Optimized Human Resources for Health Staffing

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Jerilyn Hoover, Data Analyst
USAID Health Workforce Branch
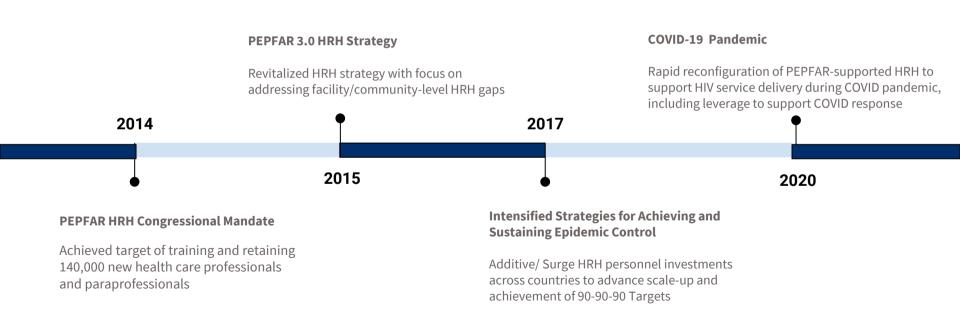
Agenda

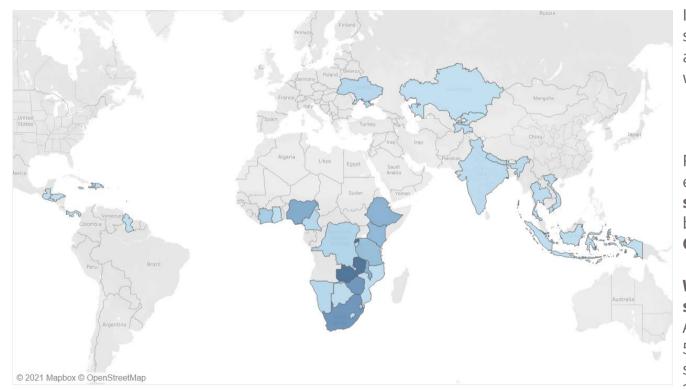|	Topic	Speaker
8:30 - 8:40 am	Introduction from ASAP program	Catherine Brokenshire-Scott
8:40- 8:50 am	Welcome and Intro USAID and PEPFAR HRH technical priorities	Diana Frymus
8:50 - 9:20 am	Collecting and Using HRH Data	Jerilyn Hoover
	Considerations for Optimizing HRH	
9:20 - 10:00 am	Perspectives from partners	Prof. Sam Phiri, Partners in Hope, Malawi
		Dr. Goodluck Mwakitosha, Benjamin Mkapa Foundation, Tanzania
10:00 - 10:30 am	Discussion and Q&A	All

USAID AND PEPFAR HRH TECHNICAL PRIORITIES

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HISTORICAL OVERVIEW OF PEPFAR'S INVESTMENT IN THE HEALTH WORKFORCE

PEPFAR 3.0 HRH Strategy

Revitalized HRH strategy with focus on addressing facility/community-level HRH gaps

COVID-19 Pandemic

Rapid reconfiguration of PEPFAR-supported HRH to support HIV service delivery during COVID pandemic, including leverage to support COVID response

2014

2017

2015

2020

PEPFAR HRH Congressional Mandate

Achieved target of training and retaining 140,000 new health care professionals and paraprofessionals

Intensified Strategies for Achieving and Sustaining Epidemic Control

Additive/ Surge HRH personnel investments across countries to advance scale-up and achievement of 90-90-90 Targets

4

USAID IPs employ over 90,000 health workers worldwide across clinics and communities for HIV service delivery to overcome critical gaps

Total HRH_CURR

0 — 14,456

In FY20 USAID, through PEPFAR, supported **90,268** health workers across facilities and communities worldwide

> **-58% lay workers**
> **-16% clinical staff**

PEPFAR supported staff have enabled **rapid adaptation of HIV services during COVID** and have been **leveraged to support the COVID response**

Workers are being mobilized to support COVID-19. In South Africa, PEPFAR mobilized nearly 5,000 CHWs to support COVID screening within days, including 2,200 CHWs from USAID partners.
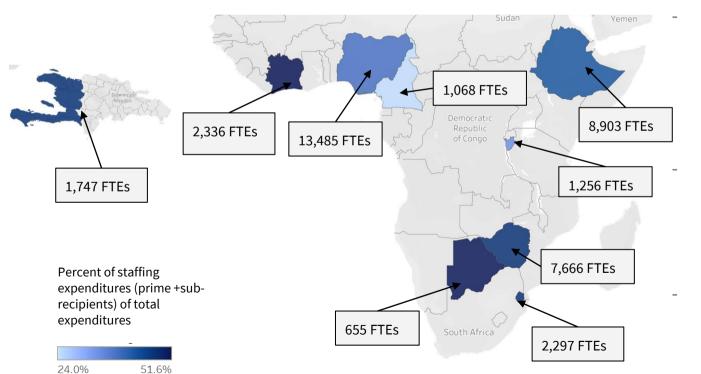
COVID-19 and Impact on HRH

	Issue/Solution
	Countries have reported **service delivery delays** including **fear among health workers** in areas where there had been inadequate PPE. Health workers have contracted COVID-19 and also been victims of violence through the pandemic.
	Majority of countries have reconfigured HRH staff to support HIV service delivery during COVID. Adaptations have included decanting facilities and use of community workers and **mobile health teams**, the **expansion of telehealth** use, and providing **virtual training/supervision for health workers**. Need for continued monitoring of staffing and shifts to understand impact of HRH on COVID and to inform future rapid shifts. **Need to consider how to maintain some of the staffing shifts and delivery models within continued COVID operating environment.**
	Macroeconomic impact of COVID-19 has affected **resource availability for HRH** wages/risk allowance/ hiring in some countries. Need to increase focus on more optimized use of HRH staffing including community workers to yield efficiencies and ease resource gaps .

