"Healthcare is not something you can isolate from life in general": Factors influencing successful clinical capacity building in the Pacific

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Abstract

Capacity building assistance (CBA) uses multiple techniques, including training and technical assistance, to develop a sustainable infrastructure for healthcare agencies. Although there is some evidence that CBA is effective, much remains to be learned about the best ways to implement it. We assessed factors influencing the delivery of an HIV-related CBA project for health professional in the U.S. Affiliated Pacific Jurisdictions. We found some factors clearly facilitated CBA (e.g., implementing programs over long time periods), while others were clearly limiting influences (e.g., AIDS-related stigma). Lessons from this study can be applied to other CBA programs, where CBA providers can assess barriers and facilitators to implementation in order to target their services to the needs of local health experts. (PHD 2007 Vol 14 No 1 Pages 57 - 65)

Introduction

Capacity building assistance (CBA) has become an increasingly important means of developing human resources for health worldwide.[1,2] In 2006, the World Health Organization (WHO) identified many advances in the development of human resources for health, highlighting the successes of local CBA programs in developing nations.[3] The 2005 annual report of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), identified CBA as a critical strategy to create sustainable HIV prevention and treatment programs worldwide.[4] However, much remains to be learned about the best ways to implement CBA programs. The WHO suggests conducting further research on the context in which CBA programs are delivered. Adapting CBA strategies to the local context is essential to their successful uptake. Identifying the contextual factors affecting CBA implementation is a critical step in this process.

In this article we present factors that influenced the implementation of a CBA program in the U.S. Affiliated Pacific Island (USAPI) jurisdictions. Since 2000, the Pacific AIDS Education and Training Center (PAETC), through its Hawai'i AIDS Education and Training Center (AETC) site, has worked with USAPI health professionals to develop local organizational and clinical HIV capacity. In 2005, we evaluated the program to understand the contextual factors affecting the delivery of CBA services.

BACKGROUND ON THE PROJECT

PAETC delivers AIDS-related training to healthcare professionals in California, Arizona, Nevada, Hawai'i, and the USAPI (American Samoa, Commonwealth of Northern Mariana Islands, Federated States of Micronesia [FSM], Guam, Republic of the Marshall Islands, and the Republic of Palau). The agency is part of a national network of AETCs whose mandate is to improve the care of people living with HIV/AIDS by providing education, training, clinical consultation, and other assistance to HIV-treating clinicians. Within the AETCs, Minority AIDS Initiative Programs assist minority-serving community agencies to build organizational and clinical HIV capacity.

In 2000, the PAETC launched a multi-year Minority AIDS Initiative Program in the USAPI. While each jurisdiction has a formal relationship with the U.S., they differ from

it – and one another – in terms of culture, language, economics, healthcare, and access to resources. In a desire to understand this region better, PAETC conducted an assessment of the needs of clinicians in the region prior to launching the program. Findings showed a limited level of direct experience with HIV care, treatment, and prevention, though experience levels varied somewhat by jurisdiction. The assessment also showed overburdened health workforces and limited healthcare resources in most jurisdictions.

In response to these findings, the PAETC and Hawai'i AETC launched a CBA program to enhance the HIV-specific clinical skills of health professionals and strengthen the capacity of healthcare organizations in the jurisdictions. The program's main capacity building mechanisms included:

- Annual clinical training conferences in Guam and Hawai'i, with a focus on informational and skills-based training sessions, and organizational strategic planning
- Periodic site visits to each jurisdiction and on-site clinical consultation. Expert health policy advising with local clinic administrators, Health Ministers, and other officials
- Clinical "mini-residencies" in Hawai'i and California. Health professionals from the jurisdictions shadowed U.S.-based expert HIV clinicians during clinical practice
- Bi-monthly satellite-based teleconferencing
- On-going expert consultation via telephone and email, for clinical and organizational matters

These activities were carried out over the course of four years. In addition, specific CBA was provided in Chuuk, FSM to establish a regional training center. Since its establishment the Chuuk AETC faculty members have participated in U.S.-based professional development, and have conducted trainings in every state of FSM and in Republic of the Marshall Islands. Further description of all these activities can be found in the preceding paper in this journal.[5]

BACKGROUND ON CAPACITY BUILDING ASSISTANCE

In the last two decades, CBA has become a popular strategy to develop sustainable human resources for health in developing countries.[4,6-11] Definitions of CBA contain several core elements. First, CBA projects create change at multiple levels in organizations and among those organizations' personnel.[3,10,12-15] Most literature on CBA identifies change for individuals, organizations, and at some broader level (e.g., systems, cross-organizational, and community level). Second, capacity building projects usually occur over longer periods of time than traditional training interventions.[9,16,17] Third, CBA is considered the sum of several overlapping interventions or services tailored to the specific needs of the agency receiving assistance.[16]

