Global Health Initiatives and Human Resources for HIV/AIDS Services in Malawi, Uganda and Zambia

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GLOBAL HIV/AIDS
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GLOBAL HEALTH INITIATIVES AND HUMAN RESOURCES FOR HIV/AIDS SERVICES IN MALAWI, UGANDA AND ZAMBIA

Key findings

- Scale up of GHI funding has not translated into significant increases in the health workforce. Rural areas - where HIV/AIDS services are most neglected - received proportionately fewer staff than urban areas, and increases in staff for non-clinical HIV/AIDS services were not replicated for clinical services.
- In all three countries the national health workforce has not grown proportionately to the increasing number of clients seeking care and treatment for HIV/AIDS. As a result, workloads have increased across all health cadres.
- Training takes time and it is still too early to determine accurately the effects of scale up, although increased capacity is reported in most countries. Monitoring of training is weak, however, and time set aside for training has stretched an already overburdened workforce, leading to high levels of absenteeism from work.
- Relatively low salaries for government health workers made it difficult for employers to retain staff, who were attracted by the higher wages offered by GHI-supported NGOs.

In most sub-Saharan African countries, a region where just 3% of the world's health workforce treat and care for 25% of the global disease burden, significant investment in Human Resources for HIV/AIDS services (HR) is required [1-2]. This briefing paper summarises the effect that scale-up of funds from three GHIs – the President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to fight AIDS, TB and Malaria, and the World Bank Multi-country AIDS Program (MAP) – has had on HR in 3 countries: Malawi, Uganda and Zambia. Drawing on primary data from country studies conducted by researchers from the Global HIV/AIDS Initiatives Network (GHIN) (Box 4), this briefing paper focuses on a set of inter-related HR components: numbers of health workers, workload, training, and incentives and motivation [3-5].

1. Scale-up in numbers of health workers

The extent to which GHIs influence the size of a country's health workforce depends heavily on its programme design. PEPFAR funds individual national and international NGOs and places a high premium on demonstrating results. This has created a large demand for staff with managerial and administrative skills. In Uganda, for example, just one recipient of PEPFAR funding – the UPHOLD project – employed 111 staff, mostly for administrative work. By contrast, funding through a Principal Recipient who implements approved grant activities (the Global Fund model) or through the public budget (the MAP model) has not required comparable levels of administrative staff.

A common theme emerging from the three country studies is dissatisfaction from health workers who were faced with increased workload because of GHI financing but received little support from GHIs to recruit additional staff (Box 1).

Box 1: Former MAP executive in Uganda

"To implement a national programme, we realised that in some cases we needed more human resources in the technical areas to be able to implement programmes but we were not allowed to recruit and engage staff. Many CSOs, would have done better if we had supported them to recruit somebody to do home based care, counselling; … they would have done better. But we were not allowed to engage new personnel; we only worked and facilitated the existing personnel but they were not enough"

(Uganda Final Report, 2009)

Table 1: Changes in HIV/AIDS epidemiology, and GHI funding commitments in 3 African Countries

	Total population[1]	Number of people living with HIV/AIDS (2001 and 2007)[2]		PEPFAR funding[3]	Global Fund HIV/AIDS approved grants[4]	World Bank MAP commitment[5]
Malawi[§]	14,278, 404	850,000	930,000	$88.9m (2004-08)	$342.6m (R1) $17.6m (R2) $15.1m (R7) **Total: $375.3m** (period 2003-10)	$35m (2003-12)
Uganda	31, 656, 865	1,100,000	940,000	$929.3m (2004-08)	$48.9m (R1) $82.6m (R3) $70.2m (R7) **Total: $201.7m** (period 2003-11)	$47.5m (2000-05)
Zambia	12,620,219	940,000	1,100,000	$845.9m (2004-08)	$90.3m (R1) $236.3m (R4) $129.3 (R8) **Total: $455.9m** (period 2003-11)	$42m (2002-08)

Source: [1] World Bank Development Indicators; [2] WHO/UNAIDS; [3] PEPFAR Country Profiles data; [4] Global Fund Commitments and Disbursements data; [5] World Bank Projects and Operations data

Primarily to avoid recurrent costs, all three GHIs rarely permitted funding for extra health personnel, although PEPFAR was more inclined to pay salaries of existing staff. Neither the Global Fund nor MAP guidelines allowed funds to be used for recruiting additional staff or for existing staff salary payments (Table 2), although in Uganda MAP did permit national level managers to be recruited.

