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Researching National and Sub-National Effects of Global HIV/AIDS Initiatives at the Country Level

GLOBAL HIV/AIDS INITIATIVES NETWORK

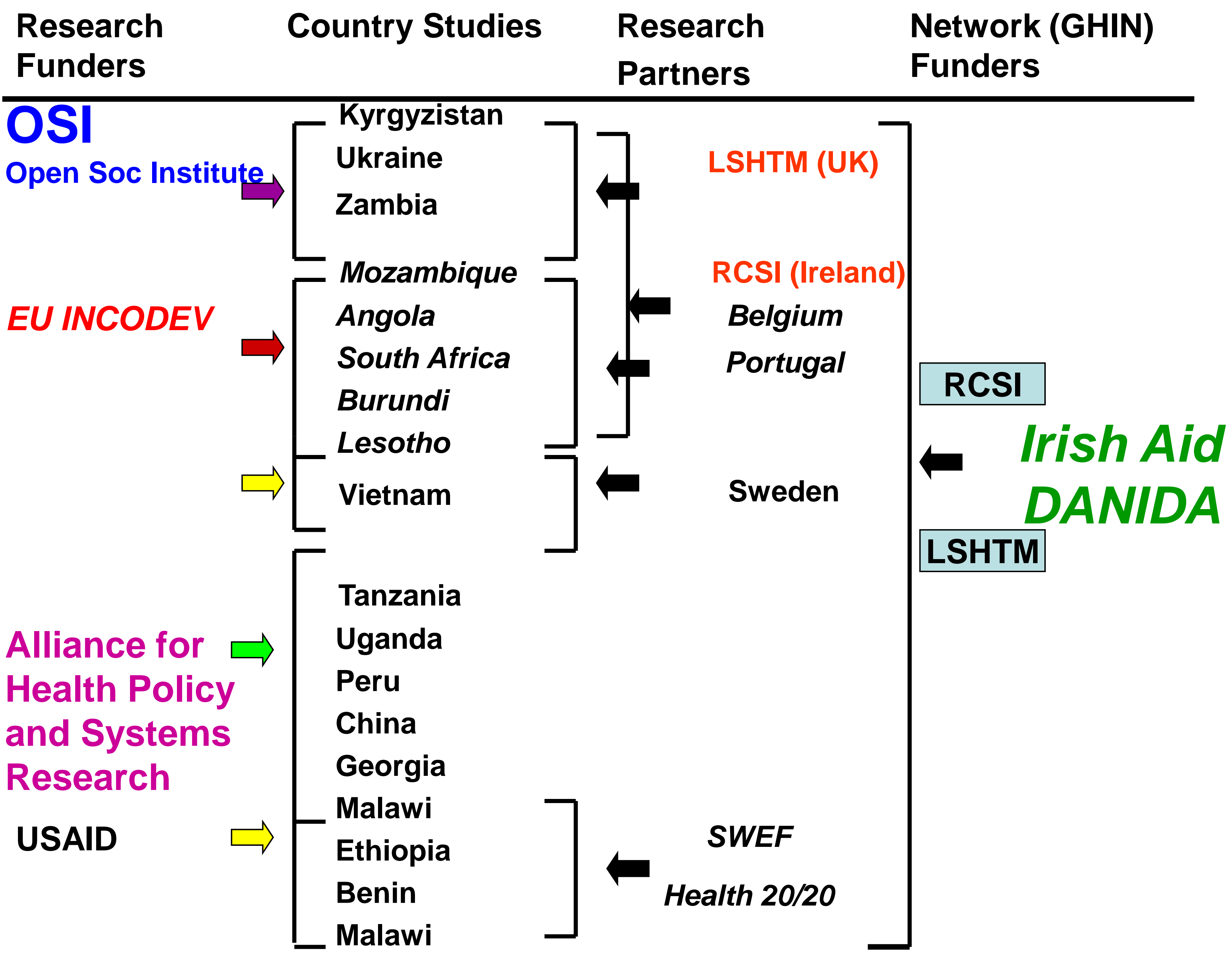
Research findings on the effects of the Global Fund on Human Resources for Health

A multilevel perspective on the people who make Fund objectives happen

Prof Ruairí Brugha

Royal College of Surgeons in Ireland
London School of Hygiene and Tropical Medicine and GHIN Network

Global Fund to Fight AIDS, Tuberculosis and Malaria
Geneva 10th February 2011



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Global HIV Initiatives Network (www.ghinet.org)

Network Aims

1. Promote comparability through common research protocols and tools
2. Share expertise across country study teams and building research capacity
3. Generate multi-country comparisons and context specific lessons
4. Coordinate dissemination of findings/recommendations at global level

Research themes

1. Scale-up of HIV/AIDS Services
2. Human Resources for Health
3. Coordination of HIV/AIDS policy/planning and service delivery
4. Monitoring and Evaluation
5. Civil Society
6. Access and stigma

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GLOBAL HIV/AIDS INITIATIVES NETWORK

Belgium, Benin, Burundi, China, Ethiopia, Georgia, Ireland, Kyrgyzstan, Lesotho, Malawi, Mozambique Peru, South Africa, Sweden, Tanzania, Uganda, Ukraine, United Kingdom, USA, Vietnam, Zambia

