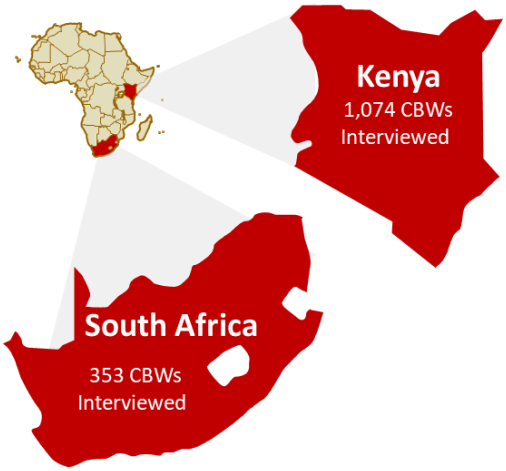
Lessons Learned from Assessing the Community-Based Workforce to Advance Optimization of HIV Programs

Community-based services are critical to the effectiveness and sustained impact of the HIV response. Donors including the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria have supported multiple cadres that deliver HIV services to clients within their communities. Loosely grouped under the title "community based workers" (CBWs), this workforce spans the health and social sectors and includes cadres formally recognized by national governments as well as non-formal workers and volunteers; all of them work to support the achievement of the global UNAIDS targets through a variety of roles. These include advancing the use of differentiated care models, supporting HIV case finding (including of out-of-facility index testing), and providing patient support to increase retention and adherence to anti-retroviral therapy (ART) and achieve viral suppression.

While community-based HIV interventions are increasingly being used, especially with onset of the COVID global pandemic as a means of decongesting facilities and supporting client retention, comprehensive analysis of the entirety of CBWs' support for HIV services and people living with HIV (PLHIV) is lacking.[1] This greater responsibility and the transformative role in advancing HIV services and beyond requires more scrutiny in how efficiently and effectively CBWs are managed in order to optimize this critical human resource for health.2 The USAID Human Resources for Health in 2030 (HRH2030) program, with PEPFAR support, conducted assessments in Kenya and South Africa between July and December 2018 to understand the composition, workload, and functions performed by the community-based health and social service workforce supporting HIV programs in South Africa and Kenya. The goal of the assessments was to identify opportunities for efficiency gains across CBW investments.



We present key findings and recommendations from these assessments to promote the need for regular analysis of the community-based HIV workforce in order to optimize investments to advance and sustain HIV epidemic control.

Approach

The assessments' specific objectives were to inventory CBWs in selected geographic areas in both countries, assess the workload, and identify sustainability factors and opportunities for strengthening linkages amongst CBW cadres supporting both health and social services. The HRH2030 team applied both qualitative and quantitative methods to the assessments. In Kenya 1,074 CBWs from 16 wards in Busia, Kakemega, Kilifi, and Nairobi counties participated in the survey. In addition, 78 workload assessments, 8 focus group discussions, and 36 key informant interviews were conducted. In South Africa, 353 CBWs from Ehlanzeni, Ekhurhuleni, eThekwini, and Johannesburg districts participated in the survey and 240 workload assessments, eight focus group discussions and 24 key information interviews were conducted. Figure 1, on the following page, shows the four data collection methods.

[1] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0219826

[2] https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-017-0219-y

Figure 1. Data Collection Methods

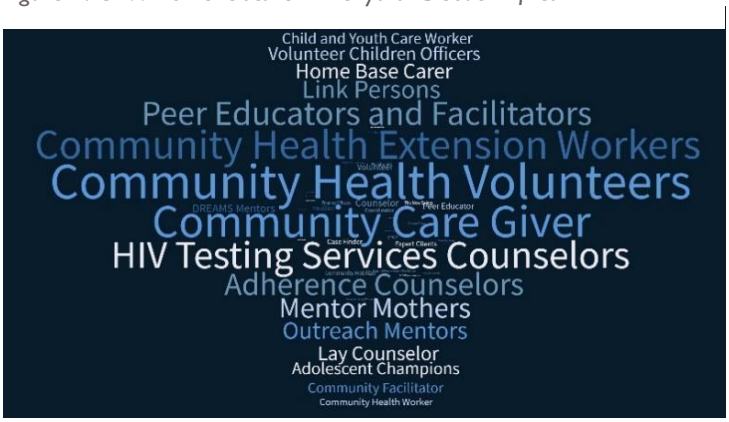
Community-based worker survey	• Included workload estimates and questions for a social network analysis • All CBWs (as enumerated by the IPs) were contacted by the IPs to set up a time for completion of the survey
Workload assessment	• Time and motion worksheet, which is a daily timesheet for recording the time spent on various services delivery tasks • Task analysis worksheet completed by an observer.
Focus group discussion (FGD) with CBWs	• How CBWs interact with the facility and communities that they serve • Challenges in carrying out their responsibilities; and recommendations for improvements
Key informant interviews	• Conducted with individuals representing the following groups: PEPFAR and Global Fund, local managers, implementing partners, and representatives of different CBW types

Lessons learned and priorities for future assessment to optimize CBWs

Examine roles across cadres and look for opportunities to streamline. There is a large diversity in types and roles of CBWs for HIV-related services (Figure 2). In South Africa, the assessment identified 32 different types of CBWs—many with overlapping roles and responsibilities—whereas in Kenya there were 12. The various types of CBWs in South Africa were largely driven by implementing partners who created the CBW naming conventions as well as their roles and responsibilities. There was substantial variation across geography regarding the types and numbers of CBWs engaged and their scopes of work, roles, and responsibilities, which links to challenges in harmonization and consolidation of this group as an efficient workforce. Ensuring that inventories are conducted across different CBW programs will help keep track of the number and kinds of CBWs working across a geographic area in order to help align CBW classifications for the HIV workforce, examine areas of role duplicity and overlap, and inform opportunities for greater efficiencies.