Table 2: Number of cases of PEPFAR and Global Fund funded activities where recruitment of extra staff was permitted (Uganda Final Report, 2009)

	PEPFAR (% in brackets)	Global Fund (% in brackets)
Allows recruitment	13 (11.4)	0 (0.0)
Does not allow recruitment	56 (49.1)	7 (87.5)
Allows recruitment with conditions	15 (13.2)	0 (0.0)
Recruits through headquarters	12 (10.5)	0 (0.0)
No guidelines	8 (7.0)	1 (12.5)
Do not know	8 (7.0)	0 (0.0)
Recruits only volunteers	2 (1.8)	0 (0.0)
Total	**118 (100)**	**8 (100)**

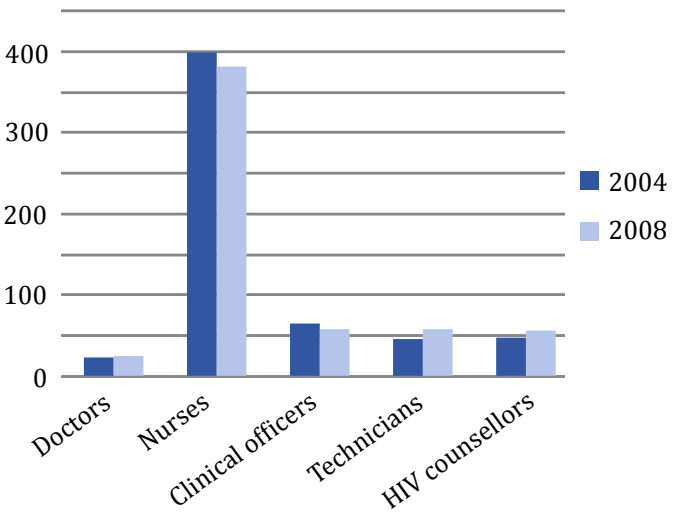
Country studies did not report significant increases in the total number of clinical staff and identify a number of common, but sub-optimal, trends.

• In Zambia total staff numbers were stagnant between 2004 to 2008 in 27 facilities and the numbers of clinical staff (doctors, clinical officers and nurses) reduced from 588 to 555 (Figure 1 & 2). In Malawi there were modest increases in the number of doctors and nurses between 2006-08 although numbers of clinical officers and medical assistants declined, especially in the central hospitals.

• While there were small changes to the clinical workforce across the three countries, non-clinical staff numbers (particularly administrative and management cadres) increased in Malawi and Uganda – in large part due to the boost that PEPFAR funding gave to the NGO community. In Zambia, there were small increases in the numbers of HIV counsellors, lab technicians and pharmacists (Figure 1 & 2). In Malawi, the numbers of Health Surveillance Assistants rose dramatically in rural areas from 54 in 2006 to 919 in 2008, but during the same period just one new doctor was recruited. In Uganda, there was a general shortage of health workers across all cadres, but an acute shortage of nurses, diagnostic technicians and pharmacists.

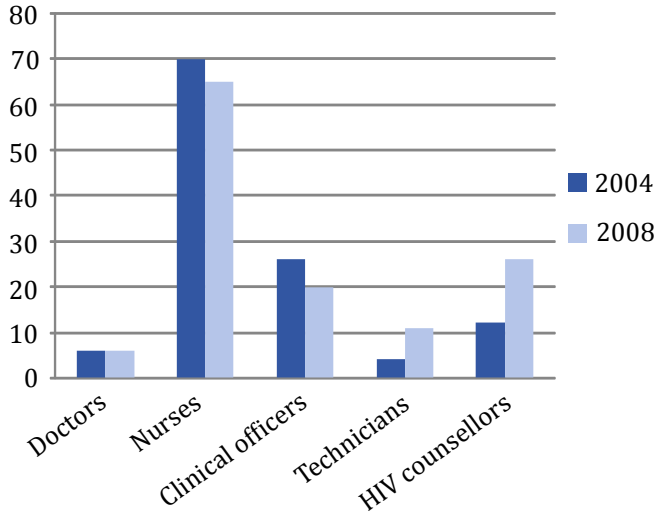
• Staff increases did not always occur outside urban areas especially the capital cities, despite an identified need. In Malawi, for example, half of the 248 medical doctors working in 2007 were located in central hospitals and training/research institutions in urban areas, leaving severe shortages in rural areas.

