

ACCELERATING THE IMPACT OF HIV PROGRAMMING ON HEALTH SYSTEMS STRENGTHENING

Pre-Conference Meeting of Health Systems Experts, HIV Researchers and Implementers
The Town House Hotel and Conference Center

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11.30 am – 13.00 pm

Session 3: Health Workforce

Helen Schneider: [Chief Researcher, University Of Cape Town South African National AIDS Council, Cape Town]

Good afternoon everybody and thanks to IAS and Jacqueline for inviting me to moderate. The session after lunch is on the theme of the *'Health Workforce'* which in some ways is the midpoint perhaps between the grand financing questions and the day to day service delivery problems around all issues of HIV and health systems strengthening.

I think most people would agree that health workforce issues get to the heart of health systems strengthening agenda and in many ways is the moment of truth on whether investments in HIV are strengthening the health system. So we are very fortunate to have four speakers who can really help us to think on this question. To explore the complexities of what health systems strengthening actually means. There are dimensions of it but perhaps even more importantly how one goes about strengthening the health workforce through disease specific programs.

So I'm going to hand out to our first speaker Freddie Ssengooba [check] who is a leading Health Systems Researcher in Uganda who I think would classify himself in the health systems camp but he can tell us more.

Freddie Ssengooba: [Lecturer of Health Policy, Planning and Management, Makerere University School of Public Health, Kampala]

**Title: Researching Health Worker Dynamics in the Context of HIV Scale-up:
 Accumulating Evidence in Complex Health Systems**

Thank you very much and good afternoon. I know it's always a challenge to speak after lunch, so it's a mixed blessing. I hope you find time to digest the good food as well as the information that I'm going to be trying to communicate in the next 10 minutes, I suppose.

Let me first of all thank several agencies because I've been privileged to lead or to be part of research beyond generation of research on health workforce in Uganda in particular; and this has been financed through various groups and agencies including London School, The Rockefeller Foundation, Centre for Global Development, Alliance for Health Policy and Systems with WHO and recently The World Bank - accept us to do a thesis around not only on the work we have been doing but also to look broadly beyond our work to see how we can approach the issue of researching and being able to understand how Global Health Initiatives can help the developments in the health workforce.

So today I've put together a presentation which is really best known in the thesis of various works that we've been doing and it is going to really bring or focus more at the upstream. I realized that there is a lot of discussion around down stream. When I say down stream, this includes things like - where health workers are and getting them to do the right thing but when we've been doing this work, we realized that really by the time you understand Global Health Initiatives, you really need to start and see where they are entering into the health system and be able to see if you can track down those effects down to the interface. And there's been rather very little research around upstream functions; and that's an area that I would like my presentation to focus a little bit more on, partly because we cannot not probably understand the impacts that are going to arise at the [health] workforce level unless we are able to track the pathways and mechanisms that through Global Health Initiatives, are going to trickle down the workforce.

So in terms of my outline, I'm going to present the framework we have developed as a way of trying to understand exactly what does managing the [health] workforce mean in terms of the context of HIV; and in that framework I will highlight four main areas but the results I'm going to share with you are going to focus on the top two. That is - 'Protecting Governance' and - 'Labor Market Dynamics'.

Now I heard during the morning sessions a lot of discussion around governance and why governance is so critical but I think when it comes to researching in that area, we are still very far behind. In order to understand that, I thought this meeting would really be a good place to kind of start that dialogue and also to see how we can kind of engage in this rather complex area. I also hope to end by talking a little bit about methods because people are asking for empirical evidence but sometimes at the health systems level we need to understand and redefine what empirical evidence means.

So quickly about the framework [\[ppt slide\]](#): I want to use it to talk about what we've tried to put together in terms of understanding the [health] workforce system. The centrality of governance sits

in the middle – there are four main points that are actually important for my perspective from the literature. There is ‘Labor Market Governance’; there is ‘Performance Management’ and of course ‘Workforce Production’ but all those are basically being coordinated through ‘Strategic Governance’ and we need to understand what that means so that strategic governance can really drive the other three.

And for us to understand the [health] workforce of course we need to have these embedded in the social-economic context. In the morning there was a lot of talk about financing policies and about the history. It was borne out in the morning that we cannot just look at the health sector because there are many players; but I think from this [ppt slide](#) framework what we are trying to say is that when you look at the health sector its main interface or perspective - rearrange managing the labor market but also the performance towards its main goals.

But when you look at labor market and production, you are really talking from the perspective of other sectors particularly education. When you are talking about HR training and performance, we are generally talking about mainly the provider perspective and all these perspectives bring about different answers especially when you start to ask what are [the Global Health Initiatives] effects. Today I’m going to focus on one of the global health effects that falls at the strategic governance level but of course we can look at, and I will share with you findings around the perspectives of a health sector and the other areas I will not be able to go to, but we have some findings, because of time are those other two areas.

So quickly, the question probably one will ask and particularly very important is this, to what extent or under what circumstances can Global Health Initiatives strengthen the governance [of health workforce] and real processes among different stakeholders? But also we need coherent policy and implementation. I think many of the issues around coherence and governance are all known to you [ppt slide](#).

I think when you look at the general evidence surrounding governance here, the simple explanation I think I could offer is responsibility - being able to have authority and resources - and when you talk of the three we realized that most governments particularly in Africa and those suffering the biggest epidemic, they have the worst case when it comes to taking care of their infected people, preventing infection. When it comes to really the other two i.e. the authority and resources - that is the domain that is increasingly crowded by funding agencies by trying to provide what they can. So you find that actually they have governance that is starting to fail.

Now there are many issues arising here [ppt slide](#). There are a lot of unresolved conflicts. There are multiple stakeholders [ppt slide](#). Of course inter-sectoral rivalries; although we were talking about all sectors collaborating, you will find that they are funded differently, pursuing different objectives and many times those objectives or funding arrangements do not allow collaboration around human resources for health. There are differences and disconnect around key issues; and

the points 3 to 6 [ppt slide] is where a lot of Global Health Initiatives are actually coming in; or they could try to use in order to improve the coordination of governance or human resource format.

