HIV/AIDS Workload and Staff Motivation in Malawi & Zambia: *Comparative Effects of Global HIV/AIDS Initiatives (GHIs)*

Baseline Study Findings

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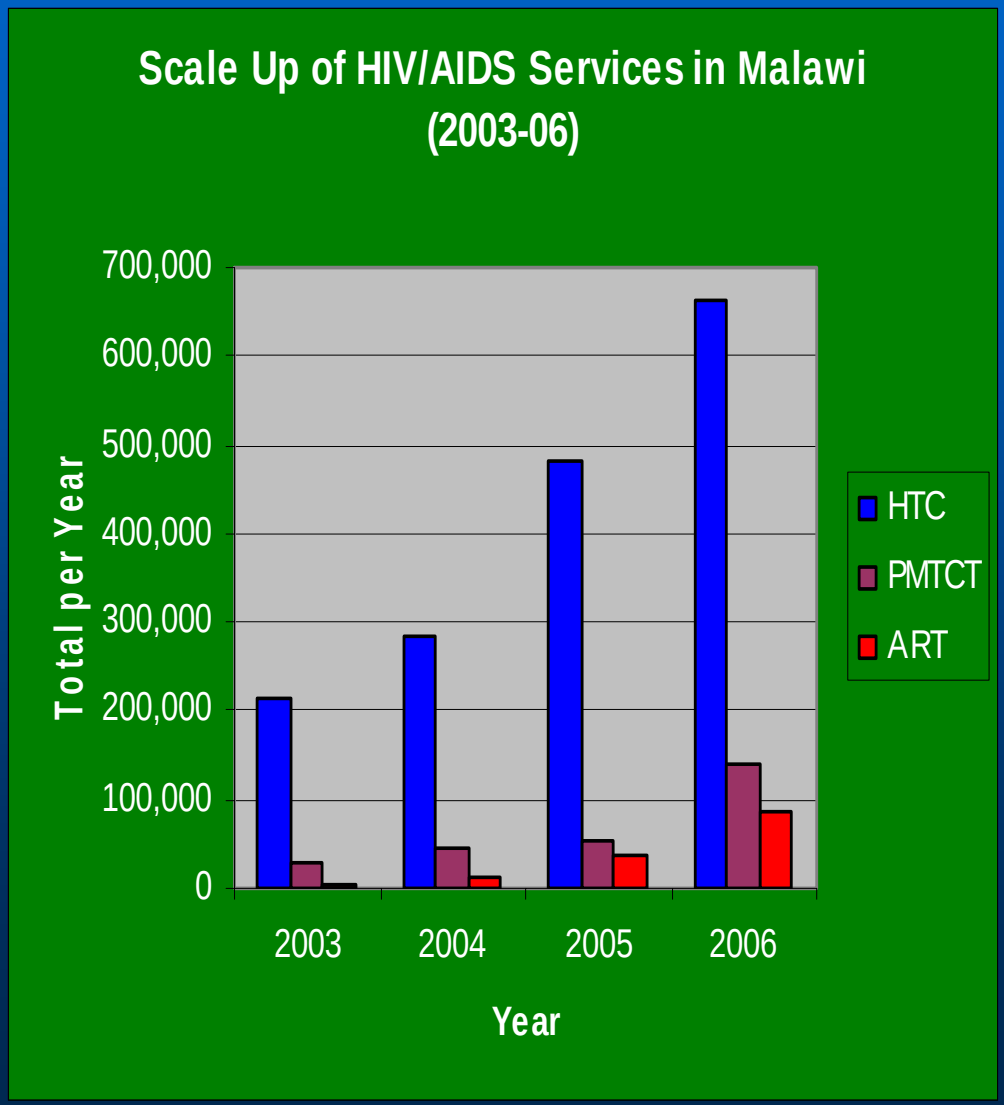
HIV/AIDS in Zambia & Malawi

- Prevalence in 15-49 yr age group
  - Malawi: 11.8% *(MDHS, 2004)*
  - Zambia: 14.3% *(ZDHS, 2007)*

- External funding for HIV/AIDS
  - Global Fund– Largest funding agency in Malawi (77%)
  - PEPFAR– Largest funding agency in Zambia (62%)

