Achieving and Sustaining HIV Epidemic Control with Better Health Workforce Data

Use of National Health Workforce Accounts to Achieve 95-95-95 Targets

This briefer provides an overview of National Health Workforce Accounts (NHWA) and illustrates opportunities for PEPFAR and implementing partners to optimize PEPFAR investments through use of NHWA for better decision-making.

Context

Many national HIV programs face workforce challenges that hinder the sustainable achievement of 95-95-95 targets. Overarching challenges for health and social service workers include: shortages; maldistribution; competency gaps or inappropriate skills mix; poor allocation of staff and tasks; high turnover; inefficient work processes or inadequate conditions; and/or insufficient performance management for the provision of quality, client-centered HIV services. These issues affect the HIV workforce and can limit immediate successful implementation of HIV policies and achievement of long-term, self-reliant epidemic control.
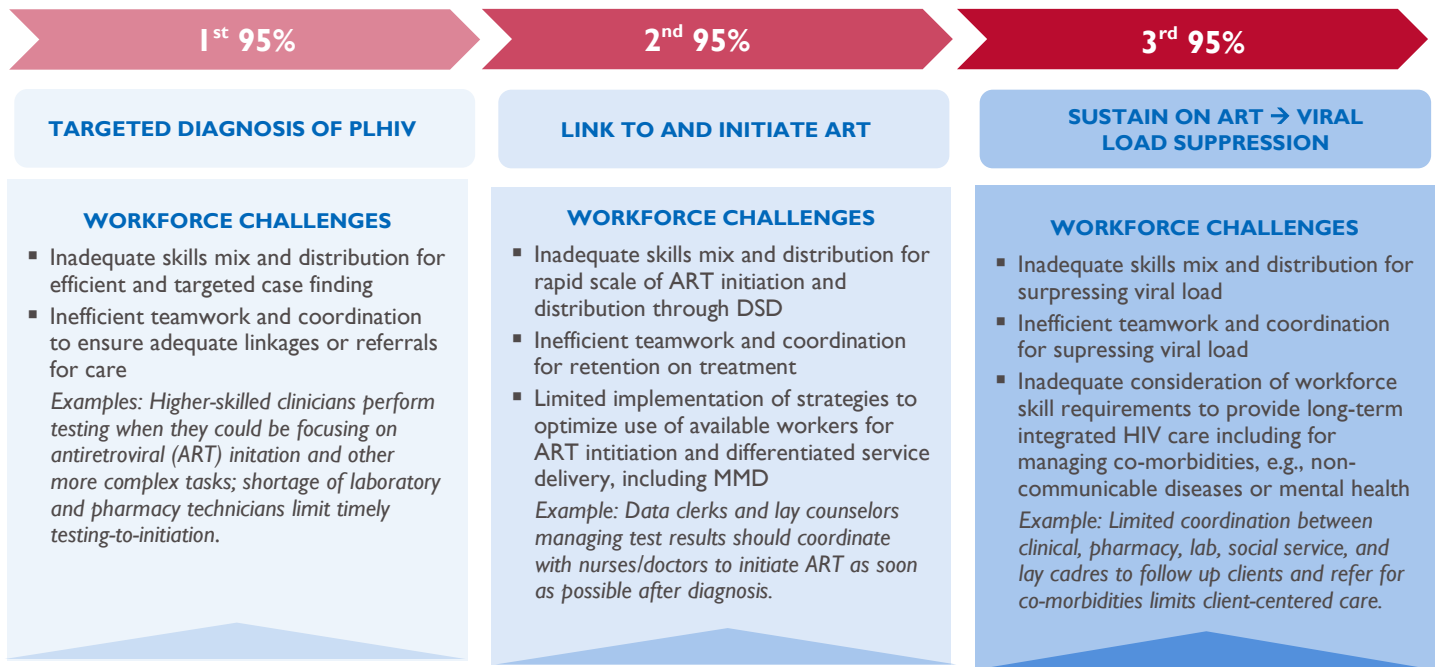
There are timely opportunities to strengthen and optimize the workforce to more effectively implement national HIV policies and more rapidly scale up HIV/AIDS services. For example, task sharing and differentiated service delivery (DSD) models such as multi-month distribution (MMD) can help improve the efficiency and effectiveness of case finding and viral load suppression.