This is a [ppt slide] slide that talks about the different stakeholders that are managing the [health] workforce. It's like entering a bus and there are about 18 different people in the bus and each one controls one wheel; the other one controls another wheel. The other controls the carburetor, the other the engine, the other is a driver. So what happens at the end of the day is that the bus does not really move in any purposeful direction and that I think is the biggest challenge we have. Because everybody is driving the [health] workforce in different aspects and I believe that somehow we need to get governance around the stakeholders into the systems engineers use. They get all the controls of the bus to one person. He drives the car and somehow in human resources we need to figure out how do we create a forum where the governance of all the stakeholders could at least be given to a central agency so that it purposeful and useful. I think we could borrow from that side.

Moving away now to the next perspective, this is around how the health sector is managing the workforce [ppt slide]. And I think here one of the main questions we are trying to address is under what condition do HIV Programs strengthen the capacity of the health sector to ensure effective [health] workforce development and equate to [health] workforce size and of course optimal weight instructions.

[I] will just take you through a case study of how these things happening at [health] systems level can trickle down, and by trying to combine evidence across both upstream and downstream can try to understand what's happening in the health systems. So this is a technical system level problem. There are a lot of empty posts. There are no people willing to take them up although there are actually salaries for these posts. So, [the Ugandan] government went ahead and advertised for 400 posts [ppt slide].

For the doctors particularly government went ahead in Uganda to advertise for 120 [positions] [ppt slide]. It had produced 170 doctors [that year] but at the end of the recruitment process we [the government] were able to attract 11 doctors and then one would ask - what is the problem? The jobs are there but the doctors are not showing up. And the doctors are being trained. Just to understand, the cartoonist put it that doctors are lining up to enter the health system but somehow the door is closed. [ppt slide] It says no pair of eyes. And on the right side they are seeing an open door but they are happily marching abroad. Rwanda is a good example of taking a lot of doctors [from Uganda], Sudan as well, but of course we have traditional [brain drain countries] like South Africa and the U.S.

So somehow doctors have an additional option of somewhere else to go to [apart from local health systems]. But not only abroad if you look at this slide you will find that how many health workers have moved over the last three years – from around 2005 – 2008. And we realize that of the 346

sample of the people we interviewed, we realized that 73% had actually moved from the previous organization to the current one where we found them

And we try to understand how that movement has been driven the heavy global [health] financing initiative where we talk of Global Fund, PEPFAR and other agencies and those organizations that have received investments – oh sorry this is too sensitive [*the speaker leaves the sentence in the middle and start somewhere else*]. And what this tells is that actually there is a lot of [health workforce] movement. Movement is particularly high especially towards organizations that are heavily financed by Global Health Initiatives particularly from mission hospitals and from NGOs but overall it says there is a lot internal movement [health workforce] staff [\[ppt slide\]](#).

If you are a manager of course that is a problem because you know that you cannot even plan knowing that staff leave in the next month or next year but of course to the people this maybe something important for them to look for [better] opportunities. This is a [\[ppt slide\]](#) slide coming up asking managers to rank on a scale of 0 to 5 how Global Health Initiatives have invested in these factors, around the work being done. You will see that the green [\[ppt slide\]](#) which represents the National NGOs - managers there believe they are receiving much broader help. In the middle you see a dotted blue line is the public sector which the scale says they receive the least and then we got the red and those are 'private not for profit' (PNFP) or called mission or faith based and of course international NGOs. In some slides most managers believe most support is going to international agencies and in the morning when I was listening to interventions, so it seems we need to localize interventions for sustainability. This is the basis of this point [that I am making] because we cannot invest in organizations that are susceptible to flight [of health workforce]. When things get hard there they [the health workforce] pack and go you know. They fly.

The other aspect of understanding what that investment means is to look at how salaries differ from different providers. Those providers are providing HIV/AIDS services. Their salaries for doctors almost as twice as those on non HIV facilities and of course across you will see [\[ppt slide\]](#) those are dollar amounts for a doctor for a month but still even small you can see it actual create a distortion that will tilt job opportunities for doctors. So the good thing here is that doctors can shop for better pay, of course the problem will be that those organizations have kind of located themselves around urban centers so this will not necessarily be a good finding for equity purposes.

Just to quickly move on I was very happy to hear Christina this morning talking about the system up and down because what this crowded slides shows [\[ppt slide\]](#) is that if you want to understand the Global Health Initiatives' impact on human resource, you really need to see how it affects the various levels within the system but also we need to understand what are the key mechanisms through which those work. And from our research we believe that there are about five areas that have shown more impetus for movement. That is payment mechanisms and particularly here, its

performance based financing which is so important in terms of global health initiatives and I guess not to mention the others - just say a little bit about that because the movement that you saw what is driving it are general factors. One is job security. The other one is salaries. Now job security somehow is more affected by Global Health Initiatives partly because you get a grant which maybe for two years so as a manager you can only give a contract for two years or less.

So somehow you won't assure the [health] worker stability so they will have to move on especially if it is probabilistic like The Global Fund for example. You have to apply [for the grant]; first, you may not get [the grant] and if you get [successful grant application], this may not be disbursed [for whatever legitimate reasons]; however, [the program] may not be assured that in two years [it] will get the continuation and that in five years [you] may not be able to apply to get another one [grant]. So as a manager at a country level, district level, organizational level you cannot assure somebody [a health worker] a contract. So this is going to increase job movements. It might not be bad for someone. I think if you are a manager for a sector - that is catastrophic funding [for the sector].

Now I will just summarize, chair; are we using the right methods? I think there is a lot of demand from paper work but let us show how to kind of look at the [health] system level, but also try to track down to the facility level what are the impacts [[ppt slide](#)]. And back up to see what are the impacts and you realize that as we try so many different methods, it's becoming difficult. So we are beginning to think that actually we need to look at new methods and I was happy to note from David Peters' presentation around '*How to really Mix Up Methods to Understand Systems*' and the way they were trying to engage with the other people, we realized that there is a science of ethnography which is really staying in the community, understand them over time and be able to see where they are coming and where they are going [[ppt slide](#)]. But I think we need to use similar methods and systems. I don't think that you can do good health systems work without protracted understanding of what is going on there because just jumping in and jumping out to understand health systems is very hard. You probably need to see them over time.