Source: POART and ITTs

Average Staffing Expenditure is 44% of Total USAID Reported Expenditures across 9 OUs

Highlights Importance of need to ensure optimized staffing patterns and alignment to targets

1,747 FTEs

2,336 FTEs

13,485 FTEs

1,068 FTEs

8,903 FTEs

1,256 FTEs

7,666 FTEs

655 FTEs

2,297 FTEs

Percent of staffing expenditures (prime +sub-recipients) of total expenditures

24.0%   51.6%

- 58% of staff reported were ancillary staff (non clinical staff providing services to clients)

- 14% staff reported supporting non-service delivery work but account for 42% expenditures

- Identified that Sub-recipients drive a sizeable amount of staffing expenditure at 33%

7

Data is the Key to HRH Optimization, here is what we need to know:

1. What is the staffing composition across mechanisms (both prime and sub) by category of staff and distribution across OUs?

1. What are the roles of staff providing service delivery and roles of staffing supporting non-service delivery/ TA?

1. How does staffing distribution across geographical hierarchies align to program targets and target achievement?

1. What staff changes are being made due to COVID-19 and how is the pandemic impacting staffing?

COLLECTING AND USING HRH DATA

Overview of PEPFAR HRH Reporting Requirements

Data source	What it captures	Limitations
MER: HRH_CURR Source: MER Indicator Reference Guide 2.4	Number of health workers who are working on HIV-related activities and are receiving any type of support from PEPFAR, as well as total spend on these workers	Only captures staff who are providing services to HIV clients, not technical assistance or program management Lumps many distinct cadres (nurses, doctors) into broad categories which limits analysis to understand link to performance
Expenditure Reporting Source: PEPFAR Financial Classifications Reference Guide	Expenditures for various staffing cost categories (HCW clinical, HCW ancillary Other Staff, IM program management)	Does not capture # of staff under cost categories Does not disaggregate staffing expenditures under sub-recipients
HRH Inventories	Entirety of PEPFAR IP staffing footprint by individual cadre/role type and associated remuneration; also may include MOH and GFATM/other donors	Not yet standardized across OUs and will replace HRH_CURR in FY21 Q4

Key Uses for HRH Data

- Examining staffing composition and geographic distribution

- Alignment of staff with targets/performance

- Understanding roles of staff providing service delivery and those doing non-service delivery / technical assistance

- Understanding which types of staff drive staffing expenditure to inform where you could make adjustments to staffing

- Inputs for estimating the staffing needed to achieve targets

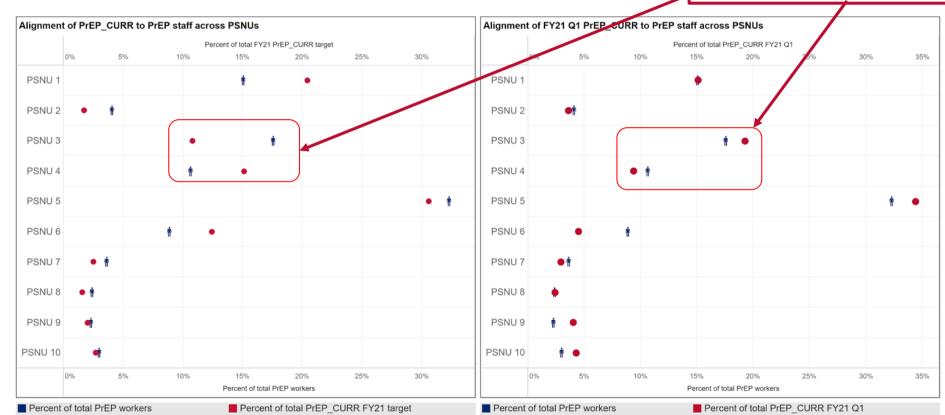# Data use example: Examining distribution of HRH staff across an OU

Psnu

Looking at the composition of staff across PSNUs can show the distribution of certain types of staff across an OU.

Composition is shown here by ER category, but it could also be done by employment title.

Data use example: Examine alignment of staff to MER Targets/Performance by PSNU
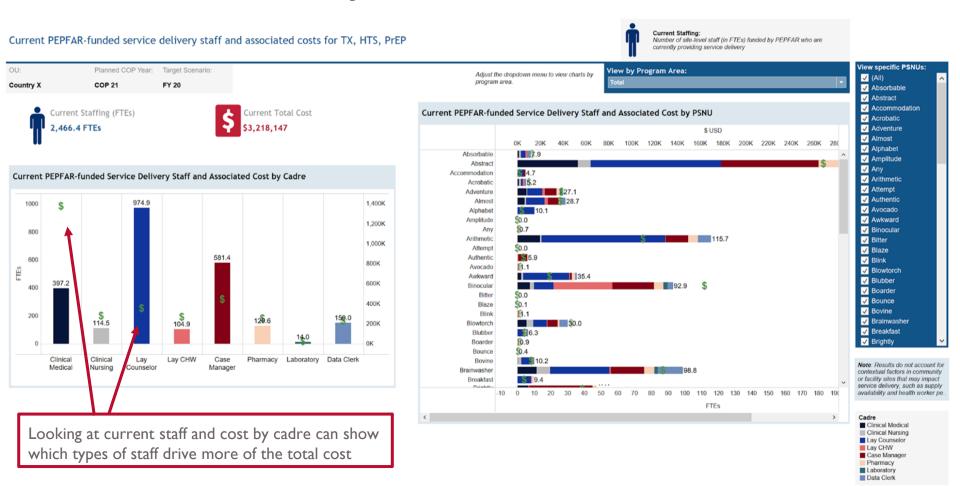
Some PSNUs may have appear to have misaligned staffing when looking at staff compared to targets but not when compared to achievement

