

APPENDIX E

Review of GFATM Round 6 and GAVI HSS Round 1 Policies and Practices for Funding Health Worker Remuneration

In recent years, the international community has committed to scaling up aid for health. Development assistance for health has risen steadily since 1990 from about US\$2 billion to more than US\$10 billion in 2003. Much of the post-2000 increase can be credited to an increasing number of global partnerships and a significant rise in private philanthropic funding. Partnerships and philanthropies have joined efforts to increase awareness and financing aimed at the eradication of major diseases. Global programs such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM); the Global Alliance for Vaccines and Immunization (GAVI); Roll Back Malaria; and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), as well as several others, represented roughly 15 percent of total health aid in 2002 and 20 percent in 2003 (Gottret and Schieber 2006). In theory, the large inflows of donor assistance for health could be used as an additional source of financing for the health wage bill, creating more fiscal space for hiring health workers.

In the area of human resources for health (HRH), donor assistance has traditionally focused on training activities rather than on funding

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additional hiring (that is, salaries of health workers). For example, a review of GFATM grants found that, in general, most countries do not sufficiently use the possibilities that the GFATM provides for health system strengthening and human resource interventions, even though a great majority of proposals recognize improving human resource constraints as key to the success of future interventions. Most proposals include some activities to address human resource constraints. The most frequent activity is training, focused mainly on short-term, in-service training. Support for preservice training and training institutions is rare, and hardly any long-term strategies are proposed to address the lack of adequately trained personnel. Recruitment plans are also frequently included, but in most cases they are limited to a small number of staff members at the program management level and do not address the shortages at the service delivery level (Dräger, Gedik, and Dal Poz 2006).

This appendix examines the policies and practices of two major donor agencies in the health sector: GFATM and GAVI. The following key questions are explored:

- What are the policies of each of the agencies regarding funding of health worker remuneration (that is, salaries, allowances, and per diems)?
- To what extent are countries using these two sources of financing to fund remuneration of health workers?
- What are some of the labor market implications associated with these practices?

The guidelines for funding applications for GFATM and GAVI Health Systems Strengthening (HSS) were reviewed. All GFATM Round 6 grant applications¹ and all GAVI HSS Round 1 approved grants were reviewed for their HRH content. Finally, the reports of the grant review committees in each agency were reviewed to identify the quality of the HRH activities in the proposals and whether they were consistent with those outlined in the guidelines. This work builds on that of Dräger, Gedik, and Dal Poz (2006), who were the first to examine human resource content in GFATM grants in a sample of African countries. The analysis extends their work by examining all GFATM Round 6 applications and GAVI HSS grants as well. The type of remuneration is also examined in much more detail (that is, salary payments for new positions that are fully funded, per diems, and salary top-ups for existing health workers) as are sustainability issues. Finally, the available evidence on the labor market effects is reviewed.

GFATM and GAVI Policies on Remuneration

GFATM and GAVI—the two agencies examined—have quite flexible policies toward funding health worker remuneration. However, a key condition is sustainability. Both agencies have increasingly recognized the importance of addressing health workforce issues to achieve results. The GFATM guidelines for Round 7 proposals say that HRH activities will be funded if a strong link between the proposed activities and health systems strengthening as well as the three target diseases can be demonstrated (GFATM 2007). It is also essential that the proposal outline the sustainability of the activities at the end of the proposal period. The guidelines clearly indicate remuneration is eligible but state that in cases where human resources are an important share of the budget, the proposal must explain (a) to what extent such spending will strengthen health systems' capacity at the patient or target population level and (b) how the salaries will be sustained after the proposal period is over (GFATM 2007).

In the proposals, GFATM requires that the proposed intervention be linked to long-term HRH development. GFATM also expects a clear human resource development plan, identification of gaps, a link between human resources and target disease coverage, a needs assessment, and integration with disease-specific national plans.

The GAVI guidelines highlight “health workforce mobilization, distribution and motivation targeted at those engaged in immunization, and other health services at the district level and below” (GAVI Alliance 2007: 5) as one of three major priority areas for funding. The guidelines state that “GAVI HSS support can be used for one-off expenditures that increase system capacity” (GAVI Alliance 2007: 7), such as pay for performance, contracting with nongovernmental organizations (NGOs), and training and technical support, as well as for recurrent expenditures such as fuel, maintenance, and per diems for outreach. Sustainability of these expenditures when GAVI HSS funds are no longer available must be demonstrated.

