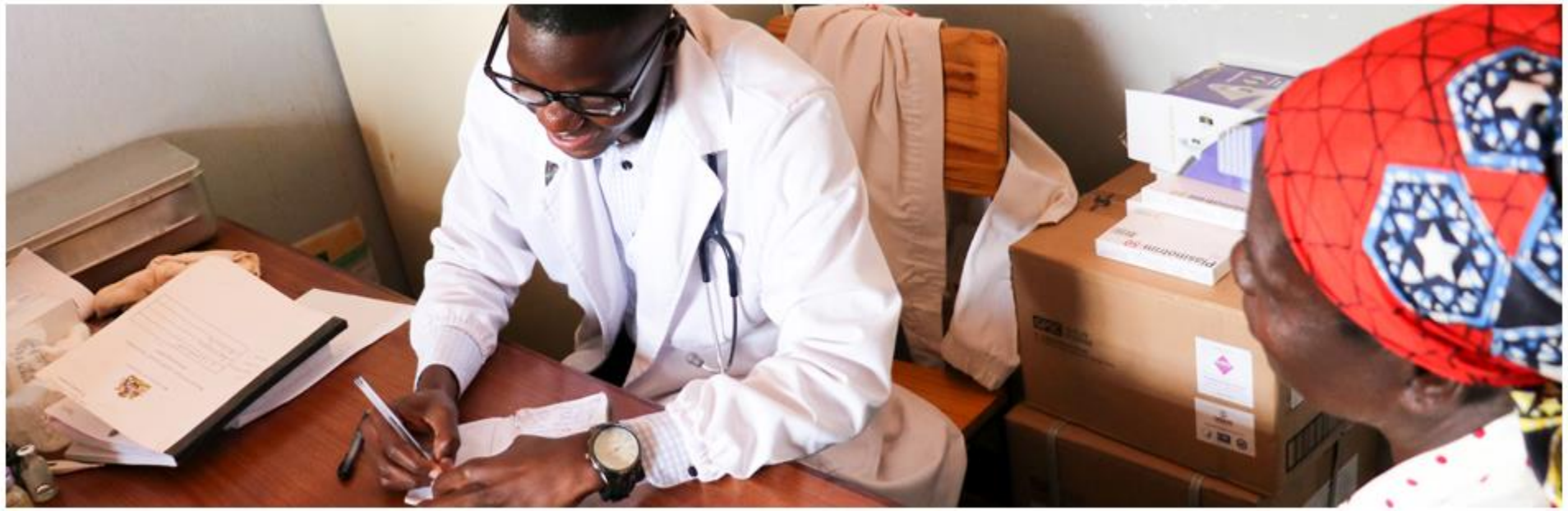

Mobilizing Domestic Resources for the HIV Workforce

Estimating investment needs

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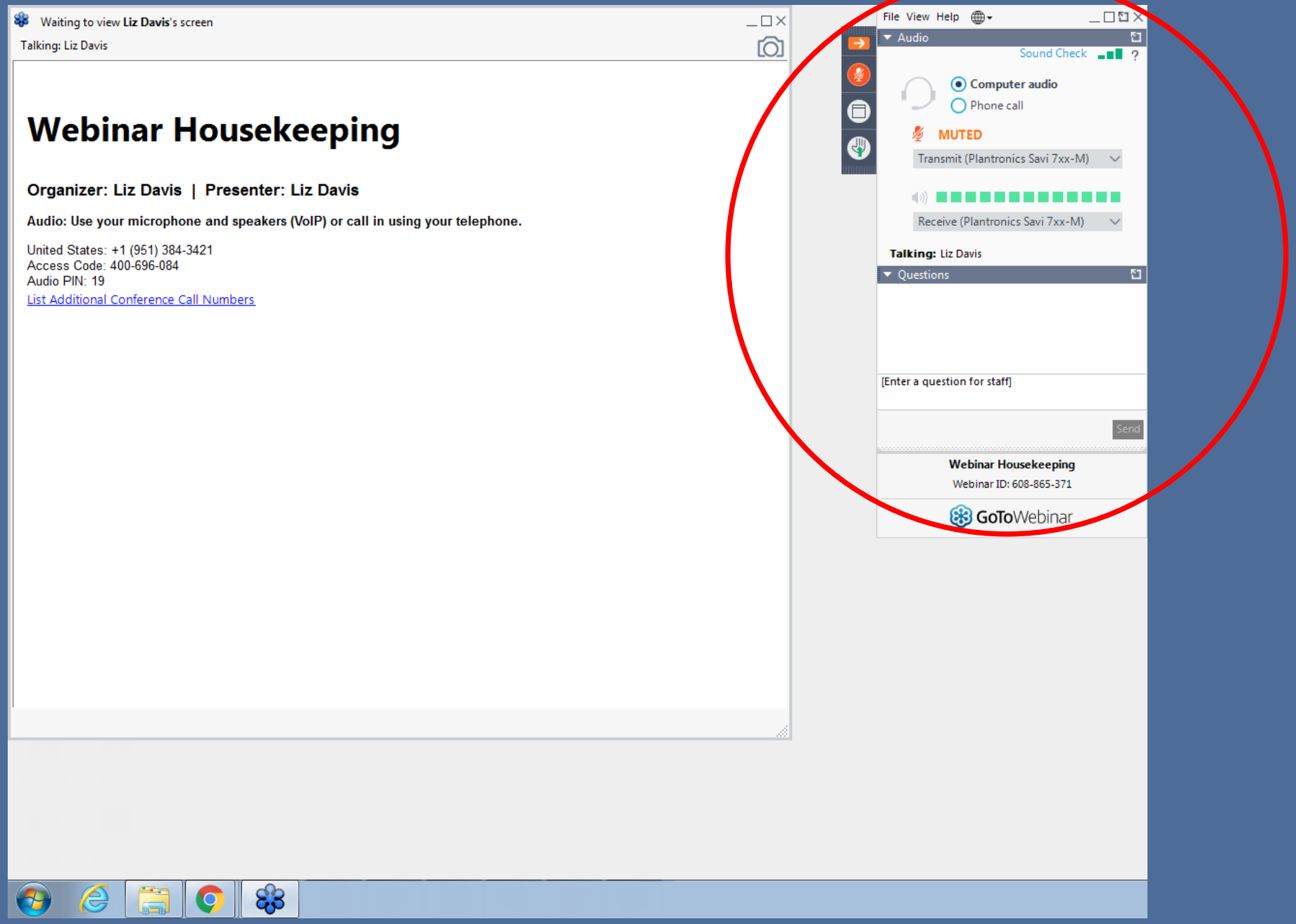
HRH2030 strives to build the accessible, available, acceptable, and high-quality health workforce needed to improve health outcomes.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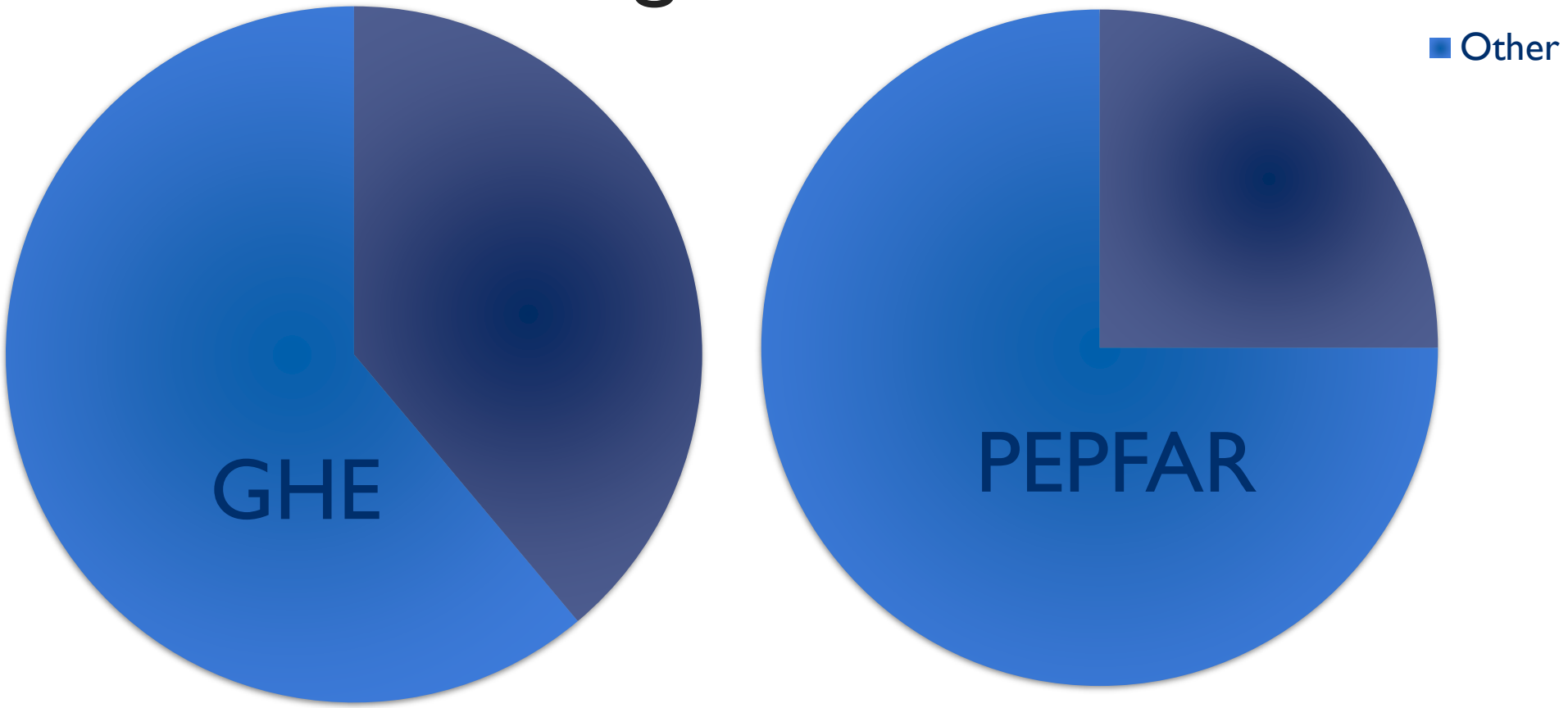
Health Workforce- A Cost Driver of Health and HIV Programs



Sources:
1 Hernandez-Pena et al, Bull WHO, 2013. P
2 PEPFAR ratios are not representative of actual data, but aim to illustrate the significance of the investment

The need for greater estimation of HRH financing requirements for HIV

- Sufficient financing of the HIV workforce is not only critical to achieving 95-95-95 targets but also maintaining achievements

- Greater analysis of the required resources is key for:
  - ✓ Making best use of available resources
  - ✓ Ensuring HIV HRH requirements incorporated into health workforce planning and mobilization of domestic resources
  - ✓ Sustainability of investments and guided transitions of donor-supported workers to domestic funding sources