However, an effective HIV workforce must be well-trained, optimally distributed, tasked, and coordinated. Workforce managers and decision makers require health system information, including from human resource information systems (HRIS), to develop strategic, targeted, and appropriate responses to optimize the HIV workforce towards service delivery improvements. Many national HRIS have been established, but many systems have not been fully scaled and data use has not reached full potential.

When HRH supply, distribution, quality and skills mix data are incomplete, not robust, or not up to date, HIV services across the clinical cascade may be negatively affected, as illustrated in Figure 1 on the following page.

Figure 1. Health & social service workforce data gaps & challenges affecting HIV service delivery across the clinical cascade

1st 95%	2nd 95%	3rd 95%
TARGETED DIAGNOSIS OF PLHIV	**LINK TO AND INITIATE ART**	**SUSTAIN ON ART → VIRAL LOAD SUPPRESSION**

WORKFORCE CHALLENGES

- Inadequate skills mix and distribution for efficient and targeted case finding
- Inefficient teamwork and coordination to ensure adequate linkages or referrals for care

  Examples: Higher-skilled clinicians perform testing when they could be focusing on antiretroviral (ART) initation and other more complex tasks; shortage of laboratory and pharmacy technicians limit timely testing-to-initiation.

WORKFORCE CHALLENGES

- Inadequate skills mix and distribution for rapid scale of ART initiation and distribution through DSD
- Inefficient teamwork and coordination for retention on treatment
- Limited implementation of strategies to optimize use of available workers for ART intitiation and differentiated service delivery, including MMD

  Example: Data clerks and lay counselors managing test results should coordinate with nurses/doctors to initiate ART as soon as possible after diagnosis.

WORKFORCE CHALLENGES

- Inadequate skills mix and distribution for surpressing viral load
- Inefficient teamwork and coordination for supressing viral load
- Inadequate consideration of workforce skill requirements to provide long-term integrated HIV care including for managing co-morbidities, e.g., non-communicable diseases or mental health

  Example: Limited coordination between clinical, pharmacy, lab, social service, and lay cadres to follow up clients and refer for co-morbidities limits client-centered care.

HIV-SPECIFIC WORKFORCE DATA GAPS

Data are often incomplete, out-of-date, insufficient, or otherwise limited to promote an understanding of the following…

Building the health workforce

- Status of HIV curricula across pre-service education institutes, and accredited in-service training requirements
- Distribution and skills of new gradautes and trainees (i.e., recip   ients of in-service training / continuing professional development)

Managing the health workforce

- o   Geographic distribution, skill mix, and performance of HIV workforce staff across high-volume sites, including: facility- and community-based workers; public and private sector; and government-, non-government- and donor-supported workers
- Standard workload requirements to forecast HRH needs for both community and facility-based case-finding and referral services, including for ART initation and integrated service delivery
- HIV workforce contracting, deployment, supervisory structures, remuneration, and other HR management trends, especially at decentralized levels and including the private and faith-based sectors
- HIV health workforce investments by PEPFAR and non-PEPFAR partners

Optimizing the health workforce

- Status and effectiveness of HRH task-sharing policies and their implementation as it pertains to HIV services
- Interoperability with service delivery data streams to assess potential linkages between HRH performance management, quality of care, and client satisfaction relative to client retention to care

BROADER WORKFORCE DATA GAPS

… which are often due to broader HRH data gaps and limitations in these areas:

Building the health workforce

- Curriculum, faculty capacity, financing, and standards/processes for accreditation for pre-service education institutions
- Health worker production (e.g., new graduates), registration, licensure, and continuing professional development

Managing the health workforce

- Health worker labor market trends (i.e., deployment, attrition, and migration) across public and private employers
- Workforce spending, remuneration, and working conditions
- Health worker performance management

Optimizing the health workforce

- Dissaggregated data on health worker type, age, demographics, geographic location, qualifications, recent trainings, and performance
- Linkages between HRH data and other aspects of health systems, including supply chain, service delivery, laboratory and referrals

National Health Workforce Accounts for Achieving and Sustaining Epidemic Control

Worldwide, countries have begun reporting health workforce data to NHWA, increasing data availability that can be used to inform more strategic implementation policies and interventions to build, manage, and optimize the health workforce—including the social service workforce—contributing to HIV epidemic control.