So in conclusion chairman I really have in general about five minutes, although I've chosen to conclude more on the research and how we should do it by human resource evidence than on the specific findings that I have given [[ppt slide](#)]. I think that HIV programs need to build strategic governance capacity with the health workforce by trying to bring those stakeholders together; creating incentives for them to work in a committed manner and the system level evidence of course for effective HIV program and health workforce and health systems. We'll need to synthesize from that proper perspective because the answers will look differently from where we start out of that framework that I showed at the beginning. Of course methods need to be diversified to study the health workforce and health systems in general and we believe that the ethnography research will be useful for health systems research and we are trying to coin the one that will probably rhyme with that. And of course we need to build local research capacity because

I think that this work requires continuous observatory capacity from an organization that is local and embedded.

Thank you very much.

Mary Ann Lansang on behalf of Rifat Atun: [Director, Health Advisory Unit / Director, Strategy, Performance & Evaluation Cluster, The Global Fund to Fight AIDS, Tuberculosis and Malaria]

Title: Addressing Health Workforce Challenges: Lessons Learned and Future Directions

Good afternoon. First of all I would like to convey Rifat Atun's apologies for not making it today. He sends his regrets. There were some pressing budget issues and resource issues that he had to attend to.

So in this talk, he was asked to talk on '*Addressing Health Workforce Challenges: Lessons Learned and Future Directions*' and the way we have approached this is to go through the challenges, then pick up some lessons from the field from different global health initiatives and then focus on the Global Fund experiences [[ppt slide](#)]. [This will include] a couple of country examples from the Global Fund and then finally go to the lessons learned and future directions.

So in terms of the health workforce as we know the health workforce is very essential to any kind of health interventions scale up and the deficit in the world today has been estimated by the WHO to be 4,3m and that costs around \$92 [check] on which the MDGs are [sentence unfinished] [[ppt slide](#)].

The increasing demand for health services is really due to a lot of factors playing in the recent years but of course the MDGs will be up there plus the significant investments from Global Health Initiatives. We shouldn't forget the inequities that we are addressing. There are emerging infections that in fact also challenge us today and of course what has been alluded to this morning, the growing problems of non communicable diseases and the global warming as well.

With regard to AIDS and health workforce as we all very well know, there are those number of people who are quite clear and the health workforce and them for ART as well authentic measures request that we address this problem [[ppt slide](#)]. But health care providers are often not providing the optimum care for this [HIV/AIDS] primarily because of the stigma associated with it but also because they themselves are taking care of sick family members or are themselves infected and the problems of their own deaths, resignations, what Freddie Ssengooba referred to as brain drain and of course the retirement.

In the horizon there is talk these days about the changing the CD4+ count threshold [for initiating ART] and then the requirements for that in terms of ART care will again be escalated. Again the

challenges of TB/HIV co-infection will have to be considered in the future too. Now the problem with the power point templates [ppt slide] is you have similar looking triangles but this is a bit different from fairly small sophisticated framework. It's really talking about how the health workforce needs to be encased in an enabling environment, and that environment is primarily - one key environment will be the policy environment, policies on staff equipment and retention; policy networks for effective response to HIV.

Health facilities will be very important because the workforce is to work in such an environment that provides drugs and commodities, supported infrastructure, and of course information management systems. This morning the primacy of the community as contributing to the health workforce was discussed and the health workforce – of course the training, the long term in-service, quality of the training and leadership development.

Just a quick review of the global scene in terms of the global health workforce – Global Health Workforce Alliance has provided leadership in this area [ppt slide]. It has provided a health action framework and of course the Task Shifting that Tony Harries will be speaking about later.

Then the Positive Synergies [ppt slide]; we published an article in The Lancet that really was a work of a large group that came up with some clear recommendations for the health workforce. I shall not go through it in the interest of time, but they are shown here and you do have The Lancet issue in your folders to go through this. And the emotion provoking Venice Meeting¹ in June came up with these four statements:

- The need for further research;
- The urgent need to develop and strengthen the health workforce;
- The central role of communities
- And also the obligations of development partners not to duplicate the work and to coordinate with the [implementing] countries.

These four statements, among others, are very relevant to this issue that we are talking about this afternoon.

What about The Global Fund experience [ppt slide]? As you know the issue of the health workforce is within the larger framework of the health systems strengthening initiative, and Round 5 really was much more explicit in terms of the invitations for health systems strengthening proposals. In Round 6 the Board decided to go back to the integrated approach to diseases'

¹ <http://www.who.int/healthsystems/New-approach-leaflet-ENV2-p4p.pdf>

proposals but in Round 8 there was a very explicit request once again for health systems strengthening proposals. And as you see as we go through the years there have been more investments in health systems research and in the Round 8 proposal there was a 48% wanting approval rate for health systems strengthening. How do we break that down in relation to AIDS proposals, you can see [\[ppt slide\]](#) that 23% were in fact allocated to human resources or a total of 23% but if you will look at the demand for training that's another 19% - so in total you would say that around 42% of the proposals for AIDS health systems strengthening, cross cutting proposals would be devoted to the health workforce and their problems.

In relation to the successful proposals in Round 8, the health workforce total budget was around 21% [\[ppt slide\]](#); and in fact the total portfolio investment of the Global Fund, one fifth would be devoted to health workforce issues. The main cost items there were in-service training at sub-district level, some management training but a large portion was on recruitment, incentives and salaries supplements including bonuses and performance based mechanisms.

Now some people of course have their views as to whether this is the right approach for the investments of The Global Fund that we are supplementing salaries. As Freddie pointed out there was a movement [of health workers] from mission facilities and government facilities to the Global Health Initiatives (GHIs).

Now this is work from our friend here that shows that of 12 countries, there are some macro-economic policies that do affect the African countries in relation to how much they can do, given [the constraints faced by] health workers [\[ppt slide\]](#). And The Global Fund is a mechanism to actually go around that kind of approach because it's more flexible in relation to how they can approve the top-ups of salaries. By that [agencies], we need to be able to top up salaries so we do believe that this Global Fund mechanism could be one direction for the health workforce to go through.