Objectives

1. Discuss how to generate evidence of HIV workforce needs and costs

1. Discuss how to use this evidence to advocate for strategic investment and mobilization of resources in HRH for HIV

Catherine Cantelmo
HRH2030 | Palladium

Estimating HIV Workforce Needs and Costs at the National or Subnational Level

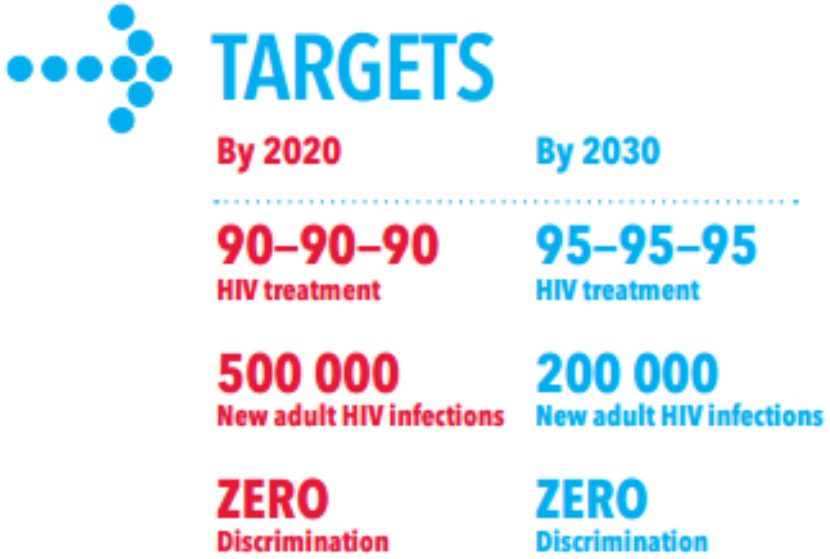
Presentation overview

- Discuss ***why*** and ***how*** to estimate HIV workforce needs and costs at national or subnational levels
- Share examples from an assessment conducted in Uganda that involved answering the following questions:
  - **Baseline analysis** – What are the current HIV HRH funding levels?
  - **Fiscal space and cost scenario analysis** – How much funding may be available for HIV HRH from 2016 to 2020, and is this sufficient to meet national HIV targets? What is the potential funding gap under different service delivery models?
  - **Political economy analysis (PEA)** – What are some of the political and structural barriers and enablers to the government increasing funding for HIV HRH?

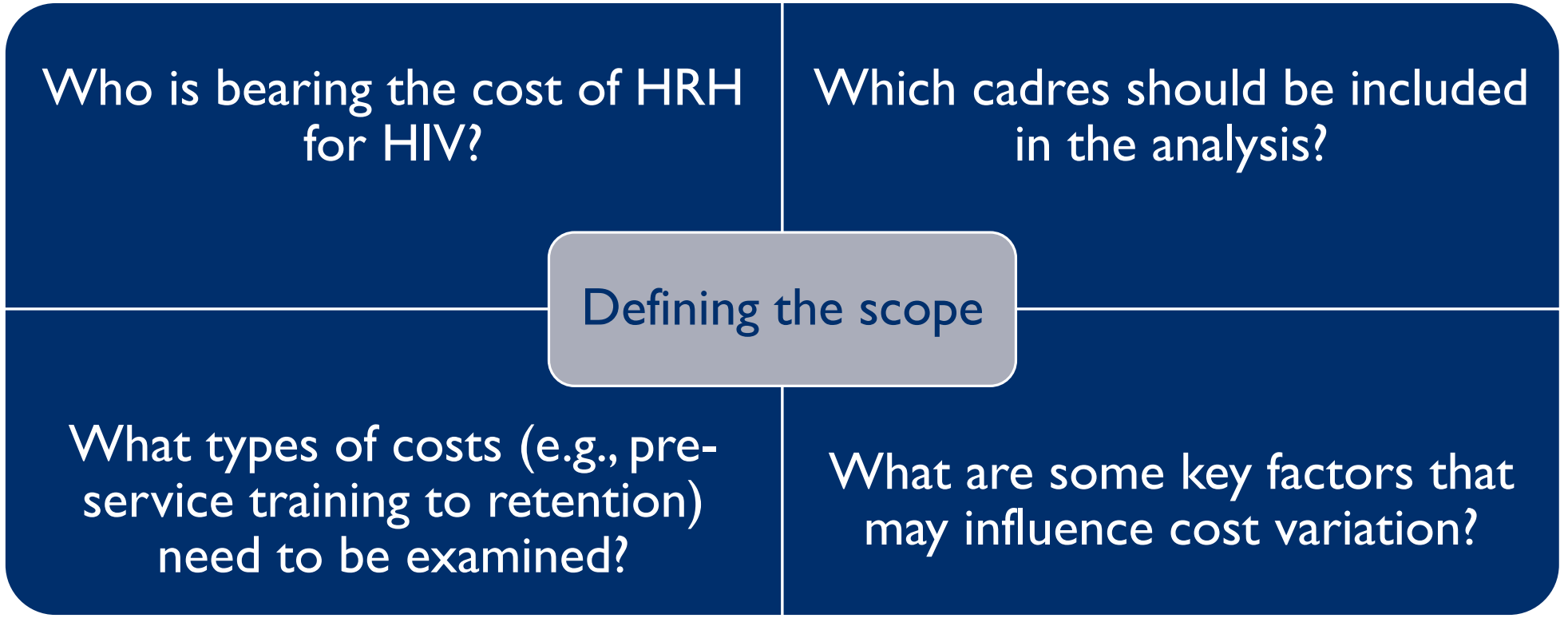
Link to reports: https://www.hrh2030program.org/investmentcaseuganda/

Why estimate HIV workforce costs at national or subnational levels?

- Need to understand the big picture - often assessments are done for specific facilities
- Critical evidence for investment cases and other domestic resource mobilization efforts
- Benefits of separating out HIV workforce needs and costs:
  - Many countries still have a high burden of HIV and have committed to ambitious targets
  - Need evidence to inform transition planning from external to domestic sources