What are National Health Workforce Accounts?
The National Health Workforce Accounts (NHWA) were developed by the World Health Organization (WHO) and adopted by the global health community[1] to support countries to **progressively** improve the **availability, quality,** and **use** of data on the health workforce—including the social service workforce—to help achieve HRH and health goals, including reaching epidemic control.[2,3] Country governments can routinely report and review data via the WHO's online, DHIS2-enabled NHWA platform.

NHWA is a set of ten modules of HRH-related indicators, categorized under the three main areas of the Health Labor Market Framework: **education, labor markets, and serving population health needs.**[4]

NHWA can promote effective HRH stakeholder relationships to define country-level data standards, governance, and interoperability, allowing **efficient multisectoral data sharing** between systems and stakeholders for **real-time data analysis and decision making** sustained within a self-reliant health system.

Data input and reported through NHWA can influence having stronger in-country HRH data systems needed to make more strategic decisions for HRH-related HIV investments. Standardized HRH data through NHWA can guide strengthened national and sub-national policy and planning to help address critical workforce gaps that are impacting the provision of quality, client-centered HIV services. Standardized NHWA data can be used with other health data streams to guide decision-making.

For example, national HIV program stakeholders can use existing standardized national health workforce data on number, type, education, training, and distribution alongside epidemiologic and facility-level service data to:

- *Review aggregated HRH salary data* to ensure consistencies of remuneration with government pay bands and inform sustainability planning of donor-supported health and social service workers.

- *Develop more effective deployment and continuing professional development strategies,* to implement complimentary staffing strategies to reduce future turnover and minimize burnout, as well as upskill staff.

- *Reduce the need for ad-hoc and redundant data collection efforts* by leveraging the ecosystem of available HRH data created by existing information systems and managed by country governments agencies from all sectors: private sector agencies, faith-based organizations, and civil society. For example, availability of national NHWA data sets would enable easier application of HRH2030's tool for estimating HRH needs for HIV differentiated care.

- *Support roll-out of HIV policies and service delivery models* Effective investments to implement and scale approaches—such as test and treat, index testing, task shifting, DSD, and MMD—should be informed by existing service delivery data alongside workforce data on number, production, and budget allocation of health and social service workers, including community-based workers. For example, in Indonesia, HRH data helped country stakeholders strategize how to implement their new Test and Treat policy. In Mozambique, HRH data is essential for reviewing coverage to prioritize and finance vacant posts to meet current and model future ones.

Figure 2 on the following page describes the NHWA modules, selected indicators, and additional examples of how national and subnational decisionmakers can use NHWA data to understand workforce skills and distribution to optimize the HIV health workforce and contribute to achieving and sustaining epidemic control.

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[1] *Resolution WHA69.19 (adopted in 2016) and 70.18 (adopted in 2017)*
[2] *WHO. 2015. The Global strategy on human resources for health: Workforce 2030. https://www.who.int/hrh/resources/globstrathrh-2030/en/*

[3] *WHO, ILO and OECD. 2016. High Level Commission on Health Employment and Economic Growth report on Working for Health and Growth https://www.who.int/hrh/com-heeg/reports/en/*
[4] *Sousa et al. 2013. Bulletin of the WHO. https://www.who.int/bulletin/volumes/91/11/13-118927/en/*

Figure 2. NHWA modules & selected indicators with country-level applications for HIV workforce optimization

Consider this illustrative example of how using data reported to NHWA can be used to address subnational health and social service workforce performance management for HIV service delivery improvements, focusing on greater ART retention and case management for viral load suppression.