- External HIV/AIDS funding: >100% of total health budget

Scale-Up of HIV/AIDS Services in Malawi & Zambia



- Scale up of HIV/AIDS Services in Zambia
  - **HTC (2006 to 2007):** 21% increase from 234,430
  - **PMTCT (2005 to 2007):** 2.3-fold increase from 72,020
  - **ART (2005 to 2007):** 3.8-fold increase from 39,351

Human Resources Status in Malawi & Zambia

- HRH: population ratio *(per 100,000 population)*
  - Doctors: Malawi: 2 *versus* Zambia: 6
  - Nurses: Malawi: 39 *versus* Zambia: 52

- Availability of HRH
  - Malawi *(% establishments filled):* Doctors: 36%, nurses: 56%,
  - Zambia *(% of requirements):* Doctors: 28%, nurses: 36%

- Average salaries for nurses *(per month)*
  - Malawi: US$175 *versus* Zambia: US$300

Study Objectives

- Broad
  - Assess and compare the effects of increased HIV funding and scale-up of HIV services on human resources for health [HRH] (clinicians, nurses & community health workers) in Malawi and Zambia

- Specific outcomes: Effects on
  - rural/urban HRH distribution
  - workload
  - incentives
  - HRH job satisfaction

Methodology: Study Countries

Methodology

Study period: Dec 2006 to Mar 2007

Study Sites

Malawi: 51 health facilities (~90% govt)

- Central Hospitals (n=3)
- Mission Referral Hospital (n=1)
- District hospitals (n=7)
- Sub-district facilities (n=40)

Zambia: 39 health facilities (~90% govt)

- 3 districts (2 urban, 1 rural)
- Govt-owned (35), Mission-owned & community based facilities (4)

Interviews + surveys

- Officers in-charge of health facilities
- Heads of sections (including HR)
- HIV service Coordinators
- Providers of HIV & non-HIV services

