanivosowba/Palladium)

DISCLAIMER

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**Acronyms**

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<th>Acronym</th>
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<tr>
<td>CBIHP</td>
<td>Community-based Integrated Health Program (MAHEFA)</td>
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<td>CHW</td>
<td>community health worker (aka community health volunteer)</td>
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<td>CSB</td>
<td>centres santé de bases (community health centers)</td>
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<tr>
<td>FP</td>
<td>family planning</td>
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<td>HR</td>
<td>human resources</td>
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<td>HRH</td>
<td>human resources for health</td>
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<td>MCH</td>
<td>maternal and child health</td>
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<td>NGO</td>
<td>nongovernmental organization</td>
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<td>SOW</td>
<td>scope of work</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WHO</td>
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Executive Summary

To best serve the health needs of communities, managers should align the maternal and child health (MCH), family planning (FP), HIV/AIDS, and other primary healthcare competencies of providers with the needs and demands of the populations served. Alignment of competencies and skills ensures that health workers are prepared to work with clients on specific issues or topics of need, such as promoting behavior change in condom use and disposal and offering counseling specific to family planning options or HIV prevention in the clinical service area.

HRH2030 adapted a task analysis methodology to create a rapid assessment approach for identifying health worker competencies in MCH, FP, and HIV/AIDS services, and implemented it among Andramasina District community health workers (CHWs) in Madagascar’s Analamanga Region. The task analysis rapid assessment approach in Madagascar will be used to inform further global scale-up and provide simple tools for health services managers to ensure alignment of MCH, FP, and HIV/AIDS skills with community needs.

For Madagascar, the results were used to inform Ministry of Health’s 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. In a global sense, the activity is intended to inform the ministry’s selection of approaches and tools toward improving the alignment of local population health needs and human resources for health (HRH). The findings can also be used to tailor continuing professional education and in-service training activities to improve the overall quality of services and health impact.

The HRH2030 team for this activity determined the specific tasks and competencies to be explored in the analysis through a virtual group of stakeholders, including local and global subject matter experts, country-specific technical teams, and the Ministry of Health. Using various CHW job descriptions and scopes of work (SOW) to select relevant MCH-, FP-, and HIV/AIDS-related tasks, the virtual group identified five tasks to include in the rapid task analysis questionnaire. The 10 Basic Health Centre (or Centre Santé de Bases [CSB]) managers in Andramasina District conducted the administration of the questionnaire; each of these managers is responsible for managing a CHW group serving communities within five kilometers of the CSB.

The results of the rapid task analysis provided insight into the self-perceived competencies, level of training, and frequency of performance for each of the five tasks. Most remarkably, in all five tasks, less than half of the respondents reported having any training (formal, informal, or otherwise) on a task. Given that the chosen tasks were relatively fundamental to MCH, FP, and HIV/AIDS care, the results gave CSB managers their first look into the experience and training history of their CHWs. At the rapid task analysis debrief and workshop held in Andramasina.
District for the CSB managers in cooperation with several Ministry of Health officials, participants confirmed the usefulness of the task analysis tool and supported the methodology. A more comprehensive rapid task analysis workshop and policy discussion was held in Antananarivo for national-level stakeholders, including Ministry of Health representatives, various nongovernmental organizations (NGOs), and several participants from Andramasina District. Using the implementation experience and associated data set, stakeholders were trained in the rapid task analysis methodology and given the opportunity to provide feedback on the planning, questionnaire development, data collection process, and usefulness of the tool. Given the positive feedback and results of the exercise, the ministry’s director of training signaled that she intends to implement a broader task analysis survey across several of Madagascar’s clinical cadres.

Interestingly, the portfolio of recommendations resulting from the implementation are universally applicable to global scale-up of the rapid task analysis tool. From suggestions regarding the questionnaire design to questionnaire administration and necessary follow-up, Madagascar’s experience can inform a more applicable, precise process for implementation, regardless of country context.
Rapid Task Analysis Implementation

As part of the HRH2030 program's goal of helping low- and middle-income countries develop the health workforce needed to end preventable maternal and child deaths, support the goals of Family Planning 2020, control the HIV and AIDS epidemic, and protect communities from infectious diseases, it is essential that health provider skills align with community health needs. To provide health program managers with evidence-based tools they can apply to ensure this alignment, HRH2030 is developing an abbreviated version of the Jhpiego Task Analysis methodology\(^1\) for global application, which will be informed by the pilot in Madagascar. The methodology described herein is referred to as a “rapid task analysis.” Although Jhpiego's original version assesses the comprehensive tasks of a health provider's entire scope of work, HRH2030's rapid version is meant to provide managers (including those in clinical and administrative settings) with a simple tool that can be applied quickly to better understand workforce competency for critical tasks.