Researching National & Subnational Effects of Global HIV/AIDS Initiatives at the Country Level

SEARCH »

Search the GHIN database for original research on the impact of HIV/AIDS GHIs

GHIN database advanced search

Navigation

- About GHIN
- GHIN Outputs
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Journal Articles

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September 2010: Task sharing in Zambia: HIV service scale-up compounds the human resource crisis

September 2010: How HIV/AIDS scale-up has impacted on non-HIV priority services in Zambia

September 2010: Health systems strengthening: current and future activities

August 2010: Health workforce responses to global health initiatives funding: a comparison of Malawi and Zambia

Policy Briefs

more »

May 2010: Drawing on data from eight countries, GHIN researchers have produced a Policy Brief: Understanding the effects of global health initiatives

News & Updates

more »

Nov 2010: Summary of GHIN satellite session at Montreux Global Symposium on Health Systems Research

Nov 2010: Ethiopia SWEF Report just published

GHIN Database Updates

New! »

Multi-level research on Global Fund effects on country health systems

4. Global	2009-11
1. National	2003-05 (Tracking Study)
	2006-09 (GHIN)
2. Sub-national / districts	
Health facilities (Africa)	2007-09
Community	
3. - FSU (urban)	2007-10
5. - Zambia (rural)	2010-11

National (1): Global Fund Tracking Study

- 320 key informant interviews in two phases (2003 + 2004) in 4 countries: Malawi, Tanzania, Uganda, Zambia
- New development initiatives – especially if disbursing large amounts of aid – are hugely demanding on a small number of senior national government personnel
  - Parallel systems – planning, financial management, reporting – increase transaction costs for recipient national managers
  - Parallel financial management systems can increase risk
- GHIs as ‘blue-prints’ versus ‘adapting and contextualising’
  - Trade-offs between > transaction costs on Secretariat staff or on countries
- Communication
  - between Portfolio Managers and country ministry staff
  - with the country development partners (lack of a country presence)

National (2): GHIN study

- 201 key informant interviews (2006 – 2009) in 8 countries: China, Georgia, Kyrgyzstan, Lesotho, Mozambique, Peru, Ukraine, Zambia
- Increased participation of non-government actors in service planning and implementation
  - Effectiveness of CSO participation limited by low capacity, uncertain legitimacy and conflicts of interest versus representativeness
- Lesotho – 'knowledge absorptive capacity' *(under review Soc Sci Med)*
  - Over time, national level (PR) capacity to 'manage' Fund systems develops but lower levels (sub-PRs and especially districts) lack such capacity
  - Value of a stand-alone Coordinating Unit that has learned Fund systems, which intersects between ministries (Finance = PR and Health = sub-PR)
  - National capacity to 'manage' Global Fund conditions undermined by staff migration (is this something Secretariat staff also experience?)
  - Is there potential for seconding Secretariat Portfolio Managers to be based for 1-3 years in PR entities (MoH and MoF) who have large grants??

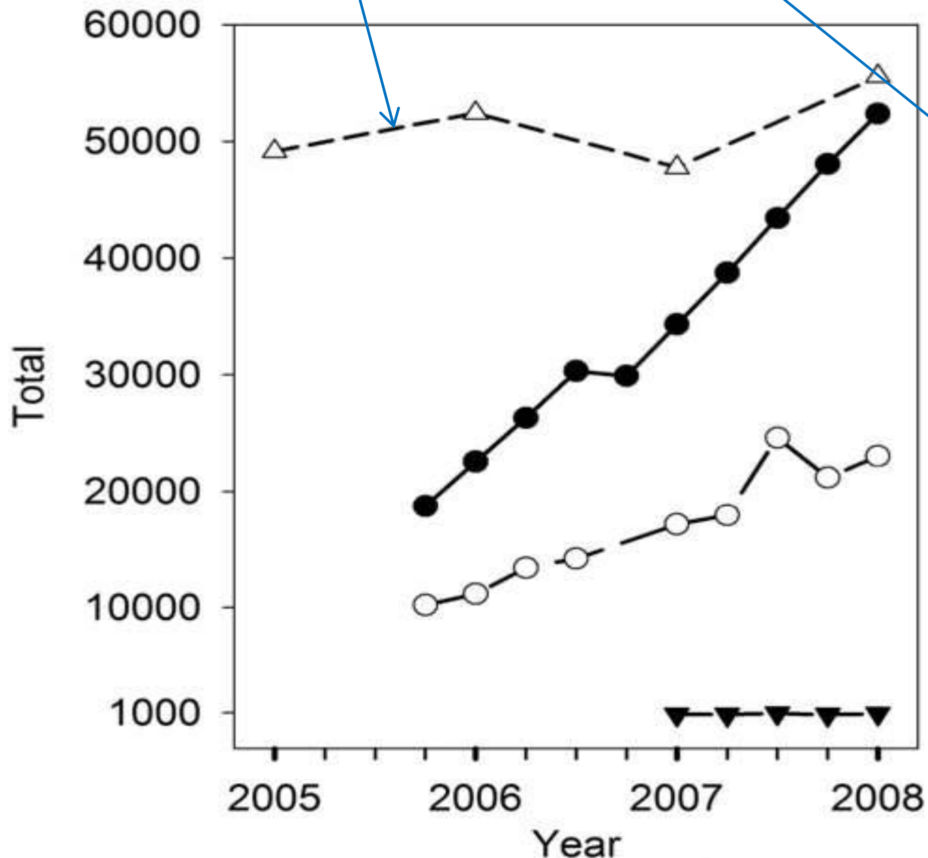
Summary of Global Fund and PEPFAR funding to HIV in Malawi and Zambia: 2004-08