Alignment of PrEP_CURR to PrEP staff across PSNUs

Percent of total FY21 PrEP_CURR target

Percent of total PrEP workers

■ Percent of total PrEP workers ■ Percent of total PrEP_CURR FY21 target

Alignment of FY21 Q1 PrEP_CURR to PrEP staff across PSNUs

Percent of total PrEP_CURR FY21 Q1

Percent of total PrEP workers

■ Percent of total PrEP workers ■ Percent of total PrEP_CURR FY21 Q1

Data use example: HRH Needs and Optimization Planning Solution

- New, data-driven approach to support countries look at service delivery staffing needs to meet targets and optimize staffing allocation to maximize PEPFAR investments for epidemic control
  - estimates service delivery staffing needs as a function of program targets for PrEP, HTS, and TX
  - analyzes staffing, staffing gaps, and costs
  - presents options for additional hiring and/or redistribution of existing staff toward more optimal health workforce allocation and investment
- Standardized approach for use of data to inform HRH staffing requirements across OUs, built upon Touch Foundation's Prioritization & Optimization Analysis (POA) methods

For more information, see technical brief from Data.FI here.

Current Service Delivery Staff and Costs Dashboard

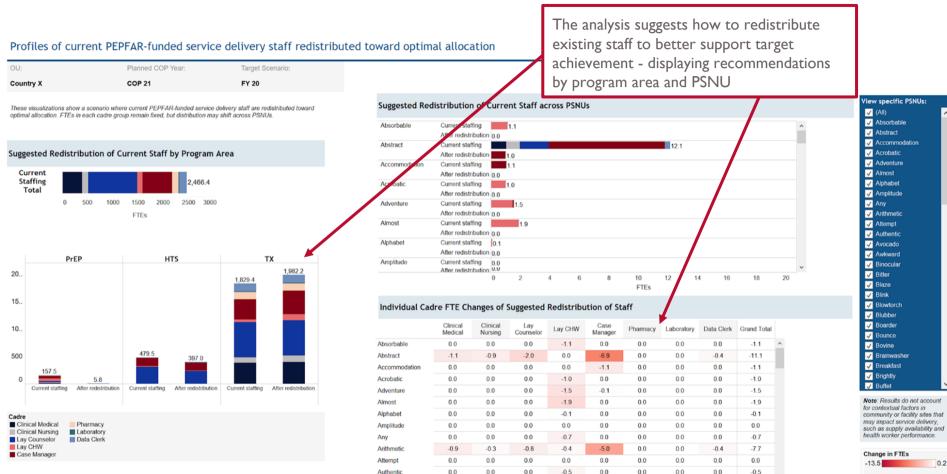Looking at current staff and cost by cadre can show which types of staff drive more of the total cost

Staffing Need and Gap Dashboard

The analysis shows the estimated service delivery staffing needed to meet targets compared to current staffing - in total and by the three program areas in the analysis

Estimated service delivery staffing need and gap for TX, HTS, PrEP

OU:	Planned COP Year:	Target Scenario:
Country X	**COP 21**	**FY 20**

Staffing Gap

2,247.6 FTEs

Cost of Estimated Need

$8,567,750

Total Estimated Need Against Current Staffing

Current Staffing — 2,466.4

Total Estimated Need — 4,714.0

(FTEs: 0.0, 500.0, 1,000.0, 1,500.0, 2,000.0, 2,500.0, 3,000.0, 3,500.0, 4,000.0, 4,500.0)

Total Staffing Gap and Associated Cost by Cadre

Cadre	FTEs
Clinical Medical	284.7
Clinical Nursing	213.1
Lay Counselor	-704.7
Lay CHW	617.0
Case Manager	381.6
Pharmacy	0.6
Laboratory	555.8
Data Clerk	899.5

(USD axis: -600K to 1600K; FTEs axis: -800 to 2000)

Adjust Program Area Targets

Observe shifts in staffing need and gap with adjustments to the program area targets

PrEP target level	HTS target level	TX target level
Target Scenario	Target Scenario	Target Scenario

Estimated Need Against Current Staffing by Program Area

PrEP
- Current Staffing: 157.5
- Total Estimated Need: 38.8

HTS
- Current Staffing: 479.5
- Total Estimated Need: 401.5

TX
- Current Staffing: 1,829.4
- Total Estimated Need: 4,273.6

(Y-axis: 0 to 4500)

Cadre
- Clinical Medical
- Clinical Nursing
- Lay Counselor
- Lay CHW
- Case Manager
- Pharmacy
- Laboratory
- Data Clerk

Redistribution of Staff Dashboard

CONSIDERATIONS FOR OPTIMIZING HRH

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USAID Priorities for Optimized HRH
Advancing a data driven-HRH response with greater accountability and impact on client-centered care

- Routine and robust tracking of staffing
- Data driven approaches to determine optimal staff needs and allocation
- Well defined approaches to monitor service delivery staff performance and address productivity/performance barriers
- Routine use of data to assess impact of staffing investments
- Monitor impact of COVID-19 on staffing:
  - Routine tracking of staffing changes being made to support HIV during COVID; staff supporting COVID
  - Tracking of concerns related to occupational health and safety of health worker staff (COVID cases, PPE shortages, etc)

Future of HRH Data

HRH inventories will be an annual PEPFAR reporting requirement starting in FY21 Q4.