Despite a growing body of literature describing CBA, little has been published on the factors that facilitate or inhibit its successful implementation.[18] In a study of factors influencing organizational capacity building in Canada facilitators to implementation included: intra-organizational leadership, policy development, funding, and partnerships. Meanwhile, Kegeles[18] describes challenges and facilitators to building organizational capacity among HIV-serving community-based agencies in the U.S., including the need for buy-in from all stakeholders and the need to enhance collaborative relationships across organizations.

Findings showed a limited level of direct experience with HIV care, treatment, and prevention

Methods

Findings presented in this paper were collected during the long-range evaluation of the program described above. Data were collected and analyzed via two qualitative methods: focus groups and semi-structured interviews. Participation in focus groups and interviews was voluntary; respondents were asked to provide informed consent using procedures approved by the University of California, San Francisco, Committee for Human Research.

FOCUS GROUPS

An external evaluator conducted focus groups (n=4) with clinicians and other health professionals from the USAPI who had received CBA from this program ("CBA recipients"). With support from Hawai'i AETC staff, we recruited focus group participants from among those clinicians attending an annual training conference in Honolulu in 2005. In the months preceding the conference, we announced the upcoming focus groups through emails and during the satellite-based teleconferences. A total of 20 participants, representing all six USAPI, participated in the focus groups. This number represented almost all the CBA recipients attending that conference, as well as a large majority of the total health professionals receiving CBA through the program.

INTERVIEWS

The evaluator also conducted semi-structured interviews with core staff and trainers ("CBA providers," n=7) involved in the development and implementation of the project. Potential respondents were initially

identified with the assistance of Pacific and Hawai'i AETC leadership. All initial interviewees were asked to identify other potential respondents. A purposeful sample was selected from these candidates to maximize familiarity with the project and diversity of perspectives and recruitment stopped when saturation of information was achieved. Because a small group of CBA providers had worked consistently on the program for its duration, saturation was achieved at a relatively smaller threshold than occurs in many qualitative studies.

FOCUS GROUP AND INTERVIEW ANALYSIS

The evaluator taped and transcribed all focus groups and interviews. Following transcription, we conducted preliminary coding by hand, engaging in iterative discussions of preliminary data to identify the emergent themes. Focus groups and interviews were considered two separate data sources, and separate codebooks were developed and applied to these two data sets. After initial analysis, we entered transcripts into the analytic software (Atlas Ti) to develop more formal focus group and interview codebooks to review response data. During this stage of analysis, focus group and interview findings were compared and contrasted to identify the most salient themes.

The development of professional and personal relationships was beneficial to successful implementation of the CBA

FINDINGS

We discovered many factors influencing the ability of the Pacific-based health professionals to implement the information, skills, and resources acquired from the CBA program. Many of these factors overlapped with one another and some were perceived at different times as both beneficial and detrimental to implementation.

RELATIONSHIPS

The development of professional and personal relationships was beneficial to successful implementation of the CBA. These relationships occurred on many levels: between CBA providers and CBA recipients; among fellow CBA recipients from the different jurisdictions; and between CBA providers and government officials in the jurisdictions. A CBA provider summed up the sentiment expressed repeatedly in interviews and focus groups: "Our bringing [the USAPI clinicians] together, particularly at the conferences, and pulling them together as a group of HIV clinicians, has given them a sense of belonging to that group. And they are able to freely communicate with each other about whatever issues come up in the region. It has developed into a camaraderie and good professional relationship."

CBA recipients saw the building of a strong group identity among their peers as particularly important and meaningful. One CBA recipient stated that program had encouraged him to build stronger connections with professional peers, "The training has led us to expand ourselves to other service providers (in our region who are not receiving the CBA). We collaborate with other people who look out for the patients' interests." This has led some CBA recipients to increase their involvement in professional organizations such as the Pacific Island Jurisdiction AIDS Action Group and the Pacific Island Health Officers Association.

One CBA provider reflected at length on her experience delivering training in the Pacific jurisdictions, "(We had to) demonstrate that we were committed to (the CBA recipients) and we were going to be there and stick with them at their pace. It took those relationships developing for us to be more effective as trainers, and that took time and good will on both parts. And that's maybe one of the hardest things to realize from a logistical standpoint, you can't just go in and think you're going to provide training and then leave and be done with it. What really fundamentally underlies effective training is good relationships between trainers and trainees."