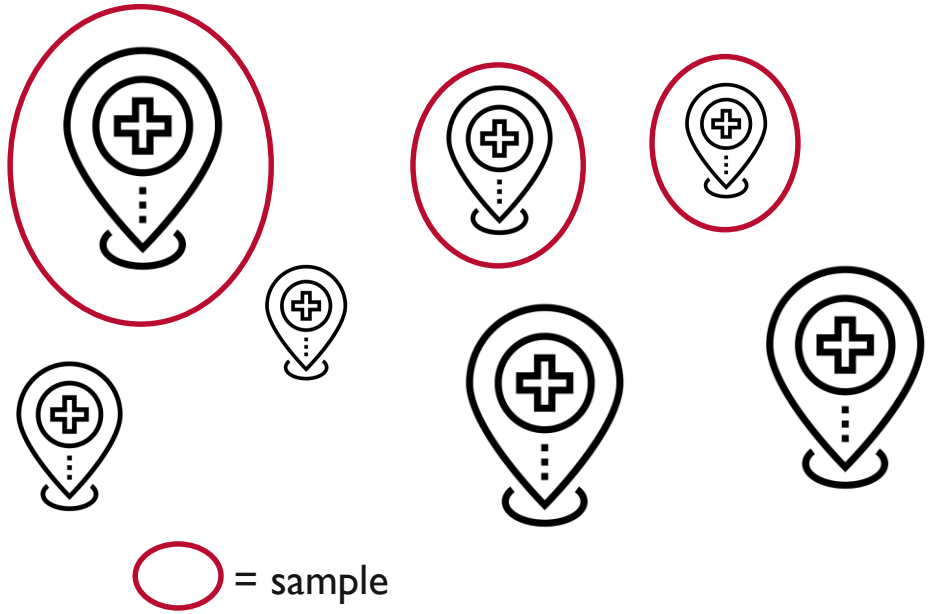


Estimating HIV workforce costs



How do you estimate HIV workforce costs at national and subnational levels?

Extrapolation from facility-based assessments



Cons:

- Difficult to estimate total from a sample
- Based on current utilization/demand

Full-time equivalent (FTE) approach

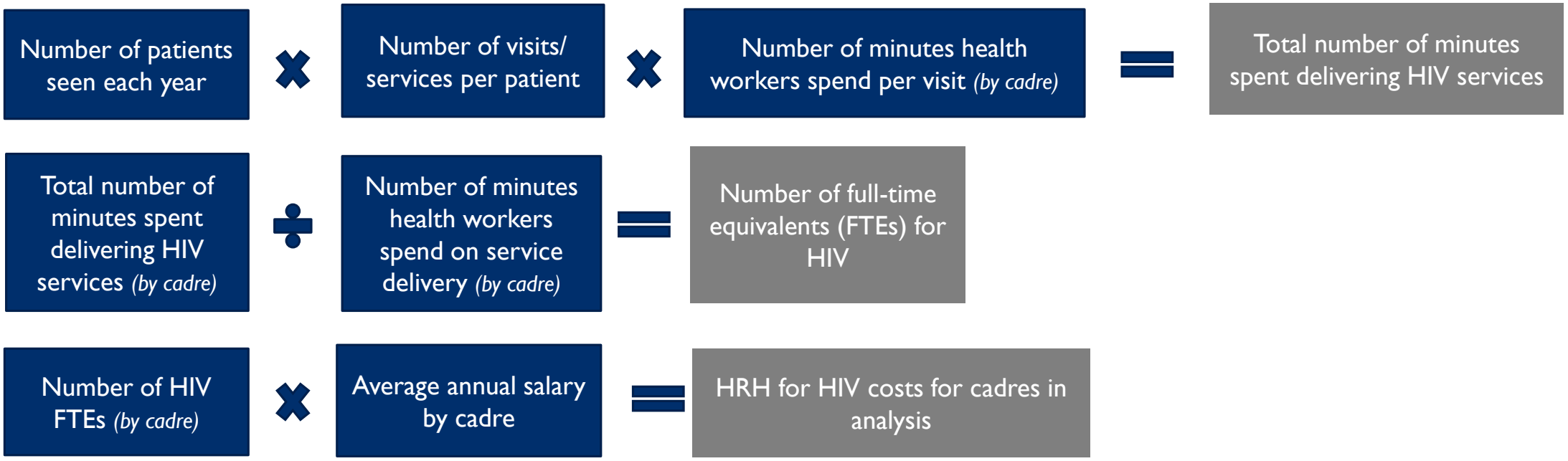
One FTE for HIV = A health worker working full-time on HIV

$$\frac{\text{Total clinical minutes required by cadre X for HIV per year}}{\text{Clinical minutes per staff in cadre X}} = \textbf{Total FTEs required for HIV}$$

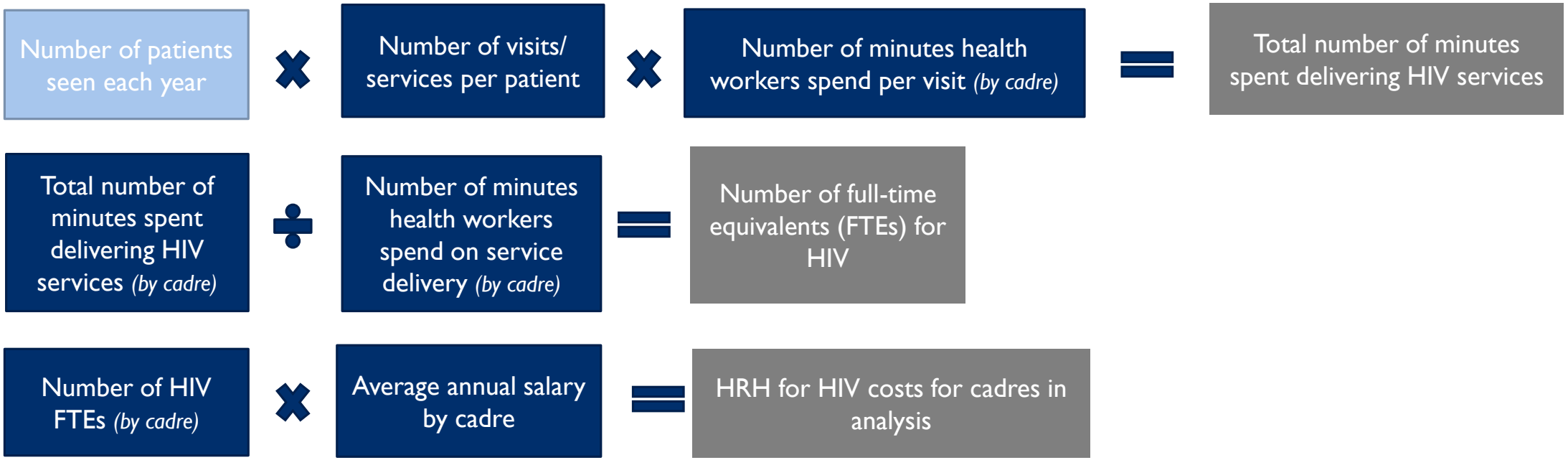
Cons:

- Need to understand division of labor and workload for other conditions in order to know how many health workers are needed overall
- Need quality data to inform estimates

Methods: Estimating facility-based clinical HRH for HIV FTEs and costs

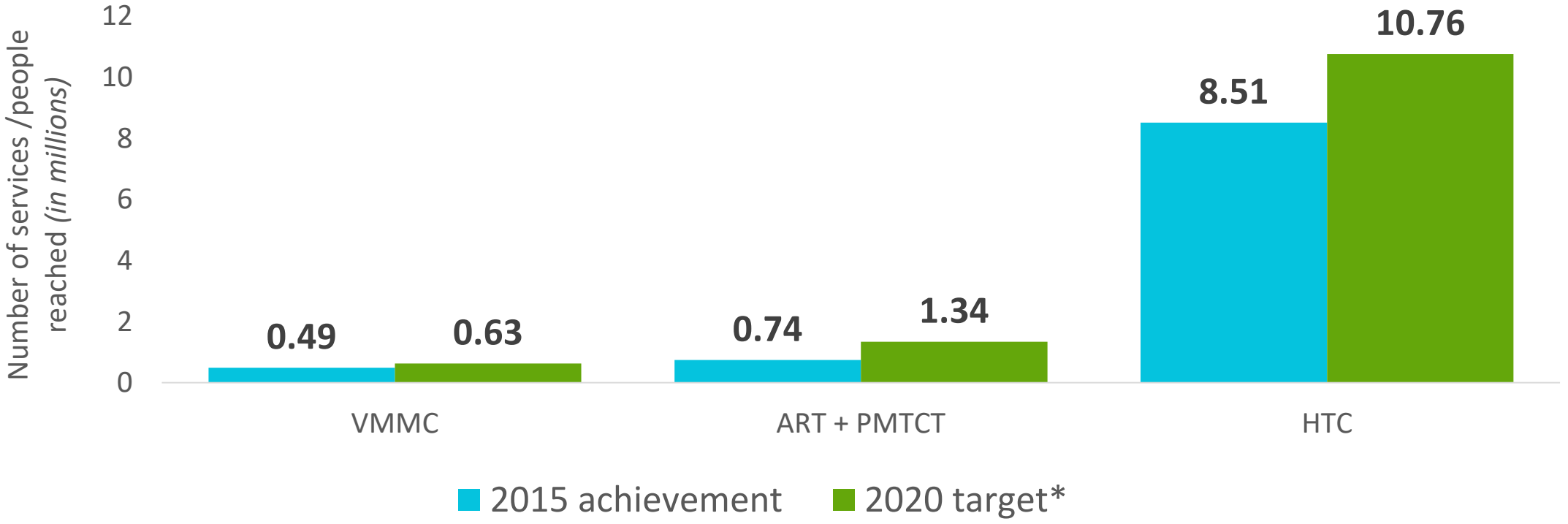


Methods: Estimating facility-based clinical HRH for HIV costs



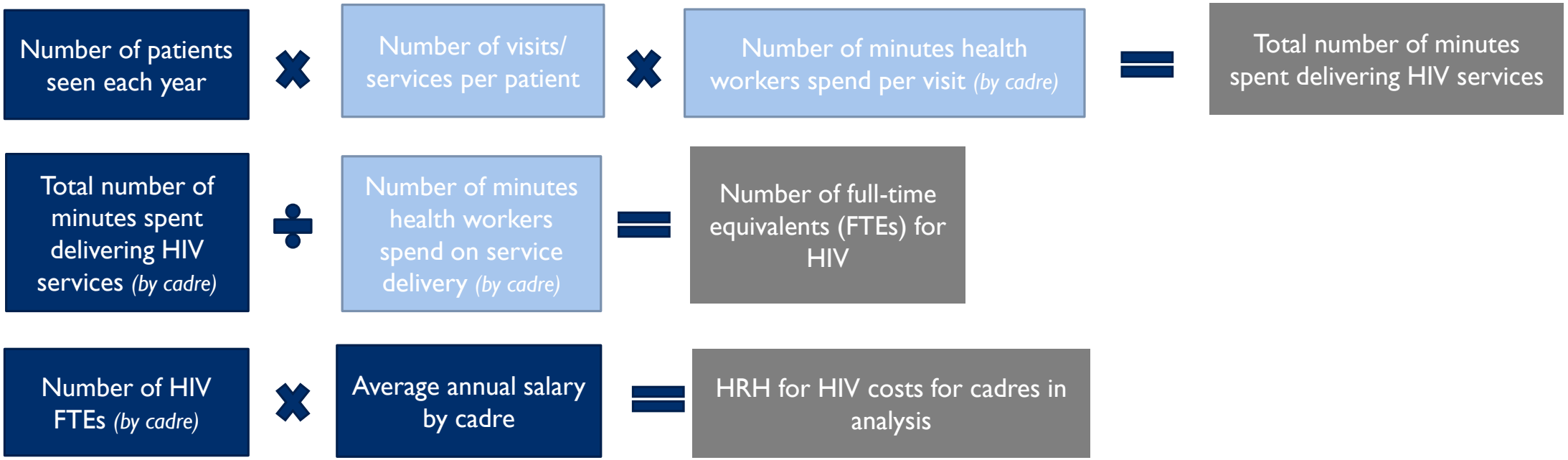
Can be based on 1) current utilization/demand, for HIV services 2) total need based on disease burden, or 3) country HIV targets

Assessment in Uganda: Assumed numbers reached based on national HIV targets



*VMMC target based on FY18 target staying constant to 2020. ART and PMTCT target based on ACP enrollment plan. HTC target based on HRH2030 calculations and will be verified by ACP before inclusion in final report.

