Center for Global Development

Think Long Term: How Global AIDS Donors Can Strengthen the Health Workforce in Africa

Christina Droggitis and Nandini Oomman

CGD Brief

September 2010

For the past decade, global AIDS donors—including the U.S. President's Emergency Plan for AIDS Relief (PEFPAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), and the World Bank's Multi-Country HIV/AIDS Program for Africa (the MAP)—have responded to HIV/AIDS in sub-Saharan Africa as an emergency. Financial and programmatic efforts have been quick, vertical, and HIV-specific. To achieve ambitious HIV/AIDS targets, AIDS donors mobilized health workers from weak and understaffed national health workforces. The shortages were the result of weak data for effective planning, inadequate capacity to train and pay health workers, and fragmentation and poor coordination across the health workforce life-cycle. Ten years and billions of dollars later, the problem still persists. The time has passed for short-term fixes to health workforce shortages. As the largest source of global health resources, AIDS donors must begin to address the long-term problems underlying the shortages and the effects of their efforts on the health workforce more broadly.

Short-term fixes for a long-term problem

Until recently, AIDS donors have paid too little attention to the effects their disease-specific interventions have on overall health workforces, most of which were weak and inadequately staffed even before the epidemic (see figure, page 3). The HIV/AIDS Monitor team and research collaborators in Mozambique, Uganda, and Zambia investigated AIDS donor practices (see box, next page, for donor specifics) to understand how AIDS donors train and employ health workers for AIDS programs.[1]

"Unless corrective action is taken, the health workforce now and in the future will constitute a main constraint to delivering the Uganda minimum Health Care Package equitably to all."

Uganda Ministry of Health

Six key findings describe how AIDS donors are using short-term measures to address health workforce challenges to meet their program needs:

Support for the HIV/AIDS Monitor is generously provided by the Bill & Melinda Gates Foundation, the Canadian International Development Agency, the William and Flora Hewlett Foundation, the David and Lucile Packard Foundation, and the Swedish International Development Cooperation Agency.

1. Nandini Oomman, David Wendt, and Christina Droggitis (CGD), *Zeroing In: AIDS Donors and Africa's Health Workforce—Six Tasks for the U.S. President's Emergency Plan for AIDS Relief, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank's Multi-Country HIV/AIDS Program for Africa to Strengthen the Health Workforce in Mozambique, Uganda, and Zambia* (Washington, D.C.: Center for Global Development, 2010).

How AIDS donors train and employ health workers

- **PEPFAR:** Human resources development activities, until recently, focused on HIV/AIDS-specific in-service training of existing health workers and hiring additional workers on a temporary basis either in nongovernmental organizations or on special contracts in the public sector.
- **The Global Fund:** Has gradually altered its guidance to encourage requests for support strengthening health systems, although in past grants most Global Fund money supported short-term interventions, particularly in-service training for existing health workers.
- **The World Bank:** Has had the least interaction with health facility workers. Most MAP funding has supported activities in ministries and community initiatives, but IT has hired technical and ministry staff. The World Bank's *Agenda for Action 2007–2011* recognizes human resources for health as a major challenge.

1) Donors have focused more on using task-shifting, in-service training, and community health workers than on training new health workers to address the shortage and reach their targets.

2) Donor investments in in-service training are HIV/AIDS-specific and do not match the needs of the health system as a whole, potentially skewing the balance of the health sector's continuing education needs.

3) Donors use task-shifting (with little knowledge about its effectiveness)—both within a facility and to the community—to free up work schedules of higher-level cadres without ensuring adequate resources and support.

4) Donors and governments heavily rely on community health workers for important activities such as home-based care and testing and counseling. Yet community health workers—usually sustained by small donor stipends and incentives—are not a recognized cadre in many national government and donor strategies.

"Many Rural Health Centers have no staff or are staffed by untrained personnel. … Hospital wards are grossly understaffed, with dozens of patients attended by one nurse."

Zambia Ministry of Health

5) HIV/AIDS-specific incentives can distort allocations of time and resources by shifting workers to HIV/AIDS programs and demoralizing health staff in other health programs.

6) Donors hire workers on short-term contracts to implement specific projects; once donor funding ends, new positions will disappear even as the need for more workers continues.

The time has passed for short-term fixes to health workforce shortages

Recognizing the need to strengthen health systems to respond to a broader set of health priorities, all three donors have committed to increasing support for health workforce development:

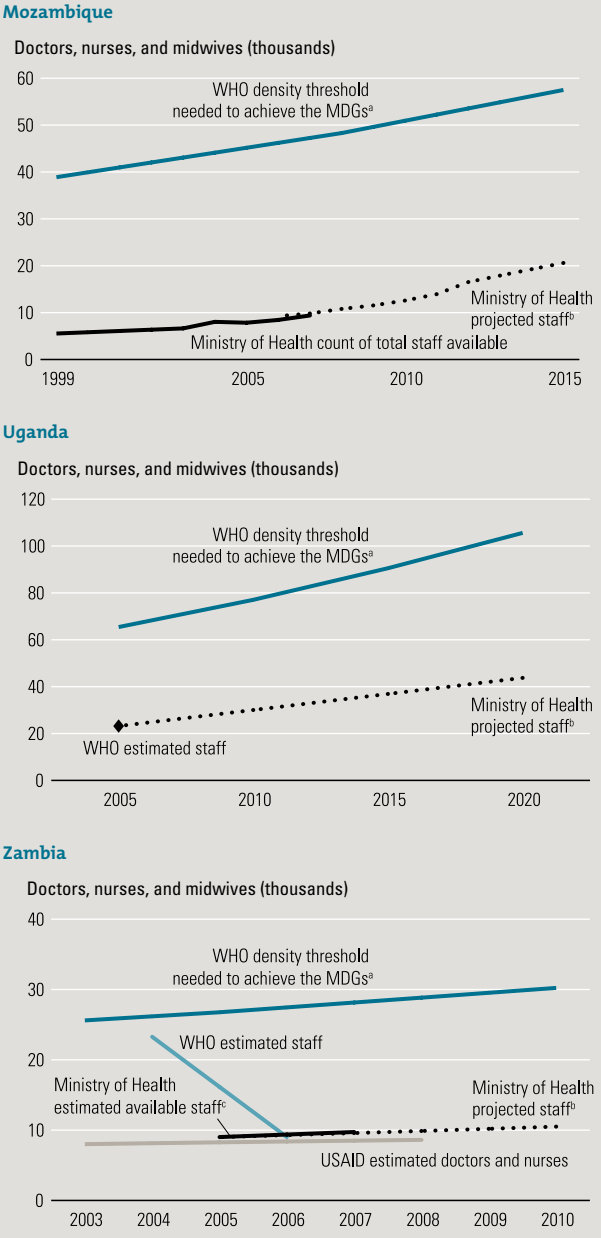
- The U.S. Congress has mandated **PEPFAR** to train and retain 140,000 health workers in Africa between 2009 and 2013, and health workforce development is likely to feature as a cross-cutting issue of the Global Health Initiative.
- **The Global Fund** has created a Health Systems Strengthening grant stream. Its five-year evaluation recommended a stronger focus on human resources for health, and proposal guidance encourages these investments as well.
- **The World Bank** is working with the GAVI Alliance and the Global Fund on a joint platform for funding national health workforce development strategies.

We propose several recommendations for donors, national governments, and other key stakeholders to improve health workforce strengthening and development in three categories:

1) To minimize negative effects

- **Train health workers as part of the health system, not just for donor-supported projects:** Align in-service training efforts with national health strategies to prepare health care workers to respond to broader health needs, not just to

Health Workforces Fall Short of Levels Needed to Achieve Millennium Development Goals



a. Based on WHO estimate of 2.28 doctors, nurses, and midwives per 1,000 people.

b. Public and mission workforce only, assuming a 3.1 percent growth rate.

c. The discrepancy across sources is likely from migration and inaccurate counting inflating Nursing Council data, leading to inflated WHO numbers for 2004, which informed many other global reports and plans.

Source: Authors' analysis based on data obtained from Kombe, et al., *Human Resources Crisis in the Zambian Health System: A Call for Urgent Action* (Bethesda, MD: USAID Partners for Health Reformplus, 2005) and Zambia Ministry of Health, *National Health Strategic Plan 2006–2011: Towards Attainment of the Millennium Development Goals and National Health Priorities* (Lusaka, 2009).

HIV/AIDS. This will minimize the imbalance in skill levels and limit the number of career pathways that rely on vertical program funding.

- **Fully invest in better task allocation for all health outcomes, not just for HIV/AIDS programs:** While task-shifting has improved HIV/AIDS programs, little is known about its effects on other health services. Training, monitoring, and financial support should accompany task-shifting to measure its effectiveness and make sure that lower-level cadres have the capacity to take on these additional tasks.

> **"[Because of] excessive bureaucracy … there are bureaucratic delays, managers lack the capacity to manage the employee's career, and staff lack motivation"**
>
> Mozambique Ministry of Health

- **Provide performance incentives within a constellation of health service responsibilities, not just to achieve HIV/AIDS program targets:** HIV/AIDS-specific incentives cause other health programs to suffer by shifting workers to HIV programs and demoralizing staff in these other programs. The development of standardized incentive guidelines, evidence-based national incentive schemes, or results-based financing can reduce the negative effects of project-based incentives schemes.

2) To maximize contributions

- **Pay to train new doctors and nurses:** Increasing the number of trained clinical health workers is a critical component of solving the health workforce shortage. Investment should be prioritized toward pre-service education to increase the supply of competent and skilled health workers.

- **Define the role of community health workers as tasks are shifted downward:** AIDS donors should document the community health workers they employ and work with governments to standardize the skills and compensation of these workers.

3) To expand the health workforce

- **Move beyond short-term hiring arrangements for a long-term disease:** Predictable, more enduring donor financing combined with greater government resources and stewardship over the health sector would allow countries to develop and act on a long-term plan for hiring and retaining new health workers. Pooled funding mechanisms

could help stabilize donor funding for health over the long term and allow countries to increase the number of skilled workers while reducing dependency on any single donor. Public-private partnerships could also increase the capacity of the health workforce and reach more people.

The Bottom Line

AIDS donors need to move away from temporary and project-specific interventions. Opting for more sustainable and long-term solutions to improve and strengthen the health workforce is necessary to achieve national and global health outcomes. To effectively strengthen and develop the health workforce, donors, national governments and development partners should meet the following prerequisites:

1) Align national HIV/AIDS strategies and plans with national human resources for health strategies and plans.
2) Establish robust information systems for planning and managing the health workforce.
3) Integrate donor inputs for health workers for their AIDS programs fully into national health workforce plans.

Sources for the pull quotes: Uganda Ministry of Health, *Uganda Human Resources for Health: Strategic Plan 2005–2020* (Kampala, 2007); Zambia Ministry of Health, *National Health Strategic Plan 2006–2011: Towards Attainment of the Millennium Development Goals and National Health Priorities* (Lusaka, 2005); and Mozambique Ministry of Health, *National Plan for Human Resources for Health Development* (Maputo: Ministry of Health, National Directorate of Human Resources, 2008).