TIME

Having enough time to build these relationships was essential to the project's long-term success. CBA recipients and providers stated that many program effects, such as improvements in HIV testing and laboratory facilities, occurred slowly. Without a long-term commitment to the program, they said, these changes may not have developed.

Some CBA recipients felt having a long-term involvement in the program enabled them to build comfort and confidence in their newly acquired skills and knowledge. In a focus group, two CBA recipients responded to a question about what had changed for them over time:

CBA Recipient A: "When we were first starting out, we learned about how to talk about sex. To me, that was really beneficial because I went back home and was talking to clients, and people were hearing me talking about anal sex and things like that. And you know, you're not supposed to say that! My biggest lesson was feeling comfortable talking about sex and getting someone to talk about their sexual behavior without feeling uncomfortable."

CBA Recipient B: "Yeah, I think the main point I get from this training is that I have more confidence when I encounter my patients. Because there are a lot of questions! It prepares me to deal with that, if they ask me some questions. Out of this training, I would like to say that I am more prepared when I encounter a patient with HIV/AIDS."

In addition, long-term participation allowed some individuals take on new roles. Most notably, the establishment of a local training office in the Micronesian state of Chuuk provided new opportunities for clinicians there to take on increased leadership responsibilities. This opportunity only emerged after several years of planning and collaboration; according to some CBA recipients and providers, it could not have occurred without that amount of development time. One CBA recipient spoke excitedly about the Chuuk AETC, "And the program is extended now to Chuuk. I think it's a step forward that we have resources that are in our backyard. Hopefully that will continue. I think the program has made that possible, I think that's a very strong point. We have experts in the area to help us now."

BUY-IN

The concept of "buy-in" commonly means that affected parties believe in the importance of an issue and of the need for action to address that issue. In this program, "buy-in" came to mean that stakeholders (CBA recipients, CBA providers, leaders in the Pacific jurisdictions and the mainland U.S., patients, and others) believed in the importance of HIV care and prevention. In particular, stakeholders from the jurisdictions valued the CBA services being provided.

Buy-in was slow to develop among some stakeholders because they did not see HIV as a health priority. Because of the few detected HIV cases and because CBA recipients were balancing numerous responsibilities beyond HIV care, HIV was not seen as a critical issue needing immediate attention. According to one CBA recipient, "We wear so many hats, and HIV is not the only disease that we are looking after. Sometimes it's very difficult to connect all the points, because of the other things that you do in-between. There is a lot of work!"

In order to build greater buy-in from the various stakeholders, CBA providers emphasized the importance of preparing the region for the future and potentially helping prevent a growth in HIV cases. In addition, the program emphasized how new skills and information acquired through trainings could be applied to other aspects of clinical care. One participant summed up the experience of many when he said that the program had allowed him to address "other areas of our work. And that's a trade off from the program, not only HIV, but we use this in other areas to develop our skills."

CULTURAL & LANGUAGE DIVERSITY

The group of Pacific jurisdiction CBA recipients was representative of the great diversity in the region, and the addition of CBA providers from Hawai'i and the U.S. mainland only increased this dynamics of the program. Such diversity was identified as both challenging and helpful to the program's successful implementation.

Most barriers associated with diversity involved issues of communication. Several CBA providers and recipients said that while having the common language of English was useful, for many of the CBA recipients, it was a second or third language. "The capacity to communicate in English is quite variable within the group," stated a CBA provider. He observed that many experienced health professionals from the jurisdictions struggled to explain things in English that they would be able to do easily in another language. But, he said, "We couldn't communicate with [the CBA recipients] without English!" Meanwhile, several CBA recipients found difficulty in translating clinical information from English to a local language for patients. According to one, "Sometimes it is easier to ask [a patient a health-related] question in English. But when you ask it in another language, you know, you really have to find the [right] words."

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The diversity of those delivering and receiving CBA also provided new learning opportunities for all. A CBA provider said that she benefited from efforts by CBA recipients to "teach us too" about their cultures and healthcare systems. While cross-cultural challenges existed, many CBA recipients and providers approached the situation with openness and willingness to learn. One CBA recipient said that "one of the biggest things I've learned, being with the other participants from the other islands, is how to be more culturally aware." She worked in a clinical setting where she saw patients of different Pacific cultures and had to learn how to adapt her word choices when conducting health assessment with some patients. "What we learned at the first sessions here was how to ask (patients) questions. I'm more culturally sensitive now (to the patients' comfort level)." Another CBA recipient said simply, "the biggest

thing that has changed in me (after) all these years is my awareness of other cultures."