Each healthcare worker participating in the task analysis is asked to make four judgments about the defined tasks. These basic judgments are appropriately worded for the chosen cadre context but generally include the following:

1. **Frequency** – How often is the task performed?
2. **Criticality** – How significant and important is the task for the patient/client?
3. **Location** – When and where was the healthcare worker educated/trained to perform the task?
4. **Performance** – What is the perceived level of competence of the health worker for the task?

The results of the task analysis provide the Ministry of Health and other healthcare stakeholders insight into a relatively simple methodology used for health system strengthening at the most relevant community-centered point of MCH, HIV, and FP service delivery. Findings can be used to tailor continuing professional education and in-service training activities, thus improving the overall quality of services and health impact. This information can then be used to design targeted in-service capacity-building interventions for health workers on specific issues or topics, such as promoting behavior change in condom use or offering counseling specific to family planning options.

Rapid Task Analysis Scoping Trip

To spur rapid task analysis adoption and support, HRH2030 conducted a scoping trip in December 2016 to orient stakeholders on the activity. Participants included the Ministry of Health’s secretary general and Human Resources Division director, managers and staff from USAID/Madagascar, and various NGOs and faith-based organizations operating in the health space. First, HRH2030 staff held informational sessions to review the purpose of the rapid task analysis. HRH2030 then used a snowball technique, permitting known stakeholders to assist HRH2030 in identifying the most inclusive stakeholder group. This scoping trip was instrumental in guiding the direction of the rapid task analysis and associated assessment processes based on ministry needs. Close coordination with USAID/Madagascar’s senior advisor for health systems strengthening and a local consultant helped to maintain progress in the post-scoping trip period.

The Ministry of Health decided to use the rapid task analysis with a CHW cohort because the CHW system is Madagascar’s most developed national system for provision of basic health services in urban, rural, and remote areas. Although the CHW system involves engaging volunteers to promote community-based maternal, neonatal, and reproductive and child health service delivery, the model also permits CHWs to sell certain basic subsidized health supplies, such as paracetamol, iron/folic acid, and oral rehydration salts, among other items. Each CHW is located within a five-kilometer radius from its managing CSB. HRH2030 and the ministry conducted meetings in February and March 2017 with two other key implementing partners that provide CHW support — the John Snow (JSI) USAID-funded Madagascar Community-based Integrated Health Program (CBIHP or MAHEFA) and the Management Sciences for Health (MSH) USAID Mikolo Project. Each meeting provided an overview of the partner’s CHW-related components, and the interview team was able to gain an understanding of overall CHW management strategy, distribution, training, and services through the various programs.

Identifying the Rapid Task Analysis Pilot CHW Cadre

In parallel with rapid task analysis questionnaire development, discussions took place with Mikolo, MAHEFA, and the Ministry of Health in May and June 2017 regarding potential cadres of CHWs with whom to conduct the pilot assessment. Logistical challenges arose with selecting CHWs for both the Mikolo- and MAHEFA-managed regions, given the remote nature of the CHW and CSB practices in Madagascar’s far north and far south. Because the ministry manages the majority of central Madagascar’s CHWs — all closer to the capital city of Antananarivo — the Andramasina District was chosen due to its proximity to the capital and the manageable number of its CHWs (154 CHWs in 10 CSBs).

Creation of the Rapid Task Analysis Questionnaire

The HRH2030 team in collaboration with the Ministry of Health, created the Madagascar CHW rapid task analysis questionnaire in May 2017 using a data collection form similar to those included in the Jhpiego’s Task Master™. The results from another recent unpublished study that reported the successful use of task analysis in Peru also helped inform the questionnaire design. That study targeted a small number of priority tasks to inform local family planning in-service training design and was used as a model for the Madagascar implementation.

To determine the specific tasks to be included, the HRH2030 team formed a virtual group of stakeholders, including local and global subject matter experts, country-specific technical teams, and the Ministry of Health. Using four separate CHW job descriptions and SOWs, the team pulled those tasks relevant to MCH, FP, and HIV/AIDS care practices, and placed them into a task matrix. Three of the four job descriptions were from Mikolo, MAHEFA, and the Ministry of Health, each of which manage separate large groups of CHWs in Madagascar. The fourth was the CHW SOW published by the World Health Organization (WHO) for global reference. The team further refined the tasks to be selected by identifying commonalities in task descriptions across the four CHW job descriptions and/or SOWs.