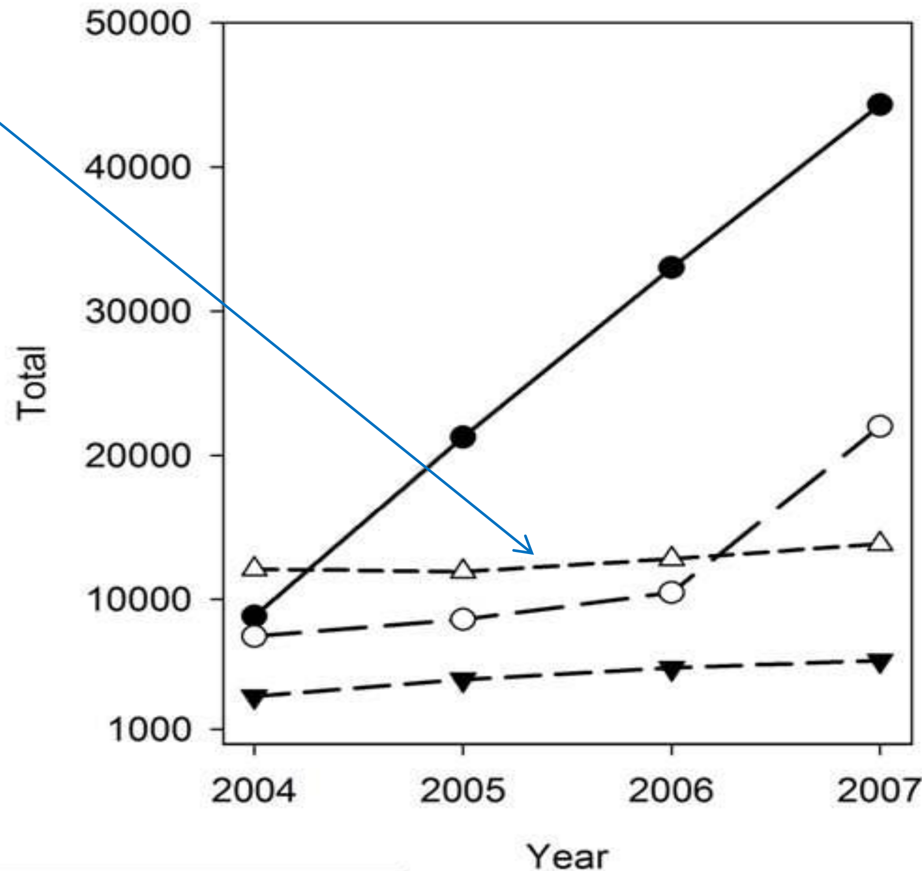
	Global Fund		PEPFAR
	Allocated	**Disbursed**	**Allocated**
Malawi			
Round 1	$342.6m	**$229.6m**	$14.5m (2004)
Round 5	$17.6m	$ 13.0m	$15.2m (2005)
Round 5 (HSS)*	$ 52.0m	$ 21.3m	$16.4m (2006)
Round 7	$15.1m		$18.9m (2007)
			$23.9m (2008)
Zambia			
Round 1	$90.3m	$ 81.9m	$82m (2004)
Round 4	$236.3m	**$128.0m**	**$126m (2005)**
Round 8	$55.1m		**$147m (2006)**
			$216m (2007)
			$269.2m (2008)

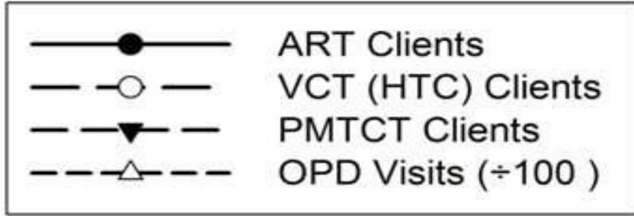
Research Methods

		MALAWI	ZAMBIA
District sampling	urban:	**3**	**2**
• probability in Malawi • small + purposive in Zambia	rural:	**6**	**1**
Facility record reviews: • Probability sampling of facilities • Similar data extraction tools • Cross-checked + supplemented by routine HIS data		**52**	**39**
Structured questionnaires to health workers and managers		571	234
Topic-guided interviews		153	61

Numbers of clients receiving ART, PMTCT, VCT + outpatient visits: Malawi and Zambia (2004-07)







Staff trends **Malawi**: 2005-08

(52 facilities)

	Mar-06	Mar-08	Mar-06	Mar-08	Mar 06_	Mar 08_	Mar-06	Mar-08
	Urban	**Urban**	**Rural**	**Rural**	**District**	**District**	**TOTAL**	**TOTAL**
Doctors	59	65	2	5	8	10	***69***	***80***
Nurses	523	651	221	199	295	329	***1039***	***1179***
Clinical Officers Medical Assistants	135	94	67	85	103	115	***305***	***294***
Total Clinical staff	**717**	**810**	**290**	**289**	**406**	**454**	***1413***	***1553***
Lab + Pharmacy	37	65	1	1	24	46	***62***	***112***
HSAs *(Health Surveillance Assists)*	74	158	**456**	**737**	205	381	***735***	***1276***
TOTAL	828	1033	747	1027	635	881	***2210***	***2941***