Figure 1: Number of urban health workers, 2004 and 2008 (16 facilities*), in Zambia



*Data for technicians and HIV counsellors collected from 17 facilities

Figure 2: Number of rural health workers, 2004 and 2008 (11 facilities*), in Zambia



*Data for doctors, technicians, HIV counsellors and registry clerks collected from 11 facilities

Governments and health workers employed a variety of mechanisms to address health worker shortages, including task shifting. For example, the Malawi government used $17m from the Global Fund to respond to the reported phenomenon of 'brain drain' of clinical staff from rural to urban areas. Attempts by the Zambian government to reduce attrition rates in rural areas are outlined in Box 2.

Box 2: The Zambia Health Worker Retention Scheme

The Zambia Health Worker Retention Scheme (ZHWRS) was introduced in 2003 primarily to address the shortage of health workers in rural areas. It aims to decrease attrition rates in rural districts by providing a monthly stipend (hardship allowance), housing rehabilitation, vehicle loans and facility incentives. In return, the health worker is required to give three years of service in a rural area. Quantitative findings from the GHIN Zambia study showed that the Scheme up to 2007 had not succeeded in increasing in numbers the available staff. The Scheme received mixed reviews from respondents from qualitative interviews, and some respondents noted a lack of accommodation options in rural areas as a barrier. Shortages of staff housing, poor living conditions in rural areas and a short timeframe for retention allowances remained a challenge in 2008, something the Health Sector Joint Annual Review has also cited.

In Malawi, health workers reportedly engaged in task-shifting in an effort to manage the increases in workload that GHI funding caused (Malawi Final Report). Staff perfomed multiple duties in Zambia, and were responsible for delivering several types of HIV/AIDS and non- HIV/AIDS services, with exception of Lusaka, where some HIV service specialisation occurred.

2. Increases in staff workload

In Zambia, GHIN data show that between 2004 and 2007 routine workload for staff providing HIV/AIDS services at outpatient departments increased by almost one third across 22 facilities, with a rise in demand for HIV/AIDS services being the principal cause. Most staff were delivering both HIV and non-HIV services. In Malawi, there was a three to five-fold increase in workload in district and sub-district facilities between 2007 and 2008, resulting in the majority of staff (68%) working beyond normal hours. Task shifting across staff cadres and days of the week was the most common strategy used to address high workload in the sampled facilities.

3. Training

Each of the three GHIs gave prominent support to short-term training of health workers and volunteers at the community level to improve HIV services. However, training can take between 3-6 years depending on cadres, and in some countries it is too early to detect the effects of investment in training on HIV/AIDS services. In Malawi, the Emergency Human Resource Relief Programme, which prioritises rural areas and training for new clinical staff, received

concerted Global Fund support to finance the capital and operation costs of health worker training institutions. The results of this are encouraging; for example, the Malawi GHIN study showed that by 2008, 71% of health service providers said they had gained more skills and knowledge from working in HIV clinics through the training provided. In Uganda, HIV donors funded training for HIV services, with PEPFAR contributing most (57.6%) to training in those organisations surveyed.

In Zambia, whilst GHIs did not fund training of new health workers, they did support training for existing staff. In a questionnaire survey completed by 234 doctors, nurses, clinical officers, laboratory and pharmacy staff, 72% said they had received training in HIV/AIDS services in the past year. In Uganda, while training was essential for developing health worker skills, it was often too frequent and a significant source of absenteeism from work. PEPFAR-funded management training programmes were, however, well received (Box 3). In Malawi, training allowances were reported as an incentive to work in HIV/AIDS services by 18% of respondents. Cash incentives provided by NGOs for training days were higher than those provided by government organisations, but training sessions were also longer.