NHWA Modules & Selected Indicators | Country-level applications | Outcomes

Module 1. Active labor stock
Health worker density (at subnational level) • Health worker distribution by age group, facility ownership, facility type • Share of health workers across health and social sectors

• At subnational levels, using disaggregated data on health and social service workforce distribution indicates which workers could be potentially available to provide HIV services, and the capacity for *which sites could be prioritized for DSD,* resulting in more efficient case management with nurses leading ART initiation and lay cadres leading adherence counseling and loss to follow up, as indicated by national policy.

Strategic use of and contributions to NHWA data

Module 2. Education and training
Master list of accredited health workforce education and training institutions • Duration of education and training

• Monitoring new graduates and HRH with upgraded skills from accredited institutions can ensure that the workforce is properly trained on HIV standards of care. **Note: Partners providing HIV in-service training should be reporting according to national HRIS data standards**.

Module 3. Education and training regulation and accreditation
Standards for duration and content of education and training • Accreditation mechanisms for education & training institutions • CPD & IST

• New HIV trainings should be based on global best practices and national standards of care, to ensure high-quality, competency-based programs from public, private, and civil society that contribute to high quality care. For example, *to plan for which institutions nurses from high-volume sites can attend to complete a NIMART refresher training*.

More complete accurate, timely, and up-to-date health & social service workforce data used for HIV program planning & implementation

Module 4. Education finances
Total expenditure on health workforce education • Cost of expenditure health workforce graduate and qualified educators per graduate • Total expenditure on IST and CPD

• Education expenditure information from both the private and public sector can support longer-term scale up and sustainability planning for health workforce production, *such as upskilling auxiliary nurses in underserved areas to registered nurses who can initiate ART, or scaling pharmacy technician production to meet future needs.*

Module 5. Health labor market flows
Graduates starting practice within one year • Entry rate of foreign health workers • Voluntary/involuntary exit rate from health labor market • Unemployment rate • Vacancy rate

• Understanding labor market flows helps manage and mitigate turnover and transition to ensure sustainability for the PEPFAR-supported health workforce. *Vacancy rates can help governments and donors identify and fill priority posts.*

PEPFAR and country government investments are better targeted; decisions impacting services are better informed by HRH data

Module 6. Employment characteristics & working conditions
Standard working hours • Health workers working with a part time contract • Health worker status in employment • Regulation on dual practice and compulsory service

• Data can ensure adequate performance management, site level workforce sustainability, and surge planning as needed. *Using standard workforce requirements can estimate how many patients can be served by a health worker team at facility and in communities.*

Module 7. Health workforce spending and remuneration
Total expenditure on health workforce • Total development assistance on health workforce • Total expenditure on compensation of health workers (disaggregated by public and private)

• Spending and remuneration data are needed to motivate, retain, and plan for absorption of the PEPFAR-supported health workforce, to *minimize disruption of HIV service availability.*

Module 8. Skill-mix composition for models of care
Sectoral workforce composition • skills distribution

• Skills mix data support planning and implementation of optimization efforts such as taskshifting with community health workers, *scaling up NIMART, DSD and MMD, as well as to address co-morbidities.*

95-95-95 targets achieved

Module 9. Governance and health workforce policies
Health workforce planning processes • Education plans aligned with national health plan • Institutional models for assessing staffing needs

• Entry and exit information, as well as staffing needs based on workforce pressure, allows for HIV health and social service workforce planning that *ensures quality of services and maintaining of the continuum of care.*

Module 10. Health workforce information systems
HRIS for reporting and tracking outputs from education and training institutions, entrants/exits into labor market, active stock in labor market

• Robust HRIS and NHWA allow for up-to-date and complete data on the HIV workforce; their use could *reduce the need to conduct parallel health workforce inventories.*

Sustained HIV epidemic control

Conclusion

Implementing NHWA will improve the availability and quality of standardized HRH data that is critical for decision makers in informing HRH requirements to advance and sustain provision of quality, client-centered HIV care.