Final data elements are still being determined, but we recommended IPs track the following information internally to be prepared for the new reporting requirement.

Recommended Staffing Categories (Aligned to ER)	Data Elements
HCWs (Clinical, Ancillary), Other Staff	- Staff Cadre Type (Reflects role that staff supports for project) - Facility Assignment (if associated with 1 site)/ PSNU/SNU - Staff LOE (full-time/ part-time) - Primary program area supported - Staff employer (Prime vs. Sub-Prime) - Annual Remuneration Amount - Compensation Type (Salary, Contractual)
Program Management	- Staff Cadre Type (admin, financial, legal) - SNU - Staff LOE (full-time/ part-time) - Staff employer (Prime vs. Sub-Prime) - Annual Remuneration Amount

Summary of COP21 Guidance on Optimizing HRH Staffing

Review Available HRH Staffing Data and Identify How to Further Optimize Staffing Investments

- Utilize most recent available HRH datasets to review and conduct analysis on staffing investments:
    - What is the footprint of staff by types and associated program area of activity supported (service delivery-SD, non-service delivery-NSD, program management)?
    - What is the staffing composition (by cadre) and distribution across PSNUs?
    - How does staffing across PSNUs align to program targets and target achievement?
- Identify areas where staffing needs to be aligned to better meet need of the program in COP21. For example, decrease/increase footprint of distinct types of staff (SD, NSD, PM) and/or redistribution of distinct cadres across PSNUs to better meet the need of program and targets.
- Examine and incorporate HRH staffing implications to further scale and maintain service delivery adaptations for COVID and beyond

PARTNERS IN HOPE PRESENTATION

Prof. Sam Phiri

PEPFAR

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Optimizing Health Workforce Staffing through advanced data and analytics

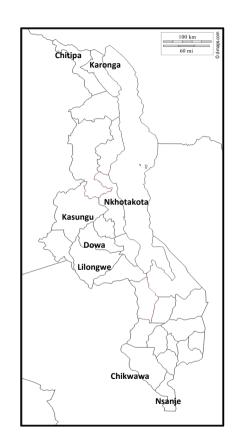**PARTNERS IN HOPE - LILONGWE, MALAWI**

Local Partners Webinar – 25th March 2021

Partners in Hope Malawi

Local Christian
NGO

High quality
medical facility
with molecular laboratory

USAID
Implementing
Partner in
8 districts
supporting 101 health
facilities

Chitipa

Karonga

Nkhotakota

Kasungu

Dowa

Lilongwe

Chikwawa

Nsanje

100 km

60 mi

©d-maps.com

Medical Facility

Molecular laboratory

PEPFAR supported
HIV services
at 101 Health
facilities

OPTIMIZING HIV SERVICES FOR EPIDEMIC CONTROL (OHSEC). PEPFAR - USAID

Purpose

The primary goal of OHSEC is to reduce HIV incidence, and HIV-related morbidity and mortality, and to accelerate progress towards HIV epidemic control in Malawi through implementation of evidence-based, cost-effective and innovative interventions to increase HIV case finding, linkage to treatment for HIV, and viral load suppression among PLHIV

Duration

Implementation period: 1st April 2019 – 30th Sept 2021

OHSEC PROGRAM OBJECTIVES

1. Number and proportion of PLHIV identified and linked to treatment increased with more efficient testing strategies

2. Quality care and treatment services for PLHIV strengthened

3. Strengthen site level Quality Management for Epidemic Control

4. Support the national viral load testing program for epidemic control

PIH HRH CHANGES IN FY 21

- **From Oct 2020, PIH transformed its staffing approach, increasing site level staffing to greatly expand direct service delivery**

- **A.** Re-distribution of site level staffing across the 8 districts and 101 Health Facilities (HFs) was guided by the following:

  1. **TX CURR volume** *(three categories: <500, 500-2000, >2000)*
  2. **Service needs as assessed from performance data dashboards**
  3. **Human Resources for Health Optimization Tool for ART Service Delivery** *(HOT4ART)*

- **B.** Adjusted mentorship approach (mentorship team structure, mentorship frequency) and shift of district-level mentors to direct service delivery at HFs

- **C.** Streamlined management structures and shifting resources to the recruitment of additional site-level service delivery staff

- **D.** Use of virtual technology to support supervision and mentorship

FUNDING ALLOCATION TO STRATEGY (FAST) TOOL

Cost Driver	HFs with TX_CURR <500		HFs with TX_CURR 500-1999		HFs with TX_CURR >2000		PIH Medical Facility HIV clinic + Molecular Lab	
Number of Sites	23		60		17		1	
	Item	Average # per site	Item	Average # per site	Item	Average # per site	Item	Average # per site
Human Resources	HIV Diagnostic Assistant	2.5	HIV Diagnostic Assistant	5	HIV Diagnostic Assistant	8	HIV Diagnostic Assistant	5
	Patient supporters	2.5	Patient supporters	5	Patient supporters	9	Patient Supporter	8
	Data Clerk Mentor	1.5	Medical Assistant	0.5	Clinical Officer	0.5	Clinical Officer	5
			Data Clerk Mentor	2	Community HIV Nurse	1.2	Community HIV Nurse	9
					Data Clerk Mentor	3.5	Lab Technician	4
							Lab Data Clerk	3
							Pharmacy Technician	1
							Data Clerk Mentors	3

SPECIFIC OBJECTIVES OF THE SITE LEVEL STAFFING ANALYSIS.