The other is the *national strategy application* that is a new way of dealing with the questions of health systems strengthening [\[ppt slide\]](#). We are in the first learning wave so I cannot give you lessons right now but there have been nine countries who were invited to give applications in relation to their national strategies; and out of the nine countries that submitted HIV proposals that were invited to submit proposals, seven actually submitted [national strategy] proposals and three have had successful desk reviews and their proposals will be reviewed by the technical review panel in August [2009]. From this we will learn again much more about the interactions between national plans and HIV programs and how these will strengthen health systems in general.

About country experiences, Tony will talk about Malawi much more but it is good to know that Malawi really is exemplary in its efforts to roll-out three related schemes and really put it in the context of its national plan [\[ppt slide\]](#). And Malawi also in its phase two in The Global Fund was able to reprogram \$40m of its grant to support expansion of the health workforce. Some other

notable features is that the Emergency Human Resources Program of Malawi was extended to form part of the national health plan and it is one of the countries where there is documentation to show that there has been mortality reduction among the health workers with this kind of plan that has been done and that of course is significant in relation to supplementing the health workforce [[ppt slide](#)].

Ethiopia also is exemplary in relation to its ability to mobilize communities through its health extension program and more recently it has had these kinds of initiatives [[ppt slide](#)]:

- Accelerating health officer training programs
- Masters programs
- Medical clinic service education including training of health workers.
- There has been some governance and leadership in Ethiopia and of course support in terms of policy and regulatory reforms for health worker retention.

So what are the lessons learnt here? We do know that much remains to be done [[ppt slide](#)]. That's why we are here today. But in country [health] strategies, there have to be more out there but you can see that there are rarely examples of such countries with written [health] strategies, with strong commitments from governments, to do this with supporting policies and regulatory frameworks.

And there are also new opportunities for example in The Global Fund grants, for the flexibility in support for the health workers. I think it has enabled countries to respond to this problem of scaling up of health services. We do need to be careful by what we mean by sustainability in the context of low income countries because this is a long term process and the economic crisis is not helping much. There are new instruments for example the Global Fund as I pointed out the National Strategy Applications from which we will learn more, and then there are new global architectures that are being formulated to help address the problem.

What in the future directions? The age old admission to get our act together but we are not phased [[ppt slide](#)]. There are positive signs that people and organizations are working together and that shows there is movement for work. There are attempts now to apply common frameworks and definitions. The World Bank, The Global Fund and WHO are now working together on that [common framework] and there will be, hopefully, many options and approaches for countries and partners to adopt harmonization of investments [in health systems strengthening] where possible.

We will learn together as I said that there are now National Strategy Applications where documentation will show that we can actually scale up in terms of the lessons [[ppt slide](#)]. There

are country case studies ongoing. We will need to develop context specific solutions not just normative guidance as we learn together. And with regards evaluating health workforce interventions, it will be very important and we need to balance our short term solutions with long term approaches like pre-service training etc. Of course the plea, someone said this morning that we are in fact having problems with resources mobilization at this time but the plea is to increase and sustain these kinds of resources for health systems strengthening.

Thank you.

Uta Lehman: [Director, University of the Western Cape School of Public Health, Cape Town]

Title: Impact of HIV scale-up on Health Workforce Dynamics: Opportunities for Rethinking Traditional Roles and Concepts

Good afternoon everybody. I was asked to talk about the *“Impact of HIV scale up on Health Workforce Dynamics: Opportunities for Rethinking Traditional Roles and Concepts”*. I have expanded the brief a little bit to talk about the *‘Impact’* and I suppose the *‘Context on Health Workforce Dynamics’*. What I’m going to talk about is broadly this [ppt slide] – what are the key factors impacting in terms of context? What have been the policy responses that we know of and where do I think evidence and policy gaps lie?

Some of what I’m going to talk about in terms of where the evidence lies, where the impact is repeats some of the evidence from the previous session. A couple of areas that impact on health workforce dynamics:

- *Firstly increasing demand:* not only the area of HIV and AIDS has many sick patients, but also increased burdens through the system but also, as we spoke about that earlier, non-communicable disease, other diseases, and injuries and so on [ppt slide].

So if you see the bar right at the bottom, all segments of the bar are increasing over the years This shows [ppt slide] how this has happened over the years in TB specifically in a couple of African countries guilty with the exception of Botswana. In all countries incidence and prevalence of TB has increased over the last five years. What this leads to is major gaps. This is [ppt slide] an example of the ART gap in South Africa if you look at what the South African Operational Plan wants to do, where their roll-out lies and what the gap is. It is dramatic and of course the key aspect of that is this - limited availability of human resources.

- The second keys of the puzzle, *there are fewer and fewer professionals to run services.* I’ve just used South African data here to make the point. It talks through some of the things that Di McIntyre talked about this morning.

We have 30% of doctors that are registered in the country serving 85% of the population [ppt slide], 42% of nurses were registered serving this population and 52% of enrolled nurses. Enrolled nurses in the past were almost entirely in the public sector but not so anymore. And then we have a very large contingent of lay health workers within the formal sector and without. And just to illustrate the point [ppt slide] – this is the staff of the clinic in the rural Eastern Cape in South Africa. This is the formal health system. That is the sister in the clinic who is responsible for a catchment population of probably around about 15 000 people - very sprawling population. Here she is again. That's her [health] system. The district hospital is very far away. Everybody around are community health workers, peer supporters, youth counselors and so on. That's the health system in that part of the country which makes the point of [health workforce shortages] I think. And very often she is a nurse who is probably 45. In many clinics the one nurse is 50 and 55 and when she retires and the post is advertised, there aren't any applications for the post.