Box 3: PEPFAR Program Official (Uganda Final Report, 2009)

"Many facilities were not ready - weak information systems and poor management skills. So, we faced a big challenge. We put up (job) adverts but this was not yielding much. So we approached IPH (Institute of Public Health) to start a fellowship for training managers for our (HIV) programs. This worked very well."

4. Incentives and motivation

As noted above, GHIs differed in the extent and types of incentives they offered to health workers. Financial incentives were the most common type given to staff providing HIV/AIDS services as a way of increasing motivation. While most incentives were given for delivering HIV services, they were also given for non-HIV services (in particular malaria and family planning). Although PEPFAR had been instructed to phase-out top-ups for public sector staff by mid 2007, the GHIN study was not able to confirm whether or not this instruction had been followed.

In Uganda, whilst donor funds were a potential source of additional wage funds, the short-term nature of Global Fund assistance did not make it a dependable supplement to wages, and overall the contribution of donor funds to the salaries of the health workers in the recipient organizations was negligible. However, research in Uganda did find that there were stronger incentives for health workers to deliver HIV-services than other health services in the country.

The Malawi GHIN study was also unable to identify tangible incentives that could be associated with Global Fund-supported activities. Consequently, financial incentives were not always a high priority and only 10 providers reported receiving extra cash payment for delivering HIV-related services (just 3% of the 332 service providers interviewed).

Low salaries in both government and non-government organisations were cited in all three countries as a major obstacle to staff retention. In Uganda, NGOs reportedly offered double the salary paid by government and mission employers for similar cadres, making it harder for government sub-sectors to retain staff. Often, disparities in wages between government and non-government sub-sectors was much higher, with reports of PEPFAR funded NGOs offering HIV sector salaries 4-5 times that afforded to government employees. One consequence has been marked staff migration between these sub-sectors.

The practice of funding short-term projects resulted in breaks in financing from GHIs, notably the Global Fund. In Uganda, this further limited employers' options for retaining health workers and has had knock-on effects for service provision as certain health cadres – often social and outreach workers – were suspended so that core staff could continue to receive wages.

Box 4: About the research

The data for this Briefing Paper is based on research conducted by:

- Malawi - Victor Mwapasa and John Kadzandira (Univeristy of Malawi)
- Uganda - Freddie Ssengooba, Suzanne Kiwanuka, Barbara Kirunda, Elizeus Rutebemberwa, Nazarius Mbona Tumwesigye, Esther Buregyeya (Makerere University School of Public Health)
- Zambia - Phillimon Ndubani, Joseph Simbaya, Jolly Kamwanga (Institute of Social and Economic Research, University of Zambia), Aisling Walsh, Patrick Dicker and Ruairí Brugha (Royal College of Surgeons, Ireland - RCSI)

The research employed mixed-methods to collect and analyse data from 24 districts across the three countries

	Districts	Methods
Malawi	9	A mixed methods study. 51 facilities surveyed (of which 41 were sub-district facilities, 7 were district and 3 were central hospitals)
Uganda	12	A mixed methods study. A survey of 130 facilities and 413 health workers (drawn from a sub-sample of 40 facilities
Zambia	3	A mixed methods study. 27 facilities surveyed; 234 health worker questionnaires; 41 key informant interviews

The research is part of the Global HIV/AIDS Initiatives Network (GHIN), a network of researchers in 22 countries that has been exploring the effects of three global HIV/AIDS initiatives on country health systems: the Global Fund, PEPFAR and the World Bank. RCSI and the London School of Hygiene and Tropical Medicine (LSHTM) coordinate the network, which is funded by funded by Irish Aid, Danida and DFID. This Briefing Paper was written by Andrew Harmer (LSHTM), with support from GHIN colleagues Neil Spicer, Gill Walt (LSHTM) Aisling Walsh and Ruairí Brugha (RCSI).

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