The analysis had three objectives,

1. Determine the optimal number and cadre of HCWs needed per site to meet the COP20 PEPFAR targets

2. Assess the current site staffing status in terms of staffing gaps or excesses.

3. Determine provider / client ratios compared to TX_CURR for ART provider

4. Provide a dynamic tool for service delivery partners, facilities, and other stakeholders to configure their health workforce for HIV services, including MOH staff

5. HOT4ART is part of a broader Malawi exercise supported by the HRH2030 program.

HUMAN RESOURCES FOR HEALTH OPTIMIZATION TOOL FOR ART SERVICE DELIVERY (HOT4ART)

- To assess staffing levels and determine the optimal number and type of HCWs needed to accomplish the Malawi PEPFAR COP20 PIH targets.

No.	Service provider type	Cadres included in the analysis
1	Medical Doctors	Medical doctor
2	Non-physician Clinicians	Clinical officer, Clinical Technician, Medical Assistant
3	Nurses/Midwives	Registered nurse/midwife, community nurse, linkage nurse, nurse midwife technician, nursing officer,
4	Community Health Workers	Community Health Workers
5	HTS Providers	HIV Diagnostic Assistants (HDAs), HTS Counselor, HTS providers
6	Expert Clients/Peer Educators	Expert client, key population (KP) peer educator, KP peer navigator
7	Data/ART Clerk/Officers	ART clerk, data clerk, data manager, data officer, M&E Manager, M&E officer, receptionist, senior clerk, statistical

HUMAN RESOURCES FOR HEALTH OPTIMIZATION TOOL FOR ART SERVICE DELIVERY (HOT4ART)

The tool was used in 18 PIH direct service delivery sites with client cohorts of 2,000 and above.

	District	No. of sites assessed
1	Lilongwe District	5
2	Chikwawa District	4
3	Nsanje District	3
4	Karonga District	2
5	Chitipa District	1
6	Dowa District	1
7	Kasungu District	1
8	Nkhotakota District	1
	Total	**18**

- Several variables were analyzed to determine staffing requirements including information on ART treatment models, HCWs, clients, tasks, and task sharing practices.

- Data was collected through focus group discussions with purposively selected ART providers, review of HIV and AIDS guidelines and PEPFAR guidance, telephone interviews with ART clinic in charges, and in-depth discussions with the PIH ART technical team in validating the analysis assumptions.

FINDINGS

- HOT4ART assessment showed that overall, 18 PIH sites require ~ 401 HCW FTEs

- Currently sites have 454 =113% of the FTEs required - an excess of 53 FTEs.

- Results differed across cadres:
  - shortage of non-physician clinicians and community health workers
  - excesses of expert clients/peer educators and data clerks/officers

Staff Type	Average FTE Required	Range of Required FTE (Min - Max)		Total Existing FTEs	Staff Excess or (Gap)	Range of Excess or Gap (Min - Max)	
Medical Doctors	0.6	0.4	- 0.9	1.0	0	0.1	- 0.6
Non-physician Clinicians	52.8	32.4	- 73.2	27.3	(26)	(45.9)	- (5.1)
Nurses/Midwives	66.1	38.5	- 102.3	53.4	(13)	(48.9)	- 14.9
Community Health Workers	6.1	4.6	- 7.5	2.0	(4)	(5.5)	- (2.6)
HTS Providers	157.4	112.3	- 250.5	136.5	(21)	(114.1)	- 24.1
Expert Clients/Peer Educators	61.6	37.1	- 86.0	153.0	91	67.0	- 115.9
Data/ART Clerk/Officers	56.8	38.8	- 74.9	81.0	24	6.2	- 42.2
Total	401.4	264.1	595.3	454.2	53	(141.1)	- 190.1

LIMITATIONS AND CHALLENGES OF THE HOT4ART ASSESSMENT

Accuracy of results of the analysis are highly dependent on the quality of the data inputs. It was difficult to access consistent staffing data, particularly for government staff.

The COVID-19 situation exacerbated the situation since the assessment team was not able to independently validate the staffing data for government workers such as non-physician clinicians and nurses/midwives at site level.