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The team then aggregated the MCH, FP, and HIV/AIDS tasks common across all the various job
descriptions and/or SOW documents and sent them to the virtual group of subject matter
experts. The team asked the experts from each area to identify two to three tasks in MCH, FP,
and HIV/AIDS (for a total of four to six) they viewed as most critical to patient care. Based on
their feedback, the team prepared a final task listing, with the following tasks selected by the
stakeholder group:

Task 1 – Discuss prenatal visit schedule and its health benefits with pregnant women and
caregivers.
Task 2 – Provide delivery counseling, including identification of danger signs and a delivery plan
with the CSB (health center).
Task 3 – Support patients in discussing options of family planning methods (including postpartum
IUD) and assist patients in choosing the best options for them.
Task 4 – Voluntary and confidential HIV screening is discussed to raise HIV awareness and
reduce stigma.
Task 5 – Teach patients from at-risk groups how to use, and properly dispose of, condoms.

The team then formatted critical tasks that had been identified into the rapid task analysis
questionnaire form (Annex A, translated into English; the original was in French).

Questionnaire Administration

In collaboration with the Ministry of Health’s training director, the HRH2030 team worked with
the ministry’s Andramasina medical inspector to secure the district’s commitment to implement
the rapid task analysis. During an onsite visit to the Andramasina District Ministry of Health
offices in early August 2017, the proposed questionnaire was reviewed and the participation of
various CSBs and their respective CHWs was discussed. These discussions included
development of an implementation plan, including a local training for CSB managers in the
application of the tool and the proposed timeline for questionnaire completion and return.

Ten CSB managers were trained to administer the rapid task analysis tool during a special two-
hour meeting held on September 1, 2017, after which they returned to their respective facilities
to distribute it for completion by each CSB’s associated CHW group. The HRH2030 team
fielded any clarifications or follow-up questions (via mobile phone contact or email) raised by
the CSB managers during the two-week questionnaire administration. The CSBs then returned
the completed questionnaires to the Andramasina District Ministry of Health offices, where the
HRH2030 local consultant picked them up.

Compilation and Analysis of Results

All 10 selected CSB sites in Andramasina District returned questionnaire results, for a total of
154 individual CHW responses. The number of CHWs per CSB ranged from a low of six up to
31. The HRH2030 team reviewed the paper questionnaires for completion and legibility; none
was identified for exclusion. The team then entered data into an Excel spreadsheet and
proceeded with review and analysis.

Results Dissemination

HRH2030 scheduled two separate results disseminations. The first was held in the Andramasina
District, with the intent of re-engaging the rapid task analysis participants, presenting the results,
and gaining feedback on the tool and its implementation. The second was held in Antananarivo and targeted national stakeholders involved with HRH policy and training, with the intent of disseminating the rapid task analysis approach and engaging policymakers on potential uses.

**Andramasina Dissemination Workshop**

HRH2030 held a three-hour workshop on September 26, 2017 in a meeting room close to the Andramasina District Ministry of Health offices, and presented overall results to nine CSB managers, four CHWs (all with the Andramasina CSB), local Ministry of Health administrative staff, and several national Ministry of Health attendees (Annex C.) The CSB managers received their individual CHW cohort results for reference during the dissemination.

The workshop included two primary goals: (1) to share the data and analysis with the respective CSBs; and (2) to receive feedback on the usefulness of the rapid task analysis, the questionnaire, and the applicability of the questionnaire administration trainings. Additionally, the Ministry of Health director of training took the opportunity to present her vision for the ministry, the national HRH training plans, and proposed strategies.

**Antananarivo National Workshop**

HRH2030 organized a half-day workshop in Antananarivo on September 28, 2017, using the Andramasina results as a basis for disseminating the rapid task analysis methodology and exploring its utility and possible scale-up across other Ministry of Health geographies and health provider cadres. Attendees included 28 participants broadly representative of national and regional ministry stakeholders, USAID, MAHEFA, Mikolo, other applicable NGOs, and project leads. (The workshop agenda is attached as Annex B.) Conducted in French, the Ministry of Health Directors of Human Resources and Training began the workshop by presenting the Ministry of Health’s HR training policy and introducing the rapid task analysis as a potential tool for designing in-service capacity-building interventions.

Directly following the Ministry of Health presentations, HRH2030 provided Andramasina’s rapid task analysis results, showing participants the development, data collection processes, and activity results. Before the breakout sessions, Dr. Rakotomanana, the Ministry of Health training director, proposed integrating the task analysis methodology within normal Ministry of Health procedures and scaling up its use to assess various cadres of health providers nationally. The workshop also was used to present a draft task analysis survey “Evaluation Rapide des Tâches et Identification de Besoins Formation” (“Identification of Training and Needs Assessment Through the Rapid Task Analysis”). This scale-up would be used to create an updated database of practicing physicians for collecting demographic information and would include several skills-related tasks through use of the questionnaire format.