How does that translate into vacancy figures, these are the figures - again South African figures. What's happening with vacancy rates – as you can see [ppt slide] between 2006 and 2008 that again increased quite dramatically. The percentage of existing posts that are vacant in the public sector – more than a third of medical practitioners posts by now which is a really frightening figure; over 40% of professionals I suppose; and all together more than well over a third of health professional posts in the public sector in South Africa are standing vacant - because they can't be filled. I remember very well Tom Hall many years ago when I started working in that area, and he worked in human resource planning and developed tools, he said if you have over a third of posts in the public health system vacant, you could close shop. It's not going to work anymore and we are there in South Africa.

- The third piece of the impact puzzle, *there has been very strong civil society response to the HIV epidemic* and that's very important [ppt slide]. Many Community Based Organizations, Faith Based Organizations, NGOs involved in various aspects of advocacy, treatment, care and so on. So there are fewer and fewer professional health workers available but increasing numbers of either paraprofessionals or lay health personnel and Turner and I and some others just did a very brief look of what's happening in that sector in South Africa.

We found that just under 40,000 are employed through different health departments which does not take into account of all those who are not linked to the formal health sector or working through NGOs. And of course it doesn't take into account the thousands and thousands of unlinked heroes who are working in households, in community based care - who are all rendering in effect what by now is essential health services. And I think that is a very important aspect of the discussion I'll come back to.

They are providing a wide range of care activities. This is showing a few examples [ppt slide] from Malawi, Lesotho, Lusikisiki which is a rural Eastern Cape and Khayelitsha in Cape Town [ppt slide]. These are data that come from MSF and some of our own data and I see that if you look at the report² that Sharonann Lynch and Nathan Ford distributed, that report talks to some of what's happened for example in Lesotho. Those are data coming from that research. So they are doing a range of different things and there are a number of old and new tasks that are being fulfilled here. There are a lot of tasks that are new to [the health] system and are as a result of dealing with the pandemic and are very much talking to the need for chronic care.

- And lastly, the last piece of the puzzle which is an important one and something we mustn't forget about. Certainly in South African context we have had *15 years of health sector reform in this country which overall have left the health workforce extremely disillusioned, extremely frustrated and feeling very betrayed* [ppt slide].

And I've got the next couple of slides, which are quotes that come out of work that Gilson and others have done which reflect that and we have done some of the research showing some of the things. [These quotes] reflect the betrayal [felt] by many nurses and staff particularly in the primary health care sector, but also in hospitals, about our own health sector initiatives. [You can just read these quotes [ppt slide]. I think they are quite self explanatory [ppt slide]. Speaker tells the participants].

So then what are the key health system policy responses to all of this? And I'll talk about three key responses:

- Increased Production
- Task Shifting
- And also the beginning, but as yet fairly unsystematic interest in the softer issues of the human resource challenge - different aspects of it.

So there has been a call for *increased production* and that is a very important part of our response [ppt slide]. It has continued to be but it is one where we are nowhere near what we have to do to even make a dent. WHO estimates that we need, we have a shortfall of close to a million doctors, nurses and midwives [in sub-Saharan Africa] which means we have to more than double the workforce amongst these professional categories alone [ppt slide]. It takes a long time to train these professionals and we don't have the training facilities at the moment. Medical schools in Africa currently churn out just over 5,000 graduates per year [ppt slide]. And as we have seen

² <http://www.doctorswithoutborders.org/publications/ar/i2008/MSF-Activity-Report-2008.pdf>

many of those go abroad and fill the gaps in UK, Australia, Canada and the US. It's our development age. This makes the point in figures

There's been call for increased in *Task Shifting* and the use of alternative cadres. There have been various reviews some of which we have been involved in at University of Western Cape (UWC) [[ppt slide](#)]. All the reviews and the growing body of literature and evidence consistently shows that delegation of tasks whether from doctors to non-physician clinicians, from nurses to nursing assistants, from nurses to non professional or health personnel lead to improvements in access [to health services]. Usually at comparably lower costs. These are some of the examples. I mean there are many examples. I'm sure Tony Harries will speak about the Malawi example as well. Examples in Uganda [[ppt slide 19](#) and [20](#)]; South Africa [[ppt slide 21](#) and [22](#)]; Malawi has led much of the work in Africa proving that point that it is possible.

But, and here we get to the policy gaps [[ppt slide](#)]; despite that evidence, despite the insights in the overwhelming success, we continue to see that health workforce problems generally remain on the periphery of the health system. I consider that emergency measures are not sustainably funded; and comply in a very religious way, with high expectations and low investments. And we were talking earlier about why health workforce problems have come and gone and are coming again and in all likelihood will go again. That's precisely why. I don't think its rocket science, we know why it is. We are not investing. That has a lot to do with a political will, it has a lot to do with professional gate keeping. Those are some of the areas we have to address if we want to make any difference here at all.

I think there is also an evidence gap though that we don't have a very good understanding yet as to how community health workers interact with [the health system] and impact households in communities. There is some work beginning to emerge but that's not very systematic so we don't know enough about impact at that level and that is something that needs to be done.

And then another policy gap into that, we are not systematically looking at how we can reconfigure health worker teams particularly at primary health care level including community level [[ppt slide](#)]. Looking at what services are we actually wanting to render; what skills are needed, who can provide these skills and these services and what needs to get shifted. So looking from the service delivery point of view rather than nurses are doing this, doctors are doing that and in that context what is particularly important is to reconfigure the role of professional nurses because it is one of the major stumbling blocks. Looking at the professional role of nurses – nurses are very resistant as a profession but there has been very little redefinition and investment into that redefinition.

And then lastly, something that's important and close to my heart there needs to be systematic engagement with the soft issues [[ppt slide](#)]. The impact of leadership, the impact of power, the impact of the politics of health, the impact of multiple motivation, of organization and professional

culture on health systems functioning, policy development and implementation – ultimately how all of that impacts on health outcomes and how we run the [health] system.

It does need different approaches, it does need that we go a step beyond the traditional calendar of methodologies that we have used and we start taking the social sciences a little bit more seriously and not only when randomized controlled trials (RCTs) really don't work anymore - that we engage with other methodologies, and other theories. Some of us have done that. We struggle to be taken seriously for that and we have to become better at it, no doubt but also there needs to be more of building engagement [around the soft issues].