MAJOR CHANGES OF HRH TRANSITION: CENTRAL CLINICAL TEAM

Central Clinical Team (CCT)	Pre	Post
Role of CCT is to cover grant needs for planning and reporting, national TWG and donor representation, leadership capacity building, site visits and supervision across 8 districts across Malawi; design and start up of new initiatives	CCT were not providing direct clinical care	All Clinical Team staff's duties have changed so as to provide direct clinical care at a supported Health Facilities once every two weeks at a minimum
	CCT staff not systematically reviewing individual patient level care decisions for HVL patients beyond site visits or case consultations	CTT are now responsible for reviewing and remediating patient level clinical interventions for HVL patients

MAJOR CHANGES OF HRH TRANSITION: DISTRICT CLINICAL TEAMS

District Clinical Teams (DCT)	Pre	Post
Role of DCT is to cover grant needs reporting, district DHO and faith-based organization coordination, clinical care and mentoring, supervision across sites, and design and start up of new initiatives	Title was *District Mentorship Team*	Title changed to *District Clinical Team* to reflect changed emphasis on Direct Service Delivery
	DMT members were spending almost 100% of their time in health facilities, and routinely support direct clinical care as needed	Continue full time presence at sites, and emphasis on supporting direct clinical care
	District Coordinators (DCs) for Scale up Districts were not providing direct clinical care	DC duties have changed so as to provide direct clinical care at a supported Health Facility once every two weeks at a minimum
	District Clinical Leads (DCLs) in Scale up Districts previously did not provide a minimum amount of clinical care	District Clinical Leads (DCLs) are now providing direct clinical care at least 50% of their time
	DMT used to cover each site with some increased time at high volume sites	Further focus on high volume sites, such that there is an increase from 97 to 145 days per month at 19 high

MAJOR CHANGES OF HRH TRANSITION: FACILITY CLINICAL TEAMS (FCT)

Facility clinical teams	Pre	Post
FCT are staff seconded to the Health Facility and providing direct patient care and service delivery activities full time	**Expert Clients**: PLHIV volunteers received stipends, working 20 hours/week	ECs were replaced by full time employed **Patient Supporters (PS).** Main roles include demand creation services, linkage, back to care and individualized patient support services
	HIV Diagnostic Assistants: focusing on case finding	Repurposed Job responsibilities to include efficient case finding, 3rd 95 activities, and includes ICT, EID, adherence, retention, Viral Load, AHD
	Absence of **Psychosocial Counselors**	Hired **8 Psychosocial Counselors** Diploma level psychosocial counselors for major hospitals to support psychosocial support, disclosure, adherence, retention and HVL activities.
	Data Clerk Mentors	Increase # DCMs to support site level EMRs both TA & DSD sites and faster data-informed programmatic decision making
	Absence of full-time facility-based **Clinicians (Clinical Officers and Medical Assistants)**	Hired 11 COs and 11 MAs their focus is entirely on providing ART care (ART optimization, DSDs, Opportunistic Infections, HVL management
	Community HIV Nurses 13	Additional 9 hired focus ART clinical care, CA cervix, Community ART Distribution

PIH STAFF FINAL DISTRIBUTION PER DISTRICT

District	Cadres	Numbers
Lilongwe	Clinician Mentors	8
	Medical Assistant	2
	Nurses (Roving & Facility based)	15
	Psychosocial Counsellor	1
	Patient Supporter	93
	M and E officers	2
	HIV Diagnostic Assistant	84
	HTS supervisors	4
	Data Clerk Mentor	58

District	Cadres	Numbers
Chikwawa	Clinician Mentors	8
	Medical Assistant	2
	Nurses (Roving & Facility based)	16
	Psychosocial Counsellor	1
	Patient Supporter	80
	M & E officers	2
	HIV Diagnostic Assistant	67
	HTS supervisors	4
	Data Clerk Mentor	45

District	Cadres	Numbers
Kasungu	Clinician Mentors	2
	Medical Assistant	1
	Nurses(Roving and Facility based)	2
	Psychosocial Counsellor	1
	Patient Supporter	41
	M & E officers	1
	HIV Diagnostic Assistant	36
	HTS supervisors	1
	Data Clerk Mentor	23

District	Cadres	Numbers
Nkhotakota	Clinician Mentors	2
	Medical Assistant	1
	Nurses (Roving and Facility based)	2
	Psychosocial Counsellor	1
	Patient Supporter	30
	M & E officers	1
	HIV Diagnostic Assistant	30
	HTS supervisors	1
	Data Clerk Mentor	19

District	Cadres	Numbers
Chitipa	Clinician Mentors	2
	Medical Assistant	0
	Nurses (Roving and Facility based)	2
	Psychosocial Counsellor	1
	Patient Supporter	15
	HIV Diagnostic Assistant	15
	HTS supervisor	1
	Data Clerk Mentor	7

District	Cadres	Numbers
Karonga	Clinician Mentors	2
	Medical Assistant	2
	Nurse (Roving and Facility based)	2
	Psychosocial Counsellor	1
	Patient Supporter	33
	HIV Diagnostic Assistant	36
	HTS supervisor	1
	Data Clerk Mentor	19

District	Cadres	Numbers
Dowa	Clinician Mentors	2
	Medical Assistant	1
	Nurse (Roving and Facility based)	2
	Psychosocial Counsellor	1
	Patient Supporter	25
	HIV Diagnostic Assistant	27
	HTS supervisor	1
	Data Clerk Mentor	14