Methods: Estimating facility-based clinical HRH for HIV costs



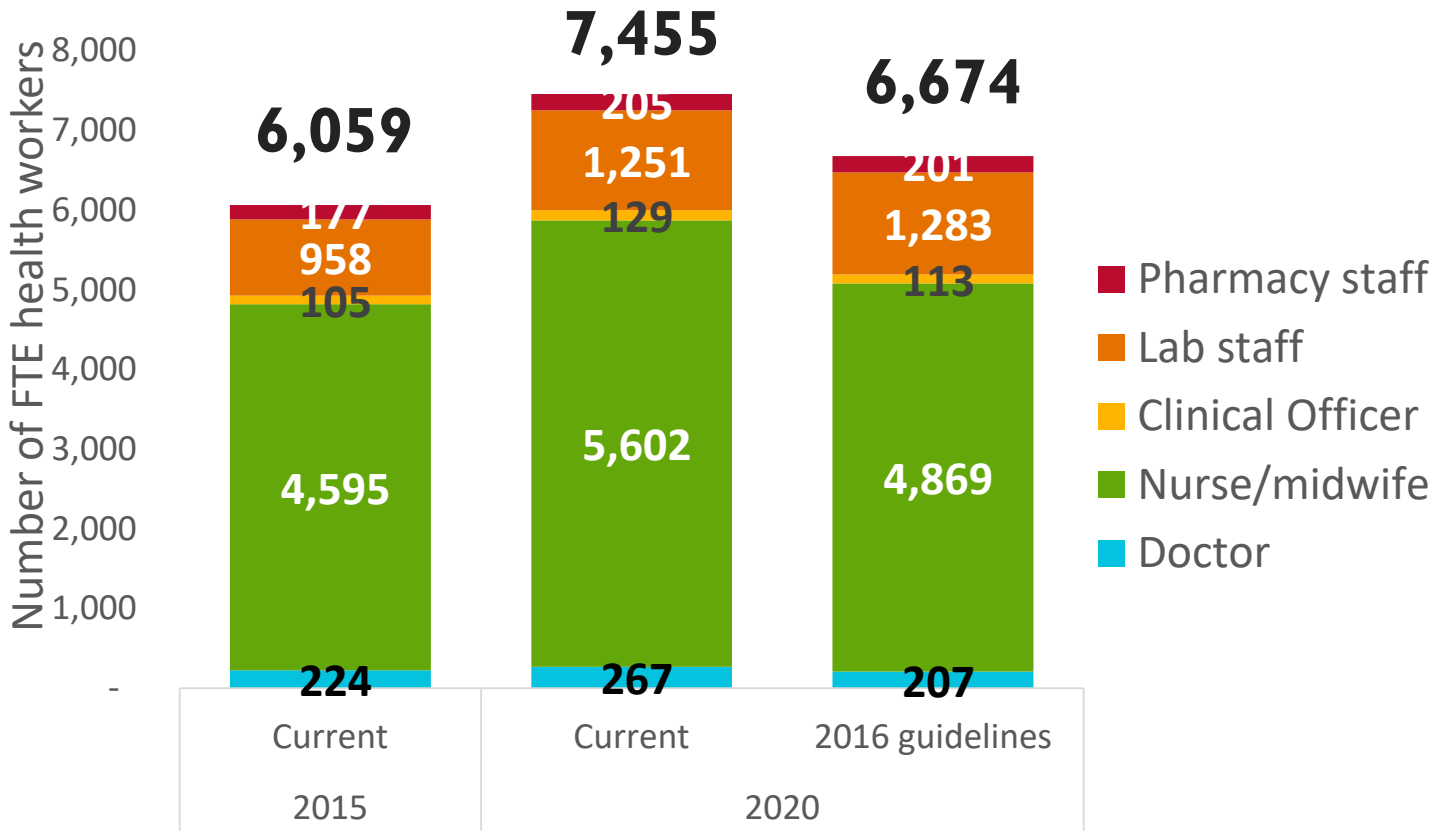
Based on service delivery standards from HIV and other clinical guidelines. Data sources for time spent per patient and by task include time-and-motion studies and health worker interviews.

Assessment in Uganda: Number of visits varies by scenario

Frequency of…	Complex or New Patients	Stable patients	Children	Pregnant and Breastfeeding Women
Scenario 1: Current model (2013 addendum ART + PMTCT guidelines)				
Clinical assessments	9/year	4/year	9/year	9/year
Drug refills	9/year	4/year	9/year	9/year
Lab monitoring	VL or CD4 – 1/year	VL or CD4 – 1/year	VL or CD4 – 1/year	VL or CD4 – 1/year
Scenario 2: Increased efficiency (2016 New ART guidelines)				
Clinical assessments	6/year	2/year	6/year	4/year
Drug refills	6/year	4/year	6/year	4/year
Lab monitoring	VL – 1/year CD4 – 1/year	VL – 1/year	VL – 1/year CD4 – 1/year	VL – 2/year

Both scenarios assume Uganda will meet same government targets in 2020, the same type of health worker and amount of time is spent with a patient per specific service, and that the same percentage of services will be delivered in the public sector.