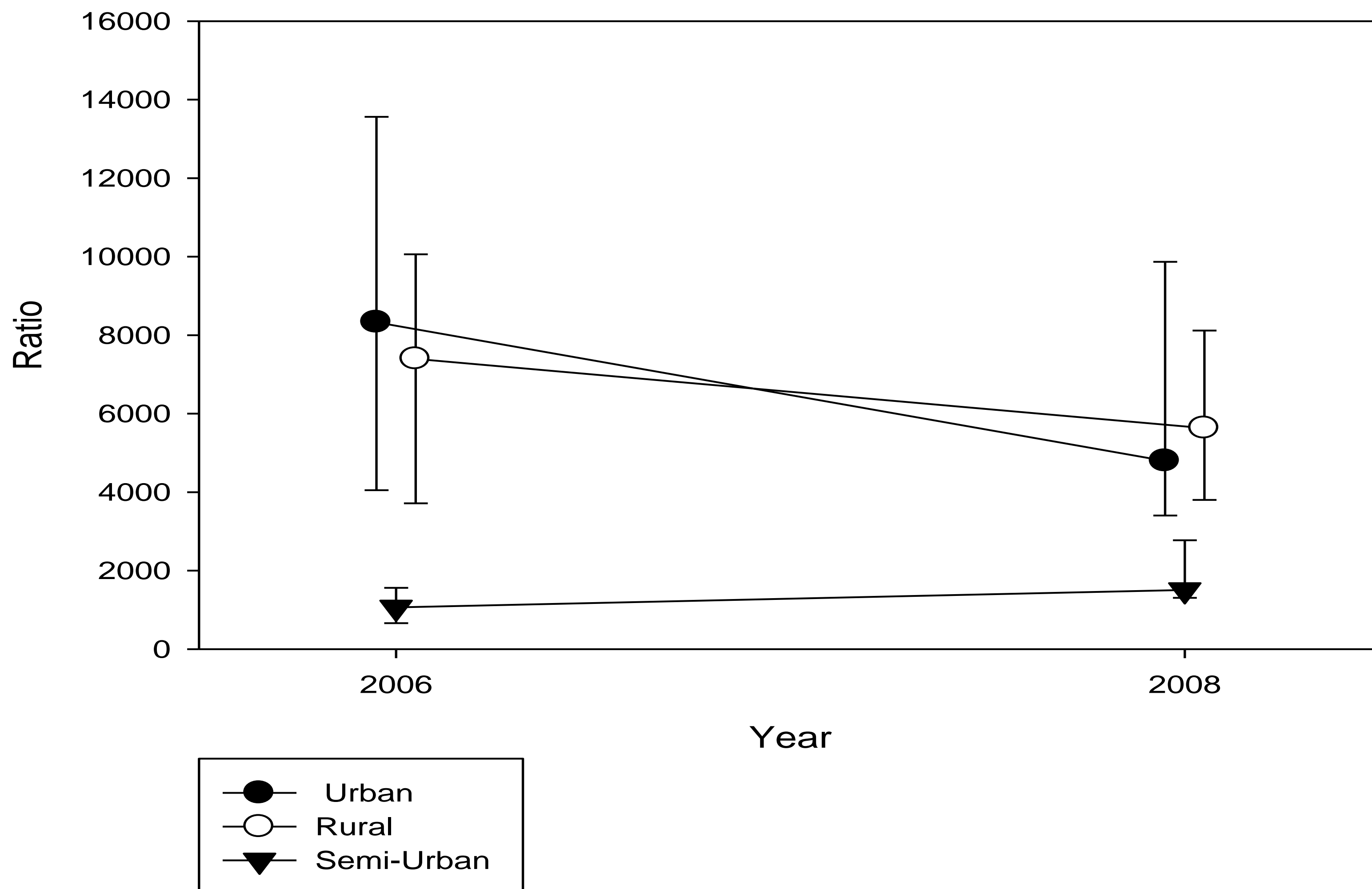
Staff trends Zambia: 2004-07

(29 facilities)