And how do we develop evidence and policy? Where does the learning take place? Here, sure but I think very importantly in local communities. We need to build local capacity for innovative practice. We need to strengthen health service delivery and civil society capacity to generate process and use evidence - very importantly for practice and for advocacy. That's a knowledge translation kind of question. We need to encourage collaboration with diverse stakeholders and I think very importantly support the research which encourages organizational motivation, better understanding of power dimensions of organizational change, better understanding of politics of health.

These are pictures [[ppt slide](#)], on the left, of engagements of the kind I'm talking about – community meetings, meetings with local managers that allow that kind of engagement. Really we need to go as much from them as vice versa. These [[ppt slide](#)] are two quotes which make us look back at service delivery at the primary health care level which talk to actually if you want us to be innovative, you must give us the space to be innovative. You must engage with us about what's possible and where that can take place.

Thank you.

Anthony Harries: [Senior Adviser, International Union against Tuberculosis and Lung Disease-The Union]

Title: Task Shift in Malawi Around Delivery of Antiretroviral Therapy

Malawi Case Study: HIV-related Task Shifting: What is the Evidence and what are the Challenges to taking it to Scale and Evaluating Efficacy?

Hello and thank you very much. Jacqueline, I thank you for inviting me to talk on this subject which is about Task Shifting and ART in Malawi. So let me give you a bit of background to start with and I've compared some features here of Malawi with those of the United Kingdom. So a small country, very poor as you can see [[ppt slide](#)], very little money available for health despite all the donor inputs and all the out of pocket expenditures, very few doctors, very few nurses - but in contrast to the United Kingdom - we do have a paramedical officer, we have clinical officers, we

have medical assistants below them we have health assistants and health surveillance assistants and as you can see a very big HIV burden.

Now when we started thinking about scaling up ART five years ago, I think we realized right from the start that the medicalized model just would not work in our country [Malawi] [\[ppt slide\]](#). If we insisted on doctors to deliver treatment, insisted on a choice of multiple ARV regimens, mandatory laboratory monitoring - we were doomed right from the outset.

So for us the key was to keep it really very simple [\[ppt slide\]](#) and this philosophy was reflected in our first two-year plan, and then our second five-year plan which we are in the middle of implementing. And in the public sector [\[ppt slide\]](#), these are the main elements of those two plans – firstly Ministry of Health selects the facilities for ART, and then credits those facilities for scale-up. We provide free treatment to HIV positive eligible patients. Eligibility is determined on the basis usually of clinical [AIDS] staging. There is only one first line regimen, only Triomune which as you all know is evident in the ART delivery by clinical officers and by nurses, standardized system of monitoring, recording and reporting and finally quarterly structure supervision.

Now this was criticized within and without but I think it has stood us in good stead. So in the last five years we have expanded in the public sector – the number of sites delivering ART to 170 by the end of last year [2008] with over 215,000 people ever placed on treatment [\[ppt slide\]](#). Not only do we know how many people have been started on treatment, we also know their outcomes. So by the end of last year [2008] we knew how many people were alive stratified by type of regimen – who is dead, when they have died, who is lost to follow up, who had stopped treatment and who has transferred out to another facility [\[ppt slide\]](#).

So what about the human resource issue around us? So when we put our first ART guidelines together – national guidelines 2003 – we stipulated that doctors and clinical officers could initiate treatment [\[ppt slide\]](#). We stipulated that nurses and medical assistants could follow up patients. They could administer follow up treatment but they not could initiate therapy and these health workers who do these tasks provided they have attended a national ARV training and providing they have passed the end of the course examination with a pass mark of 70% or more. It's a good incentive to stay away over the five days of training.

Now we maintained the database ever since we started this training [\[ppt slide\]](#). So we know for example how many people we have trained and what different cadres we have trained and this database was regularly sent to the Malawi Medical Council and the Nursing and Midwives Council of Malawi. Once we have trained the clinician or nurse they went back to the facility to prepare their site and in addition to setting up rooms etc, they had to in-turn train an ART clerk who would basically administer, monitor, and do all the registering and all the ART treatment cards. They had to train counselors in adherence counseling and they had to train pharmacy technicians [\[ppt slide\]](#).

Once all the trainings were completed [ppt slide] then we were informed and in a sort of package we would come – [from the national] HIV Department and its partners - to formally to accredit that site for ART. The drugs then would be distributed and the ART delivery would start. I think crucially we had quarterly supervision and quarterly clinical mentorship [ppt slide]. Now the HIV Department and its partners, every three months went to visit every [accredited ART] site and the focus of these supervisory visits were checking the data, making sure that data was reliable and accurate, doing the code analysis with the sites although we expected the sites to do this themselves and checking on drug stocks. And then we had the clinical supervisors' quarterly visit. These were usually by UN volunteers with a focus here on making sure that people in the clinic diagnosed diseases correctly, knew how to clinically stage patients and how to manage clinically the side effects of the ART. And we rewarded performance not in terms of targets being met but in terms of good work being done. So if the clinic has done its treatment cards properly, if the register was well completed, if the code analysis has been done and it was pretty well correct, a clinic could get a quarterly certificate of excellence signed by the Secretary for Health [ppt slide]. So it comes back to your soft part here. This was hugely motivating. It cost us absolutely nothing. The clinics worked really hard to try to get their three-monthly Certificate of Excellence.

So in the first two years this worked quite well [ppt slide]. We scaled up 60 clinics largely hospitals and we got over 40,000 ever started on ART therapy but at the end of that two year period we had three key observations [ppt slide]. Firstly, as patient numbers increased, as the excitement of ART began to wear off it became apparent to us that the nurses were taking an ever increasing role of in fact running these ART Clinics. It was also apparent to us that there was a very strong relationship between a good ART Clinic and a good hard working motivated ART Clerk and finally we realized that we had to improve access and we had to improve follow up for our patients. This was going to require decentralization to the health centers and many of our health centers didn't have clinical officers.