For the workshop portion, workshop leaders divided attendees into three groups by using a counting method (counting 1-2-3 around the table and splitting up those participants who may have naturally grouped together). Each group received a copy of the task analysis tool, and members were asked to take 30 minutes to discuss their recommendations and consider how or if the rapid task analysis methodology would be a useful tool in the context of their work. A spokesperson for each group was then asked to come forward to present his or her group’s primary thoughts about implementing and scaling up the rapid task analysis in Madagascar.
Rapid Task Analysis Results and Recommendations

Rapid Task Analysis – Selected Results Compilation

The primary purpose of applying the rapid task analysis was to provide a useful local pilot and data set to illustrate the methodology to Madagascar’s HRH stakeholders. Secondly, this same limited CHW rapid task analysis data set is intended for use by the Andramasina CSBs and local leadership to drive the formulation of in-service skills training programs that align with community health needs. CSB managers and the Ministry of Health received raw data and individual CSB results from the rapid task analysis so they could do further comparisons and data extractions, such as looking at differences in the data among CSBs with respect to confidence, training history, and frequency.

The results detailed within this report represent those aspects of the rapid task analysis data used in the workshop for teaching purposes. Because the primary workshop was designed for use by policymakers and stakeholders in a national scale-up, the report presents all data in aggregate rather than for individual CSBs, except for the perceived task confidence level per CSB (see below). For the entire CHW group, the average number of years reported as practicing was 8.04, and the average number of years as a CHW associated with the current CSB was 7.95, indicating little transfer or movement of CHWs among CSB sites.

Perceived Task Confidence Level per CSB. Figure 1 represents the range of self-perceived confidence in performing each task on a scale of 1 to 8, with 1 being the lowest confidence level and 8 the highest level, per CSB. (For a complete display of confidence descriptions, please reference the questionnaire, provided in Annex A.) The figure depicts CSB response comparisons, with the lowest confidence shown in the Anepoka CSB (1–2) and the highest reported levels of confidence in Manjaka Ouest CSB (2–5). Of particular interest is the result showing that, on average, across all 10 CSBs, CHW task confidence ranges between 2 and 3, representing a potential concern regarding quality of care.

Figure 1. Perceived Task Confidence Level, per CSB
CHWs Receiving Training, per Task. Overall results related to training showed a general lack of training in all identified tasks, as exhibited in Figure 2. None of the 10 CSBs (n=154 CHWs) reported more than 50 percent of CHW staff as having received training in any specific task. Training for Task 4 (HIV screening) and Task 5 (condom use) was markedly lacking, with only 30 percent of CHWs reporting training in either task. When asked during the workshop, CHWs attributed this lack of training to Madagascar’s cultural stigma against the recognition of HIV in communities and a relative taboo associated with condom use in rural areas.

Note: In total, 66 CHWs (all CHWs in four of the 10 CSB sites, including Andramasina, Ambohibemanjaka, Antotohazo, and Anepoka) consistently reported that they had no training in the five tasks and, for the most part, indicated they rarely performed those tasks. Based on the wording of the training question, training could have occurred at any time in a CHW’s career, not necessarily while working at the current CSB. Granted the relatively basic nature of the tasks with respect to MCH, FP, and HIV/AIDS care, these responses came as a surprise to the Ministry of Health and HRH2030 staff, leading the team to question whether the questionnaires were administered correctly. Through further discussion about the Andramasina local dissemination, it emerged that the CSB managers reported it was entirely possible that the CHWs in fact had no training in the task areas named.

![Figure 2. Percentage of CHWs (n=154) Receiving Training, per Task](image)

Share of Health Workers Receiving Training, by Task and Training Type. For respondents who reported “yes” to having received training, they then were asked whether it was pre-service, formal in-service, or informal on-the-job training (called “non-formal”). Figure 3 shows that formal in-service training is the most common form (a range of 21 to 27 percent), with on-the-job informal training next (a range of 5 to 20 percent); actual pre-service training (a range of 1 to 4 percent) has a very minor role in CHW learning methods. The majority of reported trainings span the 2012 to 2017 date range, with a minority subset reporting earlier dates of 2000 and 2005.
Confidence in Performing Task, by Training Modality. Figure 4 shows how the training method correlates with the CHW’s confidence in task performance. Across all tasks, pre-service education appears to have the greatest impact on confidence, with formal in-service education ranking second. Note, however, that the actual number of CHWs reporting that they received training via pre-service education remains low, as shown in Figure 2.
Workshop Recommendations for National and Global Scale-up

During the dissemination workshops in Andramasina and Antananarivo, HRH2030 asked participants for feedback on various aspects of the rapid task analysis assessment, including questionnaire design, task designation, training, administration, and applicability to CHW training. This exercise was not limited to the application in Madagascar but was applied more generally to inform modifications of the tool and process for global scale-up and strengthening of FP, MCH, and HIV/AIDS skills alignment.