Results: Number of facility-based FTEs needed to reach national HIV targets



Key takeaways:

- Additional facility-based HRH are needed to reach HIV targets, regardless of service delivery model
- Fewer additional facility-based HRH are needed for HIV service delivery under the differentiated care scenario compared with the current service delivery model scenario
- Biggest increase from 2015 to 2020 is for lab staff, regardless of scenario
- This is an underestimate of overall workforce needs due to exclusion of community, lay and management HRH

Estimating salary costs: Weighted average annual salaries by cadre and sector in Uganda

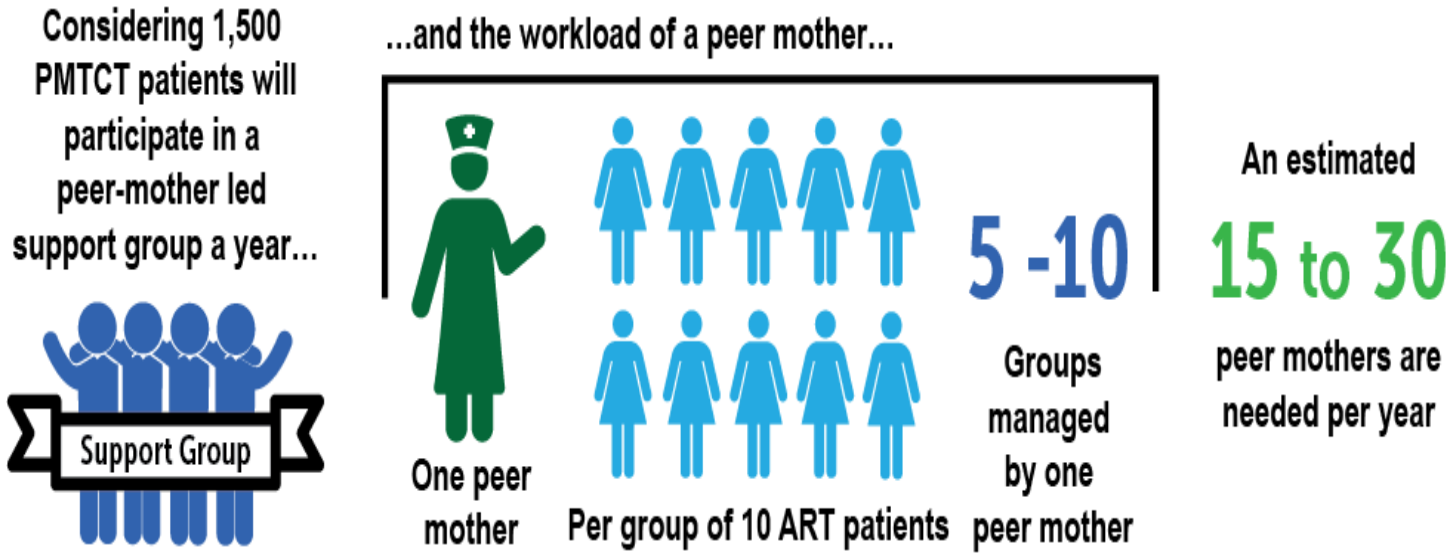
Weighted average annual salaries (2015, USD)

	Private for profit*	Private not for profit	Public
Doctors	**$8,867** *($7,882-$9,852)*	**$6,092**	**$4,730**
Nurses/midwives	**$1,349** *($1,216-$1,482)*	**$1,194**	**$1,990**
Clinical Officers	**$3,319** *($2,945-$3,694)*	**$3,052**	**$3,574**
Laboratory staff	**$2,033** *($1,893-$2,173)*	**$1,330**	**$2,335**
Pharmacy staff	**$4,415**	**$3,500**	**$3,494**

*Low and high estimates for private for-profit sector based on sensitivity analysis.
Salary calculations for private sector include National Social Security Fund contribution by employers, which is assumed to be 10% of base salary. All data was provided in UGX - we assume 1 UGX= 0.00028 $U.S. We assume real wages stay constant.

What about community-based health workers?

Example: Peer mothers



Workloads of community-based health workers depend on:

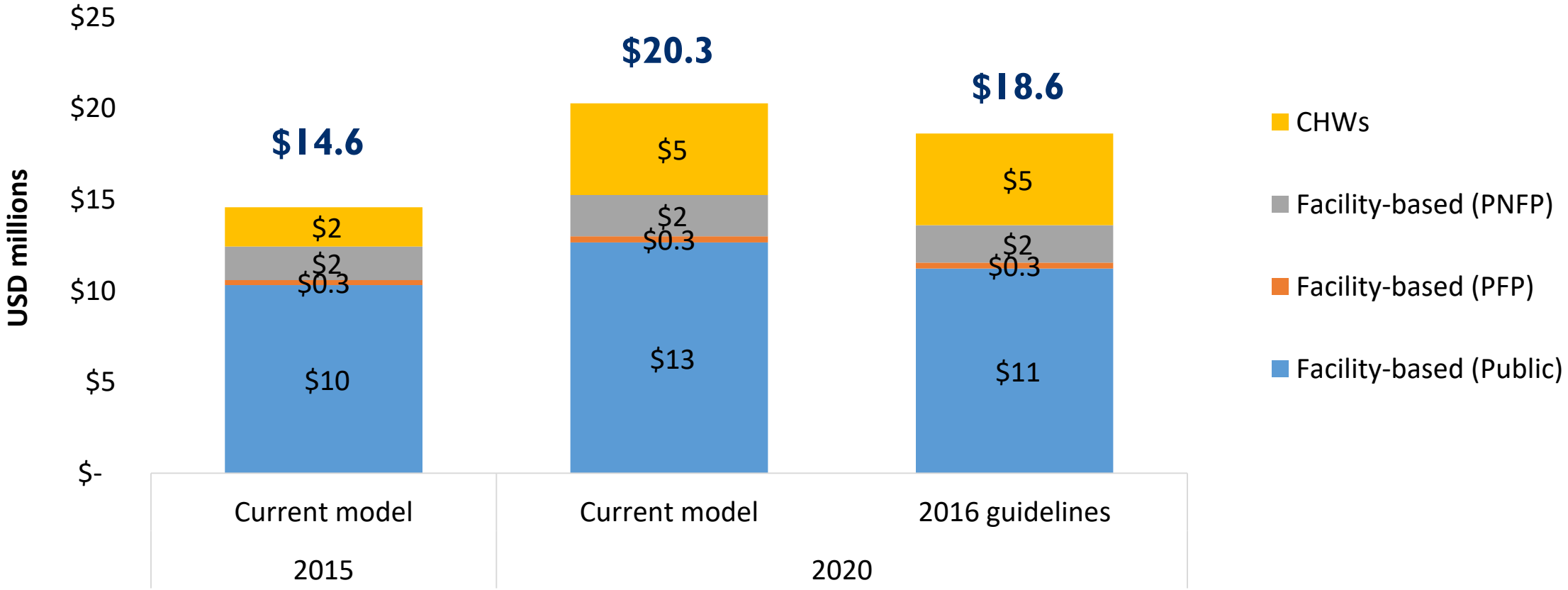
- Distance travelled
- Size of support group
- Type of support or services provided