Look for opportunities to integrate workload and time standards as the basis of performance benchmarks. Time spent by CBW types carrying out their tasks was examined as part of the time and motion portion of both country assessments. CBWs reported that they worked two to 12 hours a day on client consultations, household visits, facility tasks, record keeping, travel time, and various meetings, with great variability. All cadres spent variable amounts of time in facilities and communities delivering services, but there were limited consistent patterns across geographies nor typology of CBWs in terms of how time was spent on various tasks. Additionally, across CBWs, the amount of time spent on record keeping represented a considerable proportion of CBW time across cadres – as much as 34 percent. As partners consider opportunities to improve efficiencies and/or increase requirements (e.g., reporting), factors related to workload and time distribution should be more closely considered. Workload standards can be used to set performance benchmarks. Regular, systematic CBW assessments that include time and motion studies can provide insights for better health workforce planning, performance management, and overall, more efficient use of CBW time and level of effort.

Figure 2. CBW nomenclature in Kenya and South Africa



Look at how training is building the capacity of CBWs to perform key HIV services. Across both countries assessed, different training standards and schedules existed not only within a specific type of CBW, but also across supporting organizations and geographies. CBWs in both countries reported training gaps in areas of service being supported, including ART monitoring and adherence. This highlights the need to close the gap between what CBWs are expected to do and their actual skills and capacity. The assessment findings emphasize the need to prioritize training based on critical skill gaps and ensure up-to-date tracking of training, so that the staff most in need of training are prioritized to receive it. It also identified the need to follow up with training cohorts to assess CBWs' level of skill and confidence in order to plan any needed capacity-building programs.

Increase attention to obtaining CBW feedback on support received to do their jobs. Evidence suggests that human resource management practices strengthen motivation and job satisfaction. Unfortunately, obtaining feedback from

CBWs on the support they receive to do their jobs is not routinely integrated into assessment of supervision or performance management of CBWs. This can provide greater insight into strengthening these processes and systems that are critical to advancing the role of CBWs.

Look for opportunities to strengthen coordination and linkages within and across CBW cadres. The assessments recognized that future CBW assessments should ideally include additional methods, such as systems mapping and social network analysis. To strengthen coordination and linkages within and across CBW cadres, program implementers, funders, and CBWs themselves need a better idea of how diverse community-based health and social service workers are, how they interact and interconnect with their communities, and how they relate to and exchange information with the formal health and social service systems. Systems mapping helps to visualize the locations and functions of community-based health and social service workers within community structures and the larger formalized health system at county, district, or lower levels. Social network analysis shows the complexities of community-based health and social service systems, and the dynamics of existing engagement and coordination across key community actors within the health and social service systems. The information from the use of these techniques will help to identify opportunities for stronger linkages between CBWs, their supervisors, partner staff, health facility providers, and members from the communities in which the CBW works.

Next Steps for Further Assessment of the CBW Workforce for HIV

The global COVID-19 pandemic has exacerbated HRH challenges across countries and emphasized the importance of having a well-prepared and adequate workforce to not only be able to respond to pandemic needs but also to maintain essential services including those for HIV. CBWs have been widely leveraged and utilized in the COVID response. As the CBW environment remains complex for most countries, prioritizing the collection and analysis of data on who these workers are, where they are working, and what they are doing is critical to advance recognition of and impact of their work and optimize investments in this workforce. Assessing the availability, roles, and performance of CBWs provides important insights into their contribution to achieving the 95-95-95 targets and where efficiencies in programs supporting CBWs could be gained. Additionally, assessment is important in order to identify the system requirements needed to be able to leverage CBWs even more rapidly and effectively for future pandemic responses.

Countries that have significantly invested in CBWs delivering community-based HIV services are encouraged to conduct assessments like the two highlighted here, and to also increase use of program data to further build awareness of CBWs' contributions and impact. Future assessments could also dive deeper into areas of specific service delivery such as index or self-testing or other areas of service that are increasingly being supported by CBWs. As the HIV service delivery landscape is changing, and as these changes are accelerating from innovations and adaptations due to the COVID-19 pandemic, there is a need to consider how CBWs fit within that landscape to meet HIV goals and sustain epidemic control.

HRH2030
HUMAN RESOURCES FOR HEALTH IN 2030

www.hrh2030program.org

This material is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of cooperative agreement no. AID-OAA-A-15-00046 (2015-2020). The contents are the responsibility of Chemonics International and do not necessarily reflect the views of USAID or the United States Government.

@HRH2030Program @HRH2030

251 18th Street, S Arlington, VA 22202 | Phone: (202) 955-3300 | Fax: (202) 955-3400 | Email: info@HRH2030Program.org