STIGMA

HIV-related stigma was identified by CBA recipients and providers as a particularly challenging barrier to success. Many CBA recipients spoke about their own personal fears when they first encountered HIV patients. Most stated that lack of experience with the disease had led to misconceptions. One stated, "When we first heard about it, I kept asking myself, 'Am I ready to manage a patient who comes in with HIV or AIDS?' And that was a challenge to motivate myself personally to where I'm comfortable enough. (In the beginning) I wasn't, to be frank, prepared enough to know what I should do if someone walked into my clinic." Other CBA recipients saw HIV stigma and discrimination in their workplaces. "In the past, for our health workers, no one had been trained yet about HIV. We had one experience with a case that came from (a different jurisdiction). The family brought him to the emergency room. Some of the providers were afraid to see him, they were not accepting it. They had a little knowledge (of what HIV was), but they were afraid."

Several CBA recipients spoke about their efforts to fight stigma in their workplaces and communities as a result of their involvement in this program. One CBA recipient observed changes in his local community, "One of our cases last year, before she died, the whole island came to her place, brought food, they showed sympathy. So there was a big change, instead of accusing her, they turned around to bring food. And even our patients that we admit to the ward! When we had our first patient in the hospital no one went to see him except his brother. The next patient came, and the rest of the family came to the hospital to take care of him. I wouldn't say there's no more (stigma) now, but (the community members) understand more now."

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Some CBA recipients and providers linked community stigma against HIV to greater stigma against behaviors associated with HIV-risk, specifically sexual and/or drug use behaviors. Cultural values condemning sex between men, for example, were cited as a barrier to creating a supportive clinical environment for some HIV-infected patients. One CBA recipient related an experience with a male client who has sex with other men. While her peers were uncomfortable answering health questions for the client, she felt equipped to speak about his risk behavior in a non-judgmental way. "And now," she said, "every two weeks he calls on a long distance phone call, and he's asking for me. Maybe I'm the only one who accepted what he was asking me."

GEOGRAPHIC ISOLATION

The isolation of each participating jurisdiction from one another and other locations (including Hawai'i and the U.S. mainland has created some of the greatest challenges for CBA recipients and providers alike. The providers and recipients of CBA worked in different time zones, creating difficulties in communication. Physical isolation limited the degree to which clinicians could refer their patients to another location for specialty services. "There are issues with that," stated a CBA provider, "What if a patient is deathly ill? Where are you going to transport them? And is the airline going to transport them?" This distance was also cited as a barrier to gathering participants on a more regular basis, as travel was expensive and time consuming. Several CBA recipients said they found it difficult to take time away from their clinical practices to travel for trainings.

RESOURCES & TECHNOLOGY

Lack of resources, in particular supplies for medical care and laboratory testing, was another challenge to successful implementation. The jurisdictions' distance from larger, more populous nations limited their ability to participate in those nations' commercial activities. Thus obtaining resources was often more costly and time consuming. Access to medical supplies was difficult in some of the more remote regions of the jurisdictions. In discussing this problem in his jurisdiction, one CBA recipient said simply, "We can't get the resources, so we need the AETC training" to learn how to deal without certain supplies.

In response to this, CBA providers have tailored the program to local needs. One CBA provider asked rhetorically, "How do you work with clinicians who may not have a way of measuring viral load, not to mention doing resistance tests or having the whole armamentarium of antiretrovirals? For one, you make sure they have (medications) for primary care provider prophylaxis. We've definitely had to temper the curriculum based on the reality that not everyone has the same resources."

Lack of appropriate laboratory technology had forced clinicians in some jurisdictions to ship specimens off-island for testing. One CBA recipient described the situation: "We don't have Federal Express, so we have to work with the commercial airlines. …it's an

expensive solution, a lot of training, packaging, and capacity building. A lot of energy just to get a lab test." CBA providers and recipients alike were still struggling to determine the best way to get appropriate supplies to some jurisdictions.

In addition, communications technology was seen as unreliable in some parts of the Pacific jurisdictions, making timely communication a challenge. A CBA provider described one example of how communications technology has affected the project: "Our experience with the satellite teleconferences has been interesting: We're still having them regularly and people still attend. This is amazing particularly since we have technical problems every time always different; weather, billing, sensitive hardware! But people are still committed in spite of the barriers."