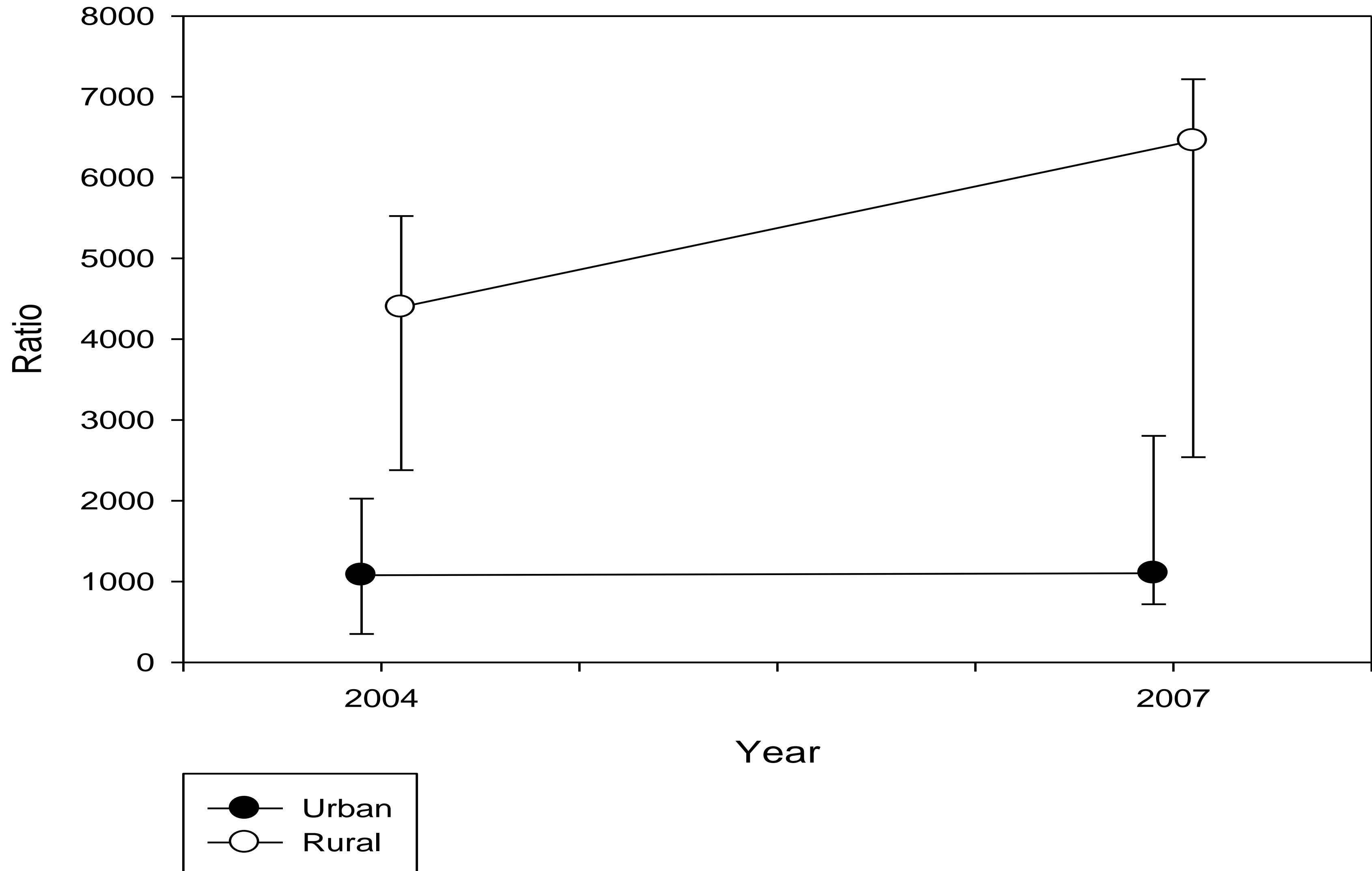
Health worker category	2004	2007	2004	2007	2004	2007
	Urban	Urban	Rural	Rural	TOTAL	TOTAL
Doctors	16	23	6	6	*22*	*29*
Nurses	384	381	61	61	*445*	*442*
Clinical Officers & Medical Assistants	76	67	16	15	*92*	*82*
Total Clinical staff	**476**	**471**	**83**	**82**	***559***	***553***
Technicians	51	62	4	11	*55*	*73*
Dedicated HIV counsellors	47	56	16	21	*63*	*77*
TOTAL	574	589	103	114	*677*	*703*