In Andramasina, the workshop provided an additional benefit to participants by the presence of the Ministry of Health’s director of human resources. His attendance provided a forum for the CSB managers and local Ministry of Health staff to express concerns and suggestions to their leadership about the rapid task analysis results. As mentioned in the Rapid Task Analysis – Selected Results Compilation (page 7), the data revealed that the CHWs at several sites had no training for these basic tasks, whereas others did have training, the majority of which was reported as “in-service” or “on-the-job.” Participants noted this lack of uniformity in training and raised their concerns with the director of human resources regarding the quality and content of services provided through CHWs across the Andramasina District, and likely more broadly in Madagascar.

The CSB managers in Andramasina appreciated the tool’s simplicity and were interested in its further application to understand knowledge gaps and advocate for additional in-service training. Similarly, in the Antananarivo workshop, participants widely viewed the tool as useful and concise in its application, providing a consensus for Madagascar to implement task assessments within both clinical and non-clinical health services cadres.

Feedback received during the dissemination workshops included specific recommendations to improve the rapid task analysis tool and its implementation. In addition to providing specific recommendations for the Ministry of Health to adapt and scale up the rapid task analysis methodology in the country, the Madagascar experience provides valuable lessons learned and recommendations for other countries to consider when using it. The following recommendations from the dissemination workshops include a mix of positive feedback on the tool and recommendations for future use. They are grouped into seven categories (flexibility, alignment with strategic goals, ease of administration, consideration of task content, questionnaire format, administration, and results use).

Flexibility

- The rapid task analysis questionnaire can be deployed quickly. For example, participants thought the task analysis could be used to assess competencies related to the recent outbreak of plague. More specifically, the task questions could be administered post-
training to assess knowledge retention and practices, including asking the right questions for identifying and referring potential plague infections.

- The tool can be administered to various levels of clinical and non-clinical Ministry of Health staff.
- The tasks to be chosen can range from those related to administrative and communication skills to higher-level clinical practice. Such flexibility allows for control of task choices at the managerial or local level.

Alignment with (Central and/or District) Strategic Goals

- Tailoring the questionnaire to address training aspects of the Ministry of Health strategic plan can help managers assess whether the plans are being adopted and understood.
- When district leadership recognizes potential challenges/deficiencies, they can create task questionnaires to address these topics.
- A task analysis could easily be administered twice per year to provide a status check on alignment.

Ease of Administration

- CHWs have some of the lowest levels of basic education, yet the HRH2030 team successfully administered the questionnaire to them in conjunction with CSB managers, proving its feasibility for use with all Ministry of Health staff.
- The task analysis can be used to make CSB monthly meetings more grounded in the reality of patient care and practice.
- The Ministry of Health training division has an existing structure through which it can easily disseminate the methodology.
- The Ministry of Health should offer continuous support in the use and implementation of the tool, including any additional training needs.

Consideration of Task Content

- The task analysis methodology allows for more local determination of tasks, but this determination would depend on Ministry of Health directives and purposes. For instance, managers may need to address variations in tasks identified for urban vs. rural service areas.
- The Ministry of Health should define goals and objectives for each rapid task analysis application before its administration and task choice.
- More open-ended response options could be created to collect some qualitative data.
- Those creating the task questions should make sure they are worded appropriately to accommodate respondents’ comprehension and reading levels.
- The Ministry of Health should provide specific training for creating/choosing questionnaire tasks.
Questionnaire Format

- Some participants felt that the questionnaire’s format was complicated and could use simplification. (They provided no specific suggestions.)
- Some participants suggested more questions (e.g., 10) should be asked (facilitators emphasized with the group that the number of questions could be determined according to need but should be kept within reason to be considered “rapid”).
- Another suggestion was to reduce the competency response scale from eight options to four because having multiple options within each competency description was confusing for some respondents.

Administration

- The questionnaire should be completed by respondents, but with a trained individual or manager present to answer questions and help guide respondents when needed.
- Administering the questionnaire during group meetings would be most beneficial.
- Results should be available quickly for immediate dissemination.
- The Ministry of Health should provide training in administration of the tool.
- Those administering the rapid task analysis should provide more counseling and communications to assure participants that the rapid task analysis is not a punitive exercise; to this end, possibly provide a written “preamble” or similar elaboration.

