

BRIEFING SHEET 2: HUMAN RESOURCES

KEY MESSAGES: STAFF ARE A CRITICAL FACTOR

- In the generalised HIV epidemic countries, the major problem was a shortage of staff to meet the growth in services. In concentrated epidemic countries there was an imbalance between the public and non-government sectors.
- Funding from Global Health Initiatives for HIV/AIDS (GHIs) has increased service delivery and therefore staff workloads. Increases in numbers of staff have not kept pace with workloads in sub-Saharan Africa.
- In all countries, key informants reported that training and motivation were key factors in the delivery of HIV/AIDS programmes, and that GHI activities influenced these in different ways.
- Many staff have received training funded by GHIs on various aspects of HIV/AIDS services, which was generally welcomed.
- Incentives are often given to health staff providing HIV-related care. The effects of this on non-HIV priorities need to be assessed.
- Staff motivation differed from country to country. In some it was low because of work overload, in others it was raised by opportunities for 'top ups' to salaries, additional training and work satisfaction.

Background

Findings presented in this briefing sheet are results from completed and on-going research by Global HIV/AIDS Initiatives Network (GHIN) members (see Box 1) in ten countries¹. See Briefing Sheet 1 for more on the background to GHIN and country studies or visit www.ghinet.org.

Early findings from GHIN country studies

Numbers of available health workers

Human resource (HR) constraints are a barrier to the effective functioning and scaling up of HIV/AIDS services in many of the GHIN research countries. Constraints include overall human resource shortages, and the frequent movement of staff within a health system. In most GHIN countries (Benin, Ethiopia, Malawi, Kyrgyzstan, Ukraine, Zambia), small or moderate increases in the number of health workers delivering HIV/AIDS services have occurred, some of which have been attributed to GHI support. These have taken place in different ways and with different effects.

- Additional staff have been recruited to implement Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) supported activities on short term contracts in Benin, Ethiopia and Malawi.
- There was a modest increase in health workers at the district level in Malawi, although health workers themselves perceived that there had been a decrease.

- In Zambia, there were small increases in staff delivering HIV/AIDS services, but there was considerable variation between facilities, and in some cases decreases were recorded.
- In Kyrgyzstan and Ukraine, there was a significant increase in workers in NGO facilities funded by the GFATM, but not in government facilities. Voluntary peer-to-peer outreach workers, including ex-clients, have become an important category of worker.

The effects of health worker shortages on the health system

- Retention of health workers in Ethiopia worsened between the baseline and follow-up study one year later, due to shifts of personnel from the public to private sector.
- HR capacity constraints have limited the scale-up of focal services as well as the continued delivery of non-focal diseases in Ethiopia. "With the scale up of ART services in hospitals, patients with chronic illnesses like diabetes, hypertension, other internal illnesses are not given attention. Hospital staff and facilities are getting engaged with HIV/AIDS related patients especially those seeking ART services". [Hospital physician]
- However, in Malawi there has been good integration between HIV and non-HIV services: PMTCT with ANC, VCT and ARV with outpatient and inpatient care, and there was no evidence that implementation of GHI interventions had affected the numbers of staff delivering non-HIV interventions.

¹ Benin, China, Kyrgyzstan, Malawi, Zambia, Ethiopia, Ukraine, Georgia, Peru.

Human resource constraints in Malawi

Human resource constraints have limited the government's ability to scale up ART services in urban areas as fast as is needed, and have hindered expansion in rural areas. Although there has been a modest increase in numbers of clinicians, nurses, pharmacy and laboratory staff at district hospitals, the numbers of nurses and clinicians appeared to have decreased in sub-district health facilities, especially in rural health centres.

A number of different incentives have led to health staff working longer hours (for example by being allowed to do locums out of hours). Records confirmed there had been an increase in the provision of VCT, ARV therapy and PMTCT services, especially at central and district hospital levels. After a policy change to allow non-medical health workers to deliver VCT, there was some evidence to suggest that health surveillance assistants had moved into 'specialising' in VCT provision, potentially weakening the general health information system. It also seemed that motivation was high among those staff providing ARV, but not among those providing PMTCT, possibly because of the lack of visible impact of the intervention.

Workload and training

- In Zambia, Ethiopia, Malawi and Peru, research found that health staff workloads have increased since the inception of the GHI HIV/AIDS programmes. While Malawi and Zambia both saw a slight increase in the number of health workers delivering HIV/AIDS services at district level, this was not commensurate with the rapid scale-up of services leading to increases in workloads. However, in Malawi all health staff salaries increased by 50% in 2005 as a result of the Emergency Health Resources Relief programme supported by GFATM and DFID, and research suggests motivation was high in spite of heavy workloads. In Peru implementation of activities was delayed due to a lack of administrative capacity for the programme.

- In Zambia some key informants were concerned about a trend towards 'trainingism', where training was seen as an end in itself rather than as an opportunity for capacity building. They suggested that some health workers participated in as many training courses as possible in order to receive more per diems.

- In Ukraine and Kyrgyzstan, most service providers felt that staffing levels were sufficient for them to carry out current activities.

- In Vietnam HIV staff appeared to benefit more than non-HIV staff from allowances received through meetings and training, largely organised and funded by the GHIs.

Motivation and incentives

- In Ukraine and Kyrgyzstan, motivation was generally reported to be high by health workers delivering HIV/AIDS services, and most service providers indicated that they had received some financial incentives for delivering HIV/AIDS related services, although these are funded by the state.

- In Ethiopia, Benin and Malawi, the majority of health workers were not offered any significant new incentives to reward

them for the increase in workload and/or responsibilities under GFATM-supported programmes, although in 2005 health salaries were raised overall for all health staff in Malawi.

- More workers in Zambia received incentives for HIV/AIDS related services, than did staff for non-HIV services.
- Government staff working at provincial level within HIV/AIDS programmes in Vietnam were paid more to work in this area because it was perceived to be of higher risk. Government staff were viewed by some key informants as less motivated to work with HIV patients, as these patients were less likely to provide informal payments to increase salaries. In Vietnam, key informants also mentioned that international NGO staff (largely PEPFAR) received higher salaries than government staff.

Box 1: Global HIV/AIDS Initiatives Network (GHIN)

GHIN is a network of researchers in 21 countries² that explores the effects of Global HIV/AIDS Initiatives on country health systems, at national and sub-national levels. Key research themes include:

- Scale up of HIV/AIDS services
- Health systems capacity including human resources for health and coordination of HIV/AIDS programmes and services
- Equitable access to HIV/AIDS services

GHIN research findings are reported on the website: www.ghinet.org and are disseminated through research briefing sheets and other short communications, presentations at conferences and meetings, and through journal publications. These cover both country specific and cross-cutting analysis. GHIN members regularly interact with national and international stakeholders both to inform decision-making and to shape research questions.

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² GHIN countries undertaking 2-4 year studies include: Angola, Benin, China, Ethiopia, Georgia, Kyrgyzstan, Malawi, Mozambique, Peru, South Africa, Tanzania, Uganda, Ukraine, Vietnam and Zambia.