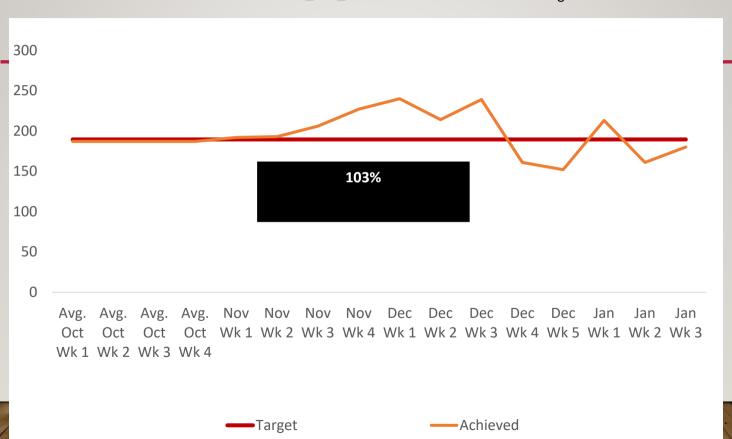| District	Cadres	Numbers
Nsanje	Clinician Mentors	4
	Medical Assistant	2
	Nurse (Roving and Facility based)	4
	Psychosocial Counsellor	1
	Patient Supporter	52
	HIV Diagnostic Assistant	47
	HTS supervisor	1
	Data Clerk Mentor	27

TRACKING AND MONITORING PIH HEALTH WORK FORCE

- Monthly Data Dashboard review, down to HF level

- Semi Annual Appraisal

- Weekly Virtual meetings

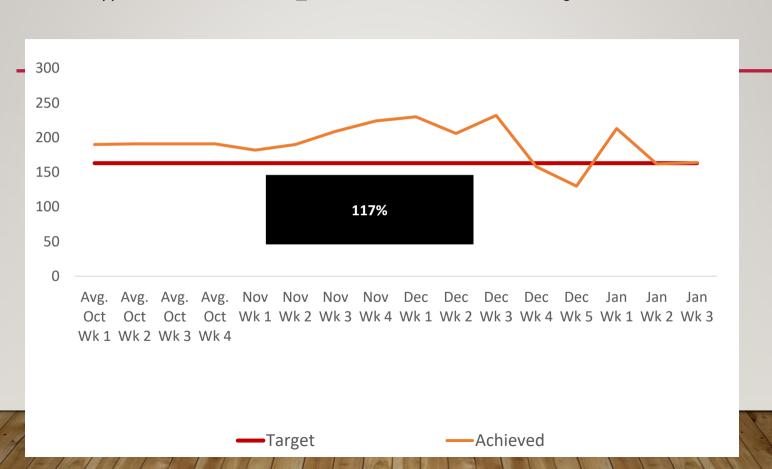- Data review and performance is used to reallocate staff to various sites based on performance

Outreach challenges for District Clinical Team during rainy season

HRH CHANGES - PROGRESS TOWARDS KEY PERFOMANCE INDICATORS TARGETS

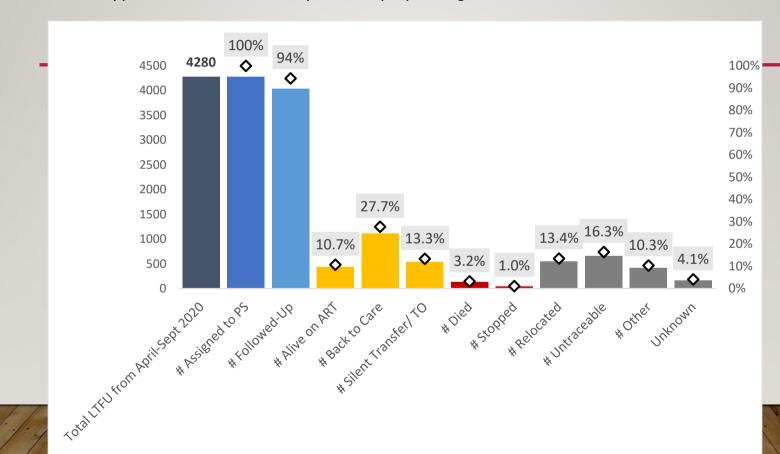*HDA contribution on HTS_TST_POS achievement towards FY21 target*

103%

Target — Achieved

HRH CHANGES - PROGRESS TOWARDS KEY PERFOMANCE INDICATORS TARGETS

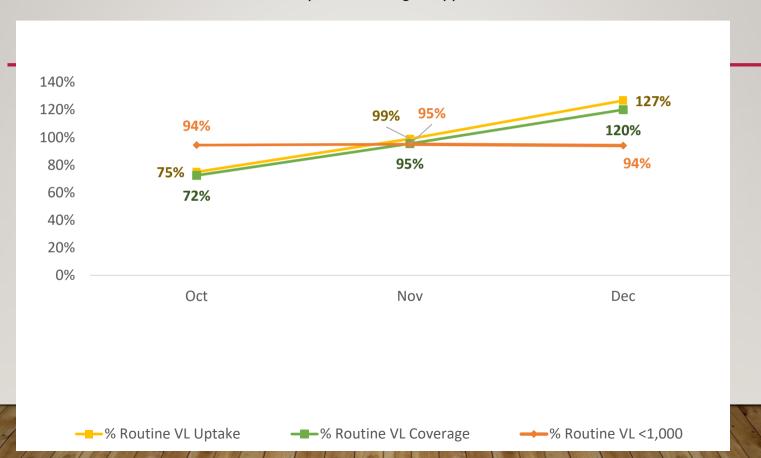*Patient Supporters contribution on* TX_NEW *achievement towards* FY21 *target*

117%

Target ——— Achieved ———

HRH CHANGES - PROGRESS TOWARDS KEY PERFOMANCE INDICATORS

Patient Supporter Back To Care 28-Day LTFU Mop-Up Tracing outcomes in 28 sites

HRH CHANGES - PROGRESS TOWARDS KEY PERFOMANCE INDICATORS

DCM, HAD, PS IMPACT ON Routine VL Uptake, Coverage, Suppression

CERVICAL CANCER VIA SCREENING

performance against the targets attributed to the presence of COMMUNITY HIV NURSES