MALAWI: average clinical staff- outpatient workload

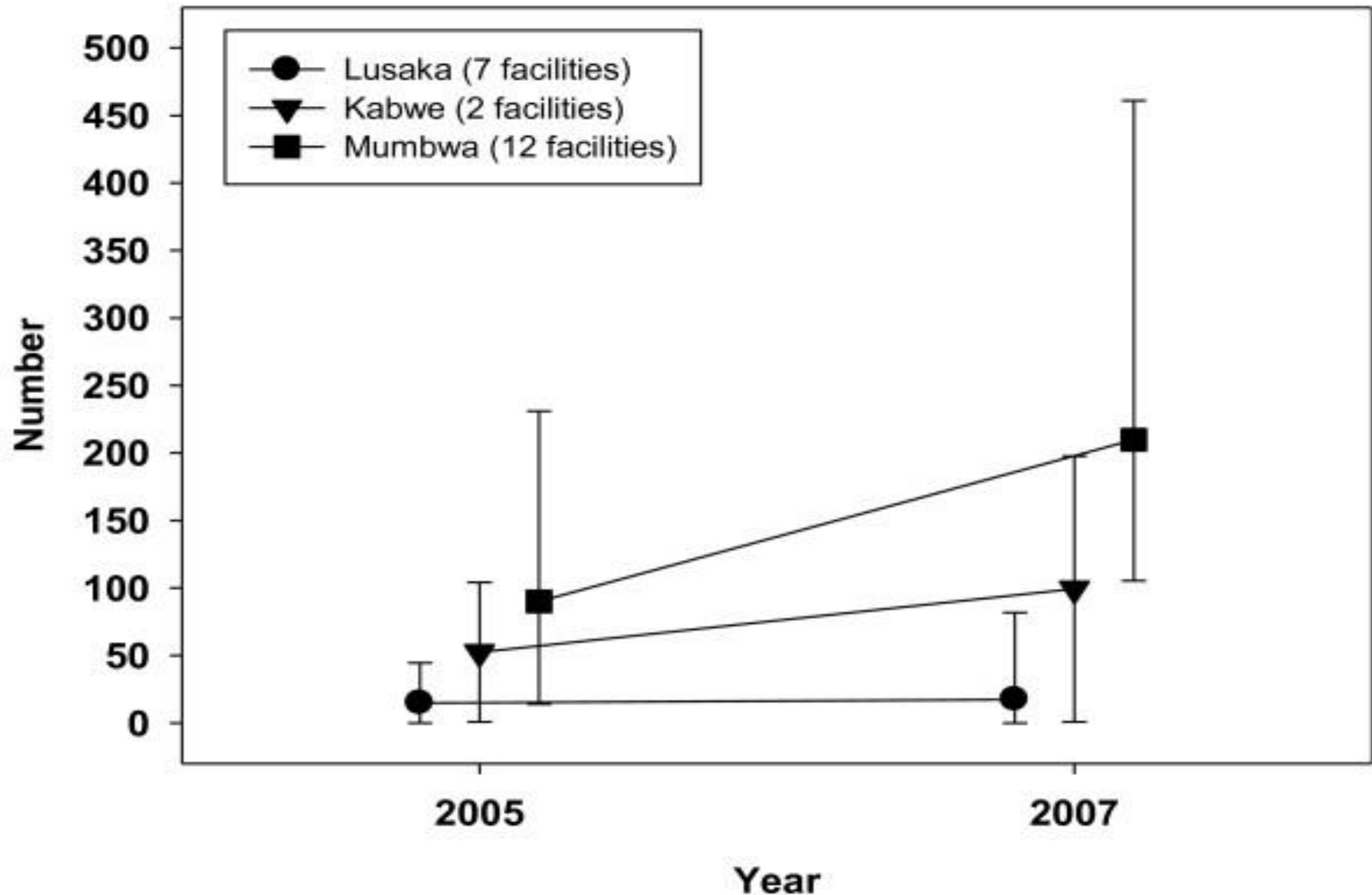
45facilities (6 urban, 7 district hospital, 34 rural health centre) 2006-08



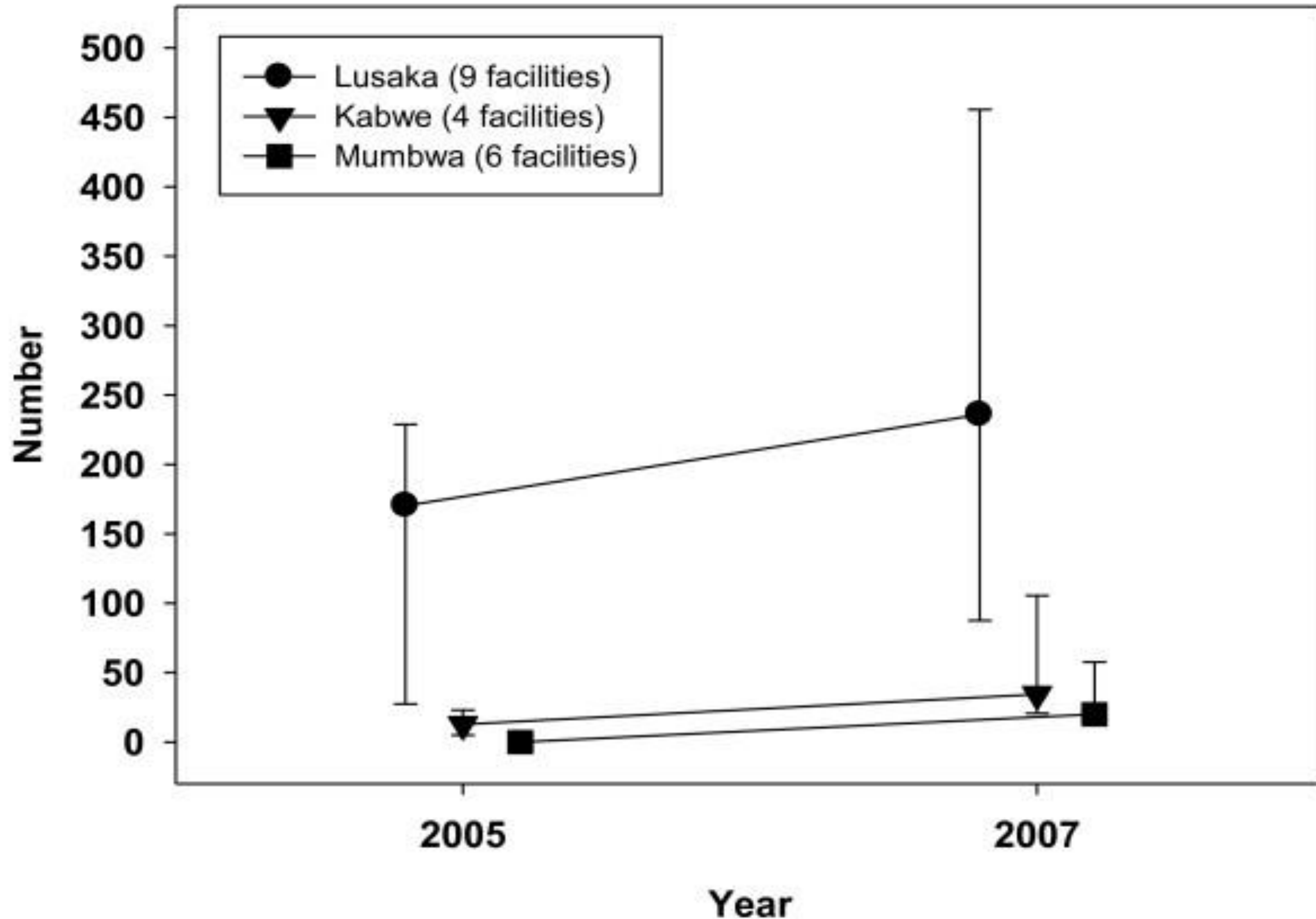
Zambia: average clinical staff- outpatient workload
22 facilities (12 urban 9 rural) 2004-07