So in our new plan 2006 – 2010 we put down our target - quite ambitious [ppt slide]. We wanted to expand treatment to 250,000 people by the end of 2010. In fact we way surpassed past these targets. We are already at 250,000 people [by July 2009] and we realized again that we had to reduce the burden of work in the hospitals and four main ways of doing that were:

- We had to reduce follow up frequency from monthly to two or three monthly.
- We were going to decentralize follow up to health centers
- We were going to decentralize initiation of treatment to health centers
- And to do that we were going to Task Shift

So this was reflected in our second and third edition of ARV Guidelines [ppt slide]. In 2006 we said right - medical assistants who are below clinical officers can initiate ART and then two years later we stipulated that nurses will also initiate treatment. I have to say it was a battle to get approval for nurses to initiate ART. Our nurses and Midwives Council were in favor. The Malawi Medical Council was dead against this approach. We had quite a long negotiation over several months between the HIV Department and the Medical Council eventually convincing them that nurses did just as well in the training, just as well in the course examination and in fact when we went around the country over three months, nurses were running the clinics [ppt slide].

We had three important national stakeholders meetings – one convened by Medicine Sans Frontier which was excellent in getting the consensus. So then we got a written change in policy endorsed by the Secretary of Health, we were then able then to write our new ART Guidelines. So by the end of 2008, over 215 000 had started ART; in that year alone 76,000 new patients were put on treatment; 170 sites delivering therapy and nearly half of them being health centers [ppt slide].

I think one of the good things we did in our supervision was every time we went to a facility we recorded how many days or how many half days in a week that facility ran ARV Clinic. Sometimes it was one day, sometimes two days or sometimes four days and how many clinicians, nurses and clerks were required to run that clinic so that we could get a good handle nationally what was the health workforce needed to deliver ART treatment to the number of patients on ART. And this shows you those results over two years at six months intervals [ppt slide]. The top row in blue shows you the number of patients ever started on ART and then the number of full time equivalent clinicians, full time equivalent nurses and clerks actually delivering the service.

So you can see in the two-year period we have actually doubled the number of clinicians, doubled the number of nurses and increased the number of clerks by two and a half times. And this sort of data allows us to do some predictions. If we carry on by increasing the number of new patients by 75,000 per annum, by 2015 the year of MDGs, we will have about 750,000 people ever started on ART treatment [ppt slide]. And for us this will mean probably 500 full time equivalent clinicians and 500 full time equivalent nurses. That's a huge drain on our already limited health sector human resources.

So what is the way forward? Well we must embrace the WHO initiative – *Treat, Train and Retain* [ppt slide]. I think this is an excellent initiative. Basically treat HIV positive health workers with ART, keep them well and keep them in the health service. Train new people and retain people within the [health] service by offering decent conditions of service if you can. This will take a bit of time to work in so there are four things that I think in the Malawi context that may help us continue scaling up ART therapy.

- First I really believe that we must keep ART treatment as simple as possible and resist calls for more sophistication [ppt slide]. Those calls come all the time. We must do laboratory testing, we must do viral load testing, you know itblah blah blah. What we need to do is to focus on who is getting onto treatment; who is retained alive on treatment; stratified by type of regimen because it's those data that you need to do your forecasting to make sure you don't run out of drugs.
- Secondly, as we must decentralize I think we must do operational research to ensure that our decentralization is matched with quality delivery [ppt slide]. Very simply for me, I would say we need to compare performance with our health centers, with hospitals and we need to compare performance with our nurse run clinics and with our clinician run clinics. Now we've not done the latter but we have looked certainly at the performance and this is Thyolo District [ppt slide] which is supported by MSF and the southern part of Malawi where we have three health centers delivering ART, compared to the district hospital looking at nutrition from care - from 12 to 14 months period, very similar with the results that we are showing you.
- Thirdly, we need to increase the number of ART clerks [ppt slide]. These people I think are crucial to the running of ARV Clinics. We can recruit them from secondary schools. We need however to formally establish this position – there's no formal establishment in the Ministry of Health, in the health sector, of the ART Clerk. We need to establish this position with clearly defined tasks and emphasize to the policy makers the central importance of data integrity, data collection and data analysis.
- And finally we've got to consider Task Shifting to even lower levels of healthcare workers [ppt slide]. To health surveillance assistants – we have already heard from Mary Ann Lansang. What about the community? What about expert patients? But a word of caution here. We looked at health surveillance assistants (HSAs) – now some background. These are people who had 10 weeks of training in general preventive activities just like vaccination and hygiene. They have not been trained in clinical or nursing care.

In 2006 we had nearly 4,000 HSAs in the health sector in Malawi and thanks to The Global Fund we've got money to expand this cadre over the next five years. Now I won't go into the details of this but in the Light House Clinic which is a big ARV Clinic in Lilongwe the capital city, we did an assessment about whether HSAs could safely follow up patients on ART and disappointingly we came to the conclusion that we can use this cadre with less important and less side effects [ppt slide]. I think we need to go back. There's a tendency to push everything to the lower sector of the healthcare worker. So HSAs can do everything. They can't do everything. I think we have to realize limitations. We have to make sure that we are going to give some quality care.

So I will conclude chair but I'm sure you are all aware that the human resources issue is really crucial [ppt slide]. For long term sustainability of the ART delivery, we've got to think of innovative solutions although disappointingly with HSAs we must go back and say how do we train better? How do we use expert patients? I think this is a great source of people we can use to follow up patients on ART. Finally we need clear political commitment about establishing new positions in the health sector funded properly through the Ministry of Health and the Ministry of Finance.

Thank you very much.

And finally there's a book by MSF on the Malawi scale up. Thank you

Discussion

Male Speaker: I would like to thank this panel very much. I think focusing on one of the key unifying demands that the joint HIV activists and all the health activists have that without the health workers we are going to get nowhere.

One of the things we missed in the discussion this morning [Health Economics and Financing] was the 'resource need estimate for the expansion of health workforce and it's strengthening'. We need that information with better figures from WHO and we need updated figures in general. But even the figures we have show that it's a very large sum especially if you increase salaries and improve working conditions to a level where you are actually training people in-service.