NHWA data—coupled with granular HIV and HRH data—can support proper planning, production, and deployment of the health and social service workforce to ensure available, quality HIV services to target investments in achieving 95-95-95.

NHWA serves as a mechanism that can standardize and improve HRH data availability and use and highlight the need for stronger HRH information systems to support NHWA indicator reporting. It promotes governance, policies, and information systems necessary to enforce data use and transparency. It promotes greater accountability of the workforce supporting HIV services by partner governments, private sector, civil society, and donors. It promotes routine data-informed decision making for financing for HRH.

In conclusion, NHWA provides a platform for data-driven processes to ensure that health and social service workers are not only available, but have the proper knowledge and skills mix to provide services on the continuum of care, perform well, maintain continuing education and are included in professional associations. When multisectoral HRH stakeholders engage across the health worker lifecycle to make evidence-informed decisions, it can result in reliable and high-quality HIV service provision.

Tools, resources, and global communities for implementing NHWA	
To learn more about NHWA, WHO has developed several global goods for use by countries and implementing partners:	
WHO Website	The WHO National Health Workforce Accounts website (https://www.who.int/hrh/statistics/nhwa/en/) provides a links to all tools, YouTube tutorials, meeting reports and a link to the NHWA web portal. (All of the below can be found on the WHO website).
NHWA Tools	Several important tools have been developed by the WHO to support countries in NWHA development and implementation: ▪ National Health Workforce Accounts Implementation Guide: A guide through the eight steps of NHWA implementation ▪ National Health Workforce Accounts: A Handbook: A detailed guide on all 10 modules of NHWA including indicator reference sheets ▪ Understanding National Health Workforce Accounts: A briefer on the nuts and bolts of NHWA
NHWA YouTube Videos	There are several YouTube videos development by the WHO to support advocacy on NHWA and use of the NHWA Online Platform: ▪ WHO: Health workforce data platform - NHWA serves as promotional video for NHWA ▪ WHO: Health Workforce - NHWA platform tutorial: Maturity Assessment provides a tutorial on use of the maturity model ▪ WHO: Health Workforce - NHWA platform tutorial: Data Entry provides a tutorial on data entry into the NWHA Online Platform
Key Stakeholder Meeting Reports	To support knowledge sharing and capacity building, reports for consultations conducted by WHO, in coordination with other partners (such as USAID/PEPFAR), from the SEARO region, Mozambique, and Dakar can serve as a reference for planning for NHWA and learning from other countries experience.
NHWA Web portal	The WHO has created a web portal to access data visuals and infographics on health workforce data using NHWA. This website is currently in progress, but the current link can be found here.
Global Health Workforce Network	As part of the Global Health Workforce Network, the Data and Evidence Hub has been established to support exchange and coordination between networks, partners and experts to enhance adoption, implementation and reporting on NHWA.

About HRH2030

HRH2030 strives to build the accessible, available, acceptable, and high-quality health workforce needed to improve health outcomes.

Global Program Objectives

1. **Improve performance and productivity of the health workforce.** Improve service delivery models, strengthen in-service training capacity and continuing professional development programs, and increase the capacity of managers to manage HRH resources more efficiently.

2. **Increase the number, skill mix, and competency of the health workforce.** Ensure that educational institutions meet students' needs and use curriculum relevant to students' future patients. This objective also addresses management capability of pre-service institutions.

3. **Strengthen HRH/HSS leadership and governance capacity.** Promote transparency in HRH decisions, strengthen the regulatory environment, improve management capacity, reduce gender disparities, and improve multi-sectoral collaboration for advancing the HRH agenda.

4. **Increase sustainability of investment in HRH.** Increase the utilization of HRH data for accurate decision-making with the aim of increasing investment in educating, training, and managing a fit-for-purpose and fit-for-practice health workforce.

Program Partners

- Chemonics International
- American International Health Alliance (AIHA)
- Amref Health Africa
- Open Development
- Palladium
- ThinkWell
- University Research Company (URC)

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