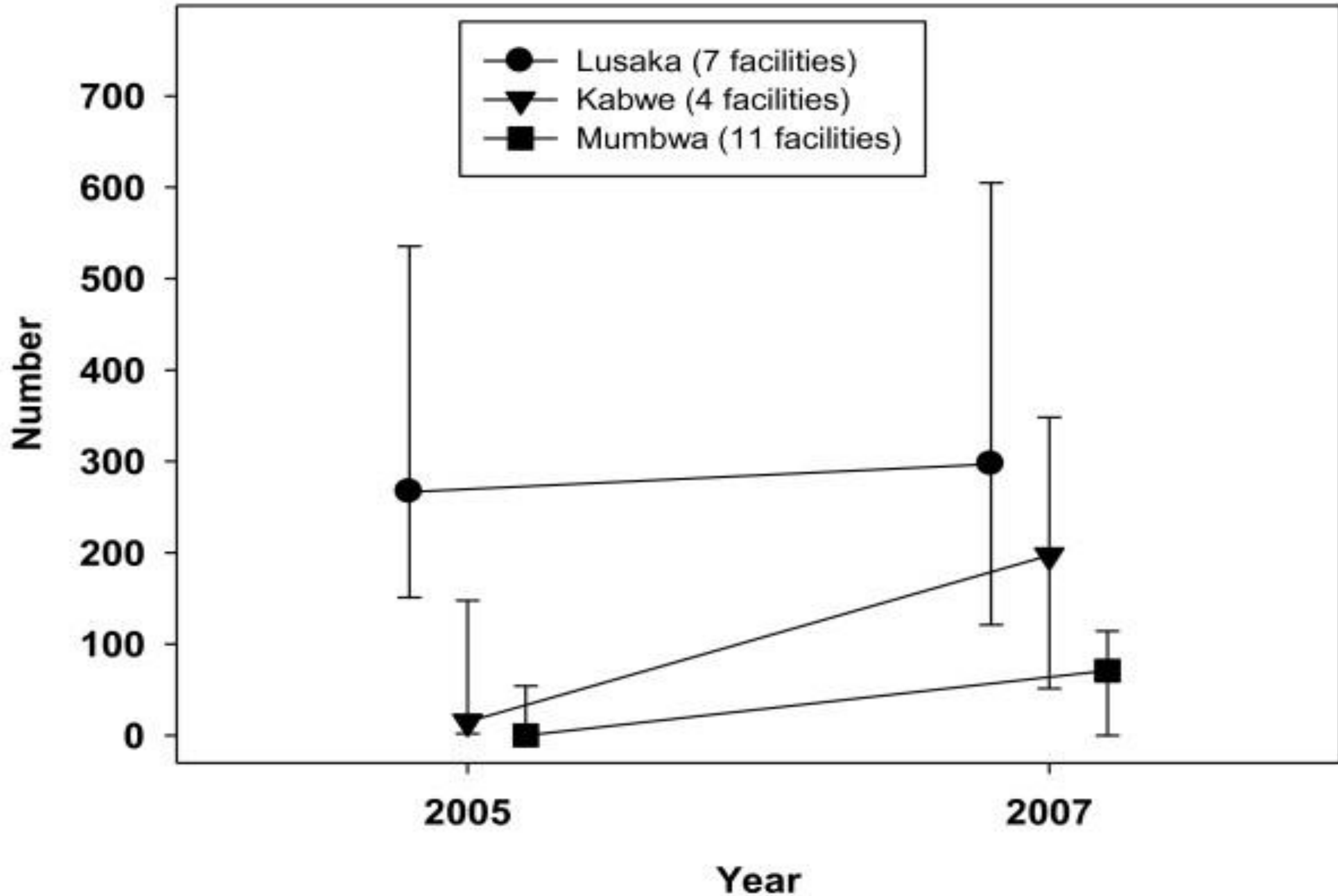
Zambia: Ratio of family planning clients to nurses (+ midwives), 2005-2007