Results Use

- The Ministry of Health should use the task analysis results to develop Ministry of Health training plans and curricula, which would align with community health needs.
- Gathering task analysis results for use at the national level may be challenging and require standardization of tasks in a way that may not be applicable to all districts/communities.
- The Ministry of Health and other stakeholders should also promote national training budgets and targeted approaches to training.
- For identified training/skills gaps, the Ministry of Health should supply in-service training resources. (Participants viewed identifying gaps without additional resources to close those gaps as unproductive.)
Conclusions and Next Steps

Stakeholders in Madagascar displayed significant enthusiasm for the rapid task analysis tool throughout the disseminations and workshop. As mentioned in the implementation section on the Antananarivo workshop, Dr. Andriambazotiana Rakotomanana, the Ministry of Health’s director of training, had already integrated the methodology into her preparation of the presentation “Evaluation Rapide des Tâches et Identification de Besoins Formation” (“Identification of Training and Needs Assessment Through the Rapid Task Analysis”). The questionnaire she presented had already integrated several tasks into a larger demographic survey targeted at Ministry of Health physicians.

The Madagascar Ministry of Health Human Resources Department now has the knowledge to scale up the rapid task analysis as needed to support any broader assessment and training goals. Using the results feedback from the Andramasina dissemination and Antananarivo workshop, Ministry of Health leadership can refine the development and administration of the rapid task analysis and apply it across various cadres of health and non-health staff. On a global scale, whether countries seek to assess tasks related to MCH, FP, or HIV/AIDS, the rapid task analysis methodology provides health services managers and leadership with a concise tool to ensure alignment of skills and population health needs.
**Annex A. Questionnaire – Rapid Task Analysis of Community Health Volunteers (CHVs)**

Associated Centres Santé de Bases (CSB):
- ☐ XX ☐ XX
- ☐ XX ☐ XX

Cadre:
- ☐ Community Health Volunteer ☐ Other

How many years of professional practice:
- _______ years

How many years working in this clinic:
- _______ years

**TASK 1:** Discuss prenatal visit schedule and its health benefits with pregnant women and caregivers.

How confident do you feel to perform this task? Please choose from options on the scale below.

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<th>2</th>
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<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>I need to update my knowledge and skills and have more practice opportunities</td>
<td>I have the basic knowledge and skills but need help to master the task</td>
<td>I have the knowledge and skills required for this task, but don’t feel confident to coach others</td>
<td>I have reached a high level of expertise and can coach others</td>
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Have you been trained for this task? ☐ Yes ☐ No

If Yes, approximate date of last training? (Month/Year) ____/______

If Yes, Training Modality
- ☐ On-the-job non-formal
- ☐ Formal in-service
- ☐ Pre-service

How frequently do you perform this task?
- ☐ Never ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily

**TASK 2:** Provide delivery counselling, including identification of danger signs and a delivery plan with the CSB.

How confident do you feel to perform this task? Please choose from options on the scale below.

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<th>2</th>
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</tbody>
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Have you been trained for this task? ☐ Yes ☐ No

If Yes, approximate date of last training? (Month/Year) ____/______

If Yes, Training Modality
- ☐ On-the-job non-formal
- ☐ Formal in-service
- ☐ Pre-service

How frequently do you perform this task?
- ☐ Never ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily
**TASK 3:** Support patients in discussing options of family planning methods (including PPIUD) and assist patients in choosing the best options.

How confident do you feel to perform this task? Please choose from options on the scale below.

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If Yes, approximate date of last training? (Month/Year)  ____/______
If Yes, Training Modality  □ On-the-job non-formal  □ Formal in-service  □ Pre-service

How frequently do you perform this task?
□ Never  □ Rarely  □ Monthly  □ Weekly  □ Daily

**TASK 4:** Voluntary and confidential HIV screening is discussed to raise HIV awareness and reduce stigma.

How confident do you feel to perform this task? Please choose from options on the scale below.

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Have you been trained for this task?  □ Yes  □ No
If Yes, approximate date of last training? (Month/Year)  ____/______
If Yes, Training Modality  □ On-the-job non-formal  □ Formal in-service  □ Pre-service

How frequently do you perform this task?
□ Never  □ Rarely  □ Monthly  □ Weekly  □ Daily

**TASK 5:** Teach patients from at risk groups how to use, and properly dispose of, condoms.

How confident do you feel to perform this task? Please choose from options on the scale below.