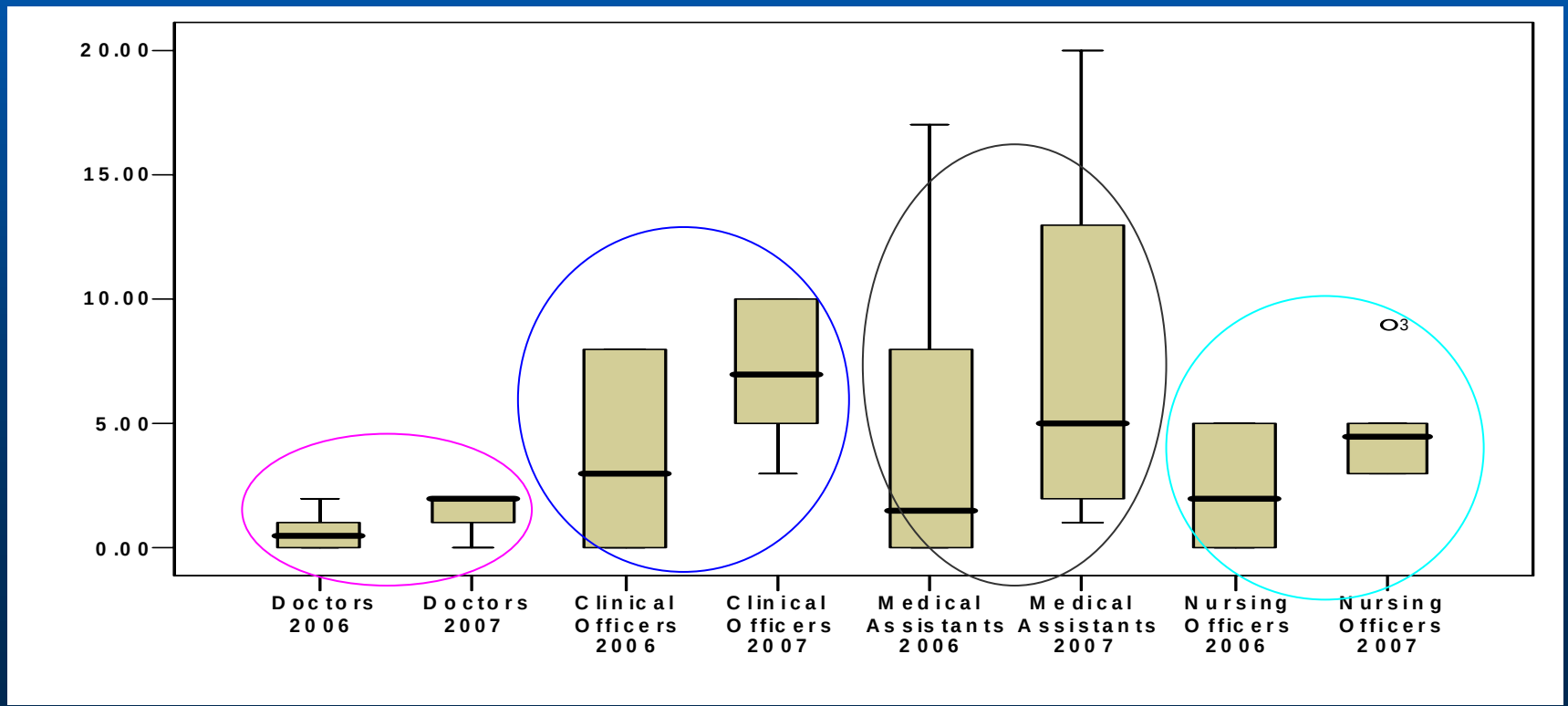
Health Facility record Review

- Inpatient, outpatient stats

Results: *HRH distribution & trends*

- In Malawi & Zambia HR worse in rural > urban health centres
  - % of health facilities in Malawi: with no clinician: 21.0%, no nurse 26.3% (n=19)

- Malawi & Zambia experienced a *modest* increase in health workers from 2006 to 2007. However, in Malawi clinicians and nurses perceived a decrease in numbers



Results: *HRH Workload & Incentives*

- Staff experienced increase in workload
  - In Malawi 82- 94% HIV service providers delivered non-HIV services vs. 60-75% in Zambia
  - Increase in service outputs outweighed increase in HRH numbers
- In both countries: no shift of staff between non-HIV & HIV programmes
- Lower proportion received extra financial incentives to provide HIV services in Malawi (7-11%) than in Zambia (21-55%)
- % of HIV service providers engaging in income generating activities outside work similar in Malawi & Zambia (31-38% vs 25-43%, respectively)
- In Malawi, increase in workload created an opportunity for health workers to earn extra income through "locums"– except in rural facilities

Results: *Job Satisfaction*

- Job satisfaction (JS) was slightly higher for HIV service providers in Malawi (50-80%) than in Zambia (51-60%).

- Job satisfaction dependent on level of h/facility & type of HIV programme
  - District level JS higher than health centre level
  - ART & HTC programmes higher than PMTCT
  - Reasons:
    - **training opportunities: per diems & time off-work/night duty**
    - **perceived impact of the intervention on patient quality of care**

- Reasons for poor satisfaction
  - **lack of resources to do their job (e.g HIV test kits!!)**
  - Workload
  - Poor incentives and salary

Discussion / Conclusions (1)

- Modest increase in health worker availability
  - Early evidence that the comprehensive donor-supported HRH programme is having positive results (In Malawi partly funded by GFATM)
- Rural health facilities still under-served in term of poor HRH numbers & staff incentives→ will limit scale-up of scale-up of HIV/AIDS services
  - Resource-poor countries need innovative ways of attracting and maintaining HRH in rural areas
- Increased workload but fairly good job satisfaction
  - Integrated health care delivery promoted team work in difficult working environment--> redistribution of workload
  - Improved patient outcomes promoted staff morale
  - However, further increase in workload without HRH increase→ compromise quality of HIV or non-HIV services.

Discussion / Conclusions (2)

- "Locums" may be a feasible way of increasing HRH remuneration without upsetting other non-health public workers
  - May maximize HRH output & prevent HWs from engaging in non-health IGAs
  - However, it may result in staff burn-out, needs good management to avoid escalating health expenditure
- Need to devise innovative "on-the-job" & integrated training to avoid long staff absences during training
  - per diems (currently ~US$10-20) per day need to be maintained in the absence of massive improvements in remuneration packages to maintain staff morale
- African public sector health workers are rising to the challenge and "coping – just about !". They need more support and better incentives