Zambia: ratio of ART clients per ART worker, 2005-2007



Ratio of new ANC clients per PMTCT worker, 2005-07



Staff allocated to HIV services in Zambia (1)

Lusaka (urban)

Little change in staff numbers providing ART and PMTCT

- Staff providing ART alone: 45 in 2005 45 in 2007
- Staff providing PMTCT alone: 16 in 2005 18 in 2007

- 50% of clinical frontline staff delivering ART and non-HIV clinical services (no change 2005 to 2007)
- 33% of clinical frontline staff delivering PMTCT and non-HIV services (no change 2005 to 2007)

- Mixture of task sharing (2/3rd) and service-specific staff (1/3rd)
- Little change 2005 to 2007, but existing staff doing more work

Staff allocated to HIV services in Zambia (2)

Outside Lusaka:

- Almost no staff delivering ART and PMTCT alone
- But significant increase in staff delivering HIV and non-HIV

Mumbwa (Rural):

- 45% increase in staff providing PMTCT and other non-HIV services
- 26% increase in staff providing ART and other services
- 73% of frontline clinical staff delivering ART by 2007

Kabwe (town):

- Increase from 20% (2005) to 81% (2007) in proportion of nurses & midwives providing PMTCT

TASK SHARING (not Task Shifting), or *Mainstreaming* of HIV care: more staff taking on HIV service delivery on top of other clinical duties

Conclusions (1)

- GHIs have contributed to equitable access to HIV care
- Apart from Global Fund in Malawi (+ Ethiopia) HIV GHIs did not fund basic HW training programmes, thereby undermining the HW response
  - Global Fund + PEPFAR focused on funding in-service training instead
- Staff in Zambia delivering care to more clients (greater workload) – i.e. task-sharing, not task-shifting which was used in Malawi.
- Is increased workload:
  - squeezing more work out of under-worked staff?
  - or increasing risk of staff burnout and attrition, as has been reported?
- Interviews with district staff and managers in Zambia reported:
  - failure to fund /implement the Zambia Health Worker Rural Retention Scheme
  - staff leaving rural Mumbwa to better paid (often PEPFAR-funded) jobs
  - NGOs recruit staff, especially middle and senior level staff, from a small pool

Conclusions (2)

- Global Fund (+ UK DfID) agreed to re-allocation of funds from **MALAWI** Round 1 grant, which supported its
  Emergency Human Resource Programme
  - Doubling in training of new health workers
  - Hiring 10,000 new staff (including 5,000 GFATM-funded HSAs)
  - Salary supplements
- **ZAMBIA's National Human Resources Strategic Plan** lacked concerted donor support for hiring new health workers

1. Recipient governments (and their partners) need to prioritise the development of HSS strategies
2. Donors can then be encouraged (pressurised) to fund them

Acknowledgements www.ghinet.org

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Irish Aid and Danida → GHIN Network

1.Health workforce responses to global health initiatives funding: a comparison of Malawi and Zambia: http://www.human-resources-health.com/content/8/1/19/abstract

2.How HIV/AIDS scale-up has impacted on non- HIV priority services in Zambia: http://www.biomedcentral.com/1471-2458/10/540/abstract/

3.Task sharing in Zambia: HIV service scale-up compounds the human resource crisis
http://www.biomedcentral.com/1472-6963/10/272

Ukraine & Kyrgyzstan: sample sizes (2007 and 2008 surveys)

	Ukraine	Kyrgyzstan	Total
NGO Providers	49	15	64
Government Providers	22	10	32
TOTAL	71	25	96

Findings: staff numbers

- Staffing numbers increased substantially among GF-financed NGOs, and to a lesser extent government providers

	2005	2006	2007	% increase 2005-7
NGOs (n=8)	68	83	128	88
Gov't (n=6)	316	356	393	24
Total (n=14)	384	439	521	36

Table: Increases in workers: sampled HIV/AIDS service providers in Kyrgyzstan

- Much of the scale-up in human resources was reported in capital cities; shortages of government and NGO HIV staff remained acute in many rural and outlying districts

- Frequent breaks in GF funding for Kyrgyz HIV NGOs undermined efforts at staff retention jeopardising client trust and ultimately the delivery of essential services

Training

- The vast majority of HIV workers received some training in HIV-related activities; a high proportion of workers reported that training had a positive impact on their skills ***'The Global Fund provided a lot of training, so now staff can use [new] methods and implement new services'.***
- Training activities have not been monitored making it difficult to measure their effectiveness, appropriateness and impact on service quality

Approach

- NGO Global Fund grantees commonly recruit former clients as staff which enhanced service access and effectiveness ***'… their work is based on the "peer-to-peer" principle. So, these people know the problem from the inside…they understand more, deeper, better and they have more trust of the clients'*.**

Motivation

- Most government and NGO staff reported increased motivation to deliver HIV services. NGO staff reported
  - that they felt their work was valuable;
  - empathy towards clients;
  - motivation from career opportunities and financial incentives
- However government HIV workers lacked salary incentives, fair bonus systems and adequate legal protection (medical staff), which undermined motivation ***'why does a driver in the AIDS Center receive 60% increase, and we who have direct contact with patients, don't?'***
- Former IDUs working for NGOs were vulnerable to extrajudicial practices by police in some areas

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