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If Yes, approximate date of last training? (Month/Year)  ____/______
If Yes, Training Modality  □ On-the-job non-formal  □ Formal in-service  □ Pre-service

How frequently do you perform this task?
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TERMES DE REFERENCE

ATELIER DE PRESENTATION DES RESULTATS DE L’EVALUATION RAPIDE DES COMPETENCES POUR CONNAITRE LES BESOINS EN FORMATION DES AGENTS COMMUNAUTAIRES

Contexte
Afin de mieux répondre aux besoins sanitaires des communautés, les responsables de programme devraient aligner les compétences des prestataires de services avec les demandes des populations desservies. Dans de nombreux pays, les responsables appliquent généralement les activités de formation durant le service en se basant sur des formules subjectives sur le type de service offert, ou sur la taille de la population cible dans leur localité. Cependant, cette approche ignore souvent le fardeau prévalent de la maladie, les besoins sanitaires de la zone desservie par le dispensaire ou les compétences réelles des prestataires de santé. Etant donné la tendance à la décentralisation des systèmes de santé et à la stagnation des indicateurs de performance du système de santé, les responsables locaux doivent s’assurer que les compétences des prestataires de service correspondent aux besoins et demandes des populations desservies particulièrement celles concernant la santé de la mère et de l’enfant, le planning familial et le VIH.

Dans cette perspective, le Ministère de la Santé a travaillé avec le projet HRH2030 afin de conduire une activité d’analyse rapide des tâches. L’analyse des tâches consiste en une « évaluation systématique des connaissances, compétences et aptitudes (comportement professionnels) qui caractérisent la pratique clinique » (Oshio, Johnson, & Fullerton, 2002). Les recherches précédentes utilisant cette approche incluent un large nombre de procédure qui consistent à :

- Appuyer de la validité par une procédure de certification
- Analyser du contenu et de la pertinence des formations avant service (Udaya, Subah, Drake, Ng, & Johnson, 2011) (Dgedge, et al., 2014)
- Informer les leaders en formation et les leaders de programmes pour les prises de décision et la mise en place de la politique (Stender, et al., 2013)


L’évaluation rapide des tâches aidera ainsi à l’élaboration et la dissémination à une plus grande échelle des méthodes et de la sélection des outils, pour améliorer l’alignement des besoins sanitaires des populations locales et les compétences des Ressources Humaines en Santé dans les années à venir. Cet alignement contribue de plus, à améliorer la qualité des services et la capacité de réponse du système selon les priorités établies par Madagascar pour fournir l’accès à la couverture santé universelle.

Ainsi, le Ministère de la Santé Publique a utilisé outil d’évaluation rapide des tâches élaboré par HRH2030. L’étude a été initiée auprès de 150 agents communautaires dans le SDSP d’Andramasina. Des questionnaires d’autoévaluation des compétences par rapport aux tâches
dévolues aux agents communautaires ont été administrés sous la supervision de l’équipe de management du district sanitaire d’Andramasina.

La méthodologie utilisée consiste à interviewer des agents communautaires sur leurs tâches quotidiennes, en se focalisant sur quatre (4) variables : fréquence, importance, formations reçues et performance. L’évaluation rapide des tâches a utilisé un nombre limité de tâches, cinq pour les AC, et est destiné aux personnels sur terrain qui disposent de ressources minimales. A cet effet, des ateliers de présentation des résultats de l’évaluation rapide des tâches seront tenus les 28 et 29 Septembre 2017 respectivement à Andramasina et à Antananarivo.

**Objectifs des ateliers**
- Démontrer les résultats de la mise en œuvre de l’approche utilisant l’évaluation rapide d’analyse des tâches
- Fournir les résultats d’un cas de test dans le cadre du développement de capacité des chefs CSB, dans l’utilisation de l’approche et pour qu’ils assurent l’alignement des compétences des AC avec les besoins en santé de la population à partir des formations internes ciblées.

**Méthodologie**
- Réunion en plénière pour les parties prenantes
- Groupe de discussion

**Lieu et Agenda**


<table>
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<tr>
<th>HORAIRE</th>
<th>ACTIVITÉS</th>
<th>RESPONSABLE/FACILITATEUR</th>
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<tbody>
<tr>
<td>8h30–9h</td>
<td>Accueil des participants</td>
<td>Administratifs SDSP, SFP</td>
</tr>
<tr>
<td>9h–9h10</td>
<td>Introduction, Ouverture officielle, Présentation des objectifs et adoption de l’agenda</td>
<td>Officiels DRH</td>
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<tr>
<td>9h10–10h</td>
<td>Présentation de la Méthodologie et des résultats de l’évaluation rapide des tâches des AC</td>
<td>Equipe conjointe DRH – HRH 2030</td>
</tr>
<tr>
<td>10h–10h30</td>
<td>Outil d’identification des besoins en formation et programmation des formations</td>
<td>Equipe DRH</td>
</tr>
<tr>
<td>10h30–11h</td>
<td>Séances de question – réponse</td>
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| 11h–12h15 | Travaux de groupe sur:  
- Formulation des feedbacks sur l’outil et la méthodologie d’évaluation rapide des tâches  
- Esquisse du Plan de formation des AC conformément aux résultats de l’évaluation rapide des tâches  
- Outil d’identification des besoins en formation et méthode de programmation des formations proposés par le SFP | Facilitateurs de groupe/de plénière |
| 12h15–12h30 | Synthèse et recommandations  
Prochaines étapes  
Discours officiel de Clôture | DRH, SDSP Officiels |
| 12h30 | Cocktail |
Annex C. Dissemination and Workshop Participants