There's no mystery why people prefer going to the Global Health Initiatives' facilities because they receive better salaries. They have better working conditions and they stay there. In fact often they [health workers] don't migrate overseas. Internal brain drain is to where there are satisfactory salaries and satisfactory working conditions. To retain those health workers in the public sector we need to raise salaries and improve working conditions to a comfortable level. And that costs are literally [in reference to the WHO estimates] hundreds more, going up to over a ten year period. And then of course there's the question - where is the money?

As we have been talking about the need of health workers for some time [WHO had a major report - its World Health Report 2006 was entirely about the global health workforce crisis] and yet during all this time period, there's been remarkably good old direct investment and scaling up of human resources for health. For true investments in health education capacity, are a pre-service training and better salaries; and in addition we have several impediments at policy level from donors and sometimes from countries and from external agencies.

So the slide which was presented in one of the presentations shows the persistent effect of wage ceilings imposed by the IMF and the historical impact those have had on average health systems

and on the health workforce. We have policies that have been consistently practiced by the U.S. that do not pay for recurrent costs particularly salaries in the public sector. There have been some minor exceptions. There's still a problem. In the short term, the nature of funding has also had indirect negative effects on countries willing to hire health workers. So we have to have real interventions to address each of the problems instead of merely identifying the problem.

Female Speaker: I just want to point out that 70% of health workers are in fact nurses and I really do feel that more attention needs to be paid to the role of nurses. I heard it mentioned, however, when you are on the ground it's very difficult for the nurses' voices to be heard. And we did a study in Ethiopia with the Ethiopian Nurses Association about retention, about job satisfaction, what would keep you in your present position and it wasn't about positions. It was about safe working environment, access to care and treatment for HIV and TB.

It was appropriate service and appreciation for the service rendered. And it was access to professional development.... [Her voice gets more and more faint].

Freddie Ssengooba: Responding to Questions

Thank you. I think my colleagues have done a good job in answering the questions. Quite a number [of health workers] stay in the country and continue in the long term. We are finding that what we are probably call private sector now is really international NGOs and I think we need to build with the local NGOs or general public sector. But also we need to pay attention to how the expansion in the private sector addresses the equity question because I think we may actually get it wrong if we over emphasize leveraging especially where there has been a lot signs of those that tend to be reached by faith based organizations. By not investing in those I think we are expanding the [equity] gap.

The other point was on policy level, how do we engage especially global decision makers? My feeling is that we get a lot of quick action by using the wrong route. Of these issues, I just want to comment about the private sector, on involving the private sector. I don't want to expand it to include NGOs particularly the international. The reason is partly clear from my talk that we need really to invest on the capacity that can sustainably build health systems and the health workforce.

Nathan Ford: Thanks to all of you for your presentations. Thanks to Tony Harries for highlighting the Malawi Report that we will make available at the back of the room which goes into a bit more detail about the decentralization and task shifting that's happened in one of the districts supported by MSF. And on that note I want to ask Tony Harries whether given the overall theme of this meeting you could perhaps say a little something about how decentralization has supported or enforced the general primary care system in Malawi because I know our experience in Chad has led to a number beyond HIV benefits and I wonder what he might say about that.

Anthony Harries: Responding to Questions

Okay so what happened with our last [CTs], good question. I think we have been too busy trying to roll the thing out. But you are absolutely right we don't have the evidence anecdotal and therefore in our body of critical people, it won't stand up and I think we need the evidence. So I think we need to get together and work out how we get that evidence. Is it my observational study or how do we do our [CTs]. I think this is why this sort of forum is very useful.

Nathan, how does decentralization strengthen systems, yes it has. I mean you train people you supervise for the first time you go out and visit health centers. You don't just look at the HIV/AIDS [services]. I mean part of the supervision is to look at how is the pharmacy, what is the infrastructure like in the laboratory, etc. That is hugely motivating as Uta Lehman said, it's not just training and then bye bye. You got to keep seeing people and pat people on the back or wag a little finger when things are not going right. You know infrastructure support. I can go on but just briefly to answer your question.

And finally, spot on. I mean we identify people too late. Yes that's the problem and I think that is where we are failing I think in the last five years we focused on - lets find out who is sick, who is HIV positive? Who needs ART? If you don't need ART in a country like Malawi, you are left in the wilderness. It's you don't need ART we will see you when you are sick. When you come with cryptococcal meningitis and then you stand a chance of being dead before ARTs work. I think we got to now start really looking at HIV infected clientele who don't need ART and we provide some form of structured care for those people. So that when they do become sick, but not too sick, we can get them onto ART.

Freddie Ssengooba: Responding to Questions

Thank you. I think I will just comment just briefly about how we should be approaching the issue of evidence. I think it's going to become an increasingly important issue especially as we develop health systems work because many of the experimental approaches have made their problems when we find especially that we intervened and failed to understand that there should be up scaling because we have very little room to actually do verification.

I mean if you are going to try governance improvements I wonder how you going to actually structure your experiments or control books. So I think we need to be embracing more other methods and understanding but also approach this from different perspectives like I have heard from the meetings like these but actually it depends on where you were and what kind of methods you use. You may come with a different answer to the same question and that sometimes is confusing the audience who wonder what they should listen to so maybe we need to engage with this around what constitutes evidence and health systems strengthening. I don't know also whether I sympathize with the point I made.

I think we do a lot through Task Shifting and especially when we are grounded in capacity development but I think lets make sure that we don't make short-term solutions the solution because I think need to be looking at how we do things now so that people can get treatment, get rehabilitated but we need to build a system that can sustain these people in the future and I think this is where I have a very funny feeling around Task Shifting we need to make sure those don't become a reality. They are just short term.

Jacqueline Bataringaya:

Thank you. I think we have saved the best for last so I want to reassure you that the session after coffee is going to be the crux of the day and many questions that have been raised about how do we measure? What's the methodology? We do have some brilliant scientists coming up after coffee. To answer those questions we've got Jos Perriens, Peter Berman and David Hotchkiss - and facilitated by Susna De who we all know is a health systems researcher and specialist. So please grab your coffee and come back in and get something to eat so that we can start in 15 minutes. Thank you

End of Session Three