While the limited availability of medical and communication technology was identified as a barrier, many CBA providers and recipients simultaneously identified benefits to having access to such technology. With assistance from the program, CBA recipients were able to use alternative means of communication, particularly email, when telephone access was unavailable. Email was described as valuable because it allowed rapid communication in spite of time zone differences that made phone or video conferencing difficult. "We send emails overnight and then in the morning get the responses," said one CBA recipient, referring to clinical consultations she received from a mainland-based CBA provider. "It was very comforting to know who to contact." CBA recipients also greatly valued access to the internet, which provided them a regular flow of up-to-date clinical information.

The distance of the islands from one another and the U.S. makes many seemingly simple activities, such as conducting telephone consultations, more difficult

DISCUSSION

This program was established because HIV in the Pacific jurisdictions, though low in prevalence, posed an emerging threat to the region. Over time, CBA providers and recipients identified numerous factors that affected the successful delivery and uptake of the program. Some factors were surprising to participants in this study, such as the benefits of getting buy-in over time; others were expected, such as the challenge of geographic isolation. But more important than detecting any particular factor, CBA providers and recipients realized that identifying all these factors would enable them to engage in a more effective CBA process that would create a more sustainable health system in the future.

Some of the factors described are particularly relevant to programs in the Pacific region. Most notably, geographic isolation will continue to be a challenge for the Pacific jurisdictions. The distance of the islands from one another and the U.S. makes many seemingly simple activities, such as conducting telephone consultations, more difficult. Isolation limits health professionals' opportunities to leave their islands for professional development, and similarly inhibits frequent visits from outside colleagues or trainers. This program attempted to overcome this challenge primarily through the use of communications technology. For many CBA recipients, the use of telecommunication technology (especially the internet) has been essential to their participation. It has improved their access to clinical HIV experts, and enhanced communication with one another about regional health issues. While availability still varies greatly across the region, investment in such technology would greatly benefit the Pacific region.

Our findings also expand upon some of the existing research on CBA. We found that stakeholder buy-in was necessary for effective program implementation. Because so many clinicians had competing professional demands, they had to carve out a special amount of time and energy to participate in the CBA activities. Moreover, the U.S.-based CBA providers learned the importance of gaining buy-in from important figures in the jurisdictions such as government officials, tribal leaders, and clinicians not participating in the program. We also found that relationships were important facilitators to program success. In this program, these relationships took many shapes, ranging from long-standing consultative relationships between CBA providers and recipients to more active participation in professional associations among the CBA recipients. Furthermore, our findings supported the existing evidence that long periods of time are needed to implement CBA programs. We show in clearer detail how the mechanism of having extended time strengthens program outcomes by allowing relationships to grow and improvements in the healthcare workforce to take root.

CBA programs are particularly well suited to strengthening health systems and human resources for health in developing regions such as the USAPI. An examination of the contextual factors affecting CBA implementation can enable an agency to deliver such services more effectively. The importance of understanding contextual factors to the delivery of CBA is perhaps best stated by one of the CBA providers interviewed in this study. As

she stated about the Pacific jurisdiction CBA recipients she trains, "Healthcare is not something you can isolate from life in general. Understanding the social, political, and economic issues that bear directly on their capacity as (healthcare) providers, and then trying to move my own head around how to support them on those things, has been tremendously challenging and meaningful."

Limitations

The use of qualitative methods, while appropriate as an exploration of barriers and facilitators, may limit the scope of our findings. However, this limitation is outweighed by the substantial depth of description collected through qualitative methods that would not be achieved otherwise. Furthermore, by comparing our findings to the existing literature on CBA, we were still able to present data that are generalizable to CBA programs in other parts of the world or that address other healthcare issues.

Interview and focus group respondents were asked to reflect on their experiences of the last several years. As a result, a particular respondent's ability to recall the events of the past accurately may have been limited

Although the evaluator conducting the focus groups and interviews was "external," he was a U.S.-based researcher brought into the program by CBA providers. His connection to the CBA provider group, both professionally and culturally, may have inhibited the CBA recipients from sharing concerns with him in focus groups. A related limitation lies in the fact that all focus group respondents were still receiving CBA services from PAETC at the time of the focus groups. Thus these respondents may have had motivation to provide overly positive responses, or to avoid identifying challenges.

Interview and focus group respondents were asked to reflect on their experiences of the last several years. As a result, a particular respondent's ability to recall the events of the past accurately may have been limited. To address this we analyzed responses with consideration of different perspectives presented in order to identify the most salient themes. We also designed focus group and interview guides in such a way as to support respondents in recalling events of the past.

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