**PARTICIPANTS**

**Pour l’atelier d’Andramasina**
Monsieur le Chef de District d’Andramasina
Monsieur le Maire de la Commune Rurale d’Andramasina
Fetraniaina Andriamanga, Directeur des Ressources Humaines — MSANP
Christiane Bodoantanta Ramamonjisoa, Directeur Régional de la Santé Analamanga
William Marie Patrick Rakotondralambo, Chef de service SDSP Andramasina
Josette Rakotonirina, Chef de Service de la Santé communautaire — DDS
Andry Rakotomanana, Chef de Service de la Formation et du Perfectionnement — DRH
Alain Rakotoson, Chef de Service de l’Observatoire des Ressources Humaines — DRH
Benja Rakotomalala, Adjoint technique — SFP
Raholimala Lisimanitra, Chef CSB Andramasina
Ratsimandresy Joachim, Chef CSB Ankorona
Hajavololona Viviane Yollande, Chef CSB Anepoka
Raoelijona Rija William, Chef CSB Manjaka Ouest
Rakotonirina Hervé Emile, Chef CSB Ambohimadiana
Raheliarisoa Marie Suzanne, Chef CSB Mangabe
Renonimalala Ernestine, Chef CSB Mandrosoa
Rahanitrinirina Lydia, Chef CSB Alarobia Vatosola
Razafiarimanana N.Voahangy, Chef CSB Ambohibemanjaka
Razanatsara Marie Germaine, Chef CSB Alatsinainy Bakaro
Harisonambinina Sophie Stephanie, Chef CSB Antotohazo
Quatre représentants des agents communautaires
Joseph Ichter, Senior Advisor — HRH2030
Landy Miary Andrianaivosoa, Consultant — HRH2030

**Pour l’atelier d’Antananarivo**
Jean de Dieu Marie Rakotomanga, Directeur Général INSPC
Hanta Ramihantaniarivo, Directeur Général de la Santé
Yöel Rantomalala, Directeur Général des Etablissements Hospitalier et Universitaire
Fetraniaina Andriamanga, Directeur des Ressources Humaines
Aro Tafohasina Rajoelina, Directeur des Districts Sanitaires
Mirana Iriatiana Ramanantoa, Directeur des Instituts de Formation des Paramédicaux
Manitra Rakotomarivony, Directeur de la Promotion de la Santé
Gilberte Randriamahavorisoa, Directeur des Hôpitaux de Référence Régionale et de District
Marie Georgette Ravoniarisoa, Directeur de la Santé Familiale
Mosa Milaso, Directeur de la Lutte contre les IST et le Sida
Harinjaka Andrianarivo, Directeur de la Lutte contre les Maladies non transmissibles
Alain Heritiana Rakotoson, Chef de Service de l’Observatoire des RHS et GPEEC
Ambinintsoa Rakotondrafara, Equipe technique du SORH
Patrick Andriamanampisoa Haritiana, Chef de Service de la Cellule de Suivi et d’Evaluation de la Performance des Ressources Humaines
Rakotomanana Andry, Chef de Service de la Formation et du Perfectionnement
Sina Israely Rambintsoa, Conseiller en RSS – Organisation Mondiale de la Santé
Hajarijaona Razafindrafito, Conseiller en RSS – USAID
Eliane Razafimandimby, Chief of Party – JHPIEGO
Jean Pierre Rakotovaoo, MCSP Technical Director – JHPIEGO
Yvette Ribaira, Deputy Chief of party – JSI/MAHEFA Miaraka
Robertine Rahelimalala, Senior Advisor Community Health – JSI/MAHEFA Miaraka
Riana Samoelina Ramanantsoa, Principal Technical Advisor – MIKOLO
Lalaina Razafinirisoa, Program Director – MSM
Nirina Ranaivoson, Directeur de Projet – HP+
Rivo Noelson, Senior Policy Advisor – HP+
Benja Rakotomalala, Adjoint technique – SFP
Clarisse Razaiaimalaza, Chef de division Formation continue des Paramédicaux – SFP
Miary Razanadrasoa, Responsable de la Base de données – SFP
Gaston Razaanapiringa, Chef de division Formation continue des Médecins – SFP
Lova Rajaonarivelo, Assistant technique – SFP
Joseph Ichter, Senior Advisor – HRH2030
Landy Miary Andrianaivosoa, Consultant – HRH203