MEASURES PUT IN PLACE BY PIH TO ENSURE CONTINUITY OF ESSENTIAL LIFE SAVING HIV SERVICES IN THE ERA OF COVID 19

- Central, district and site level staff are being actively trained and updated in COVID-19 basics and Infection Prevention and Control.
- Monthly PPE procurement and distribution
- Mental Health Support
- Tele working schedules
- Weekly virtual meetings
- Virtual Supervision schedules
- Use of phone to support linkage, adherence, retention and VL management
- Regularly reviewing the situation at district and health facility levels on almost a daily basis
- C19 Vaccination

SUMMARY OF EFFECT OF HRH INVESTMENT ON PROGRAM PERFORMANCE

- Tracking of HRH Data influenced deployment and redeployment of staff based on facility needs

- Shift to more direct service delivery influenced more centred patient care at the facilities

- Transition of Expert Clients to Patient Supporters influenced program performance during the surge in FY21 Q1

- Shift and availability of full time Data Clerks at facilities improved facility data management, Data Quality and reporting for Program review

- Training dedicated HCWs like Cervical Cancer Providers at sites improved program performance

ZIKOMO

Data dashboard discussions at Ngala HC, Nkhotakota

BENJAMIN MKAPA FOUNDATION PRESENTATION

Dr. Goodluck Mwakitosha

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Optimizing HRH Investment to Accelerate Service Delivery

Outline

- Introduction

- Key issues and intervention

- Leveraging of BMF experience in HRH management

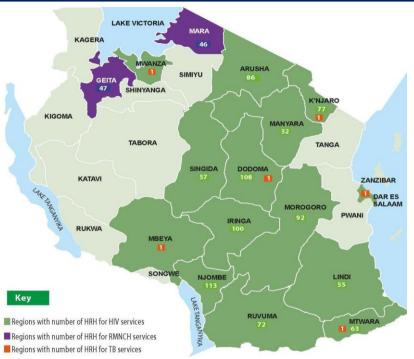- One year in implementation

- Challenges

- Next steps

Introduction

- Started in Feb 2020- Ending in Feb 2025
- Coverage in FY 21:
  - 16 regions
  - 94 LGA
  - 496 HF
- Supported service areas:
  - HIV/AIDS - 921
  - TB - 6
  - MCH – 93

Key issues targeted to optimize HRH

Issues/Problem	USAID Afya Endelevu Intervention
· **No standardized approaches for HRH identification and allocation across partners**	Evidence driven identification and allocation of HRH-aligning with service delivery targets and priorities.
· **Lack of alignment with GoT system -Mismatch of HCWs renumeration package and scope to sustain PEPFAR HRH investment**	Alignment of recruitment with GoT policies and practices, standardization of benefit packages.
· **In adequate Government stewardship and supportive policies:** • **Employment permits** • **Sustaining Data clerks and** • **Recognition of CHWs**	High level GoT engagement to maximize HRH impact and sustainability of data management staff and CHWs.
· **Un -coordinated leadership and HRH management within Ministerial entities.**	TA to GoT on HR management focusing on building capacity in HR planning, recruitment, and retention.

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Leveraging on experience & Best Practices from BMF

- Over 14 years experience in HRH management and capacity building
  - ✔ Evidence driven in allocating, distribution, re-distribution of HCWs to accelerate HIV, RMNCH and TB services
  - ✔ Deployed and co-managed over 3,500 skilled HCWs in 136 LGAs
  - ✔ Enhanced leadership and management from national to beneficiary LGAs

- Effective engagement with GoT systems and alignment with recruitment policies focusing on service delivery improvement

- Success in mainstreaming of 80% contracted HCWs into GoT employment system and continuation of service delivery in various BMF HRH projects

One Year in Implementation

- Alignment of recruitments with GoT policies, practices and benefit package

- Informed by service delivery targets and needs in consultation with Touch Foundation by applying POA

- More coordinated management of HCWs

- Increased availability & visibility of HCWs support both with PEPFAR and GoT through inclusion of HCWs into HRHIS

- Cost saving for adding more HCWs and more services coverage

- Offloading TA partners from HRH management

Challenges

- Increased demand of additional number of HCWs vs available financial resources

- Aligning salaries vs retaining HCWs

- Management of HRH in the context of COVID-19
    - Perceived less commitment in patient care due to fear
    - Unavailability of adequate PPEs
    - Increased workload due to added screening task and re-allocation of HCWs from primary roles into isolation centers
    - Increased need for capacity building on IPC particularly to newly recruited HCWs
    - Inadequate implementation of response plans including case finding and reporting

- Low pace of GoT in releasing employment permits which are few and less focused

Next Steps

- **Improve data use-** Concretize on standardized tools for enhancing identification and allocation of HRH by continuing engaging with Touch Foundation

- Enhancing productivity and performance of HCWs in accelerating service delivery targets

- Engagement with GoT and FBO Institution to ensure sustainability of PEPFAR investment in HRH

- Collaboration with service partners to ensure alignment of HCWs allocation with service delivery targets

Thank You!
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DISCUSSION AND Q&A

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Discussion Questions

- What type of staffing information do you currently collect, and how do you use this data?

- What impact has the COVID-19 pandemic had on the health workers you support?

- Are there changes you have made to your staffing and service delivery models as a result of the COVID-19 pandemic that you plan to continue longer term?

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