Assumptions for community-based health workers in Uganda

Cadre	Number of Patients Managed by One Health Worker Per Year			Percentage of Time Spent on HIV	Stipend Cost Per Patient Per Year
	ART	HTS	VMMC		
CASA/Expert Client	250–300	250–300	N/A	100%	$0.60–0.72
CCLAD Leader	60–100	60–100	N/A	100%	$1.80–3.00
Mentor Mother	100–150	100–150	N/A	50%	$0.75–1.13
Linkage Facilitators	400–500	400–500	200–250	100%	$0.50–0.62
Drama Member	300–350	300–350	500–700	50%	$0.06–0.08

Analysis assumes 70% of ART patients interact with an expert client, all stable patients interact with a CCLAD leader, all pregnant women test at the community level, all PMTCT patients interact with a mentor mother, all new patients diagnosed at the community-level and 25% to 75% of VMMC clients interact with a linkage facilitator, and all patients are exposed to drama members.

Projected HRH Salary/Stipend Costs for Providing HIV Services in Uganda



HIV HRH Funding Gap in Uganda(2020)

HIV HRH financial space scenarios	HIV HRH Cost Scenarios	
	Scenario 1: Current service delivery models	*Scenario 2:* Increased efficiency (ART differentiated care model)
Scenario 1: Constant funding levels (all sources)	Facility-based HRH: $2,827,296 gap Community-based HRH: $2,877,424 gap	Facility-based HRH: $1,167,494 gap Community-based HRH: $2,877,424 gap
Scenario 2: Increased government funding	Facility-based HRH: $987,667 gap Community-based HRH: $2,877,424 gap	Facility-based HRH: $672,135 surplus Community-based HRH: $2,877,424 gap

- Community health workers face large funding gap
- Uganda may not reach its HIV goals unless HRH recruitment targets are met, efficiency gains are made through national roll-out of differentiated HIV treatment models of care, private sector health workforce is leveraged for HIV service delivery, and investments are made in the community health workforce.

Methodological challenges and solutions

Common challenge	Potential solution
Separating time spent on a specific health area versus others, particularly for staff that do not directly interact with patients	Triangulate multiple data sources (e.g., interviews, direct observation); develop assumptions based on resource intensity (e.g., volume of patients)
Lack of data on community-based, lay, and managerial staff	Primary data collection/use of expert opinion, sensitivity analysis
Lack of data on the private sector	Primary data collection/use of expert opinion, sensitivity analysis
Evolving service delivery models (e.g., differentiated care for HIV)	Generate scenarios that show potential efficiency gains across models of care

Key takeaways

- Analysis in Uganda is relevant to other countries that may face fiscal space and political will constraints to increasing investment in the HIV workforce
- To develop a comprehensive HIV workforce investment case, countries need to:
  - Generate evidence on the HIV workforce, especially estimates of the resource requirements to meet needs and targets
  - Bring together stakeholders, including civil society, development partners, and government, to identify priority areas for HRH investment and develop a unified funding task
  - Develop a comprehensive investment case document that crafts arguments for increased HRH investment for HIV
  - Use the investment case to conduct targeted, relevant budget advocacy during key windows in the budget cycle

Diana Frymus
USAID/Washington
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Panelist

Bryan Patenaude
USAID/Washington
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Vamsi Vasireddy
Office of the Global AIDS Coordinator
Panelist

Panel Discussion

Diana Frymus
USAID/Washington
Moderator

Catherine Cantelmo
HRH2030 | Palladium
Panelist

Question 1:

How does this methodology compare to other tools available to estimate health workforce needs and costs?

Diana Frymus
USAID/Washington
Moderator

Bryan Patenaude
USAID/Washington
Panelist

Question 2:

How can this information be used to support long-term sustainability of PEPFAR-supported staff and transition to domestic resources (this goes beyond public sector)?

Diana Frymus
USAID/Washington
Moderator

Vamsi Vasireddy
Office of the Global AIDS Coordinator
Panelist

Question 3:

What has been country experience in using evidence to advocate for more strategic investment in the health workforce, including for HIV?

Diana Frymus
USAID/Washington
Moderator

Catherine Cantelmo
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Panelist

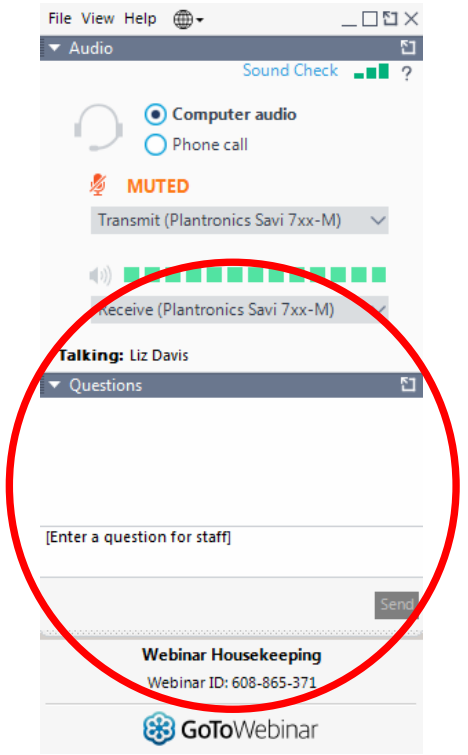
Bryan Patenaude
USAID/Washington
Panelist

Vamsi Vasireddy
Office of the Global AIDS Coordinator
Panelist

Question 4:

What other pieces of evidence are needed to convince ministries of finance and other stakeholders to invest in the HIV workforce, including community-based health workers?

Diana Frymus
USAID/Washington
Moderator



Questions?

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