To get a sense of the extent to which countries are using GAVI HSS and GFATM grants to pay health workers, this research reviewed Round 1 GAVI HSS approved grants and Round 6 GFATM applications. The methods of remuneration were also reviewed.

Country Practices

The share of GAVI HSS and GFATM funding used for payments to staff members varies widely across countries. On average, countries

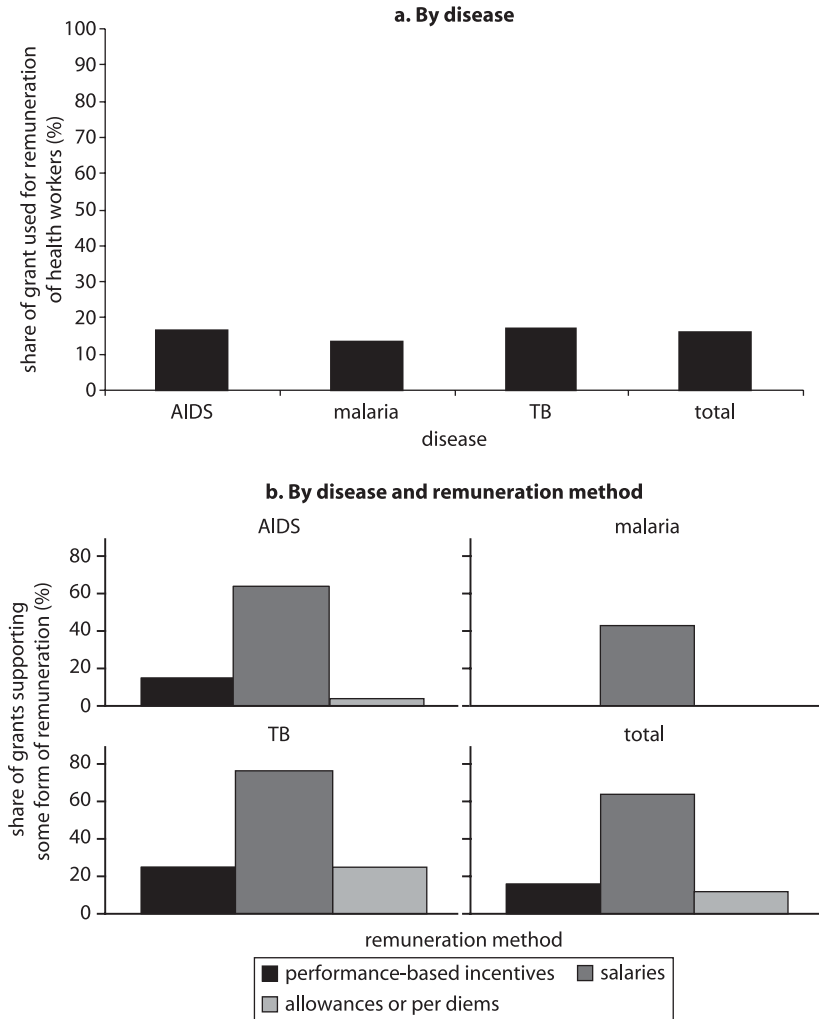
devote 12 percent of GAVI HSS and 16 percent of GFATM funds for paying health workers. However, this amount ranges from 0 to 28 percent (Kenya) within GAVI HSS and from 0 to 46 percent (Indonesia for malaria) within GFATM. Within GFATM, the share devoted to payments to staff members is quite consistent over the different disease priorities. Within GAVI HSS, part of the variation is because the size of the HRH component varies widely, and within the HRH component, the focus also varies (that is, among training, payments to staff members, and other activities). Clearly, some countries are quite aggressively using GAVI HSS funds for payments to health workers. In Burundi, the entire GAVI HSS grant is being used to pay staff members.

The method of remuneration for payments to staff members within GAVI HSS and GFATM grants is diverse. The most common form of remuneration within GFATM grants is salary payments. In only 20 percent of grants does one find any payment of allowances and per diems or performance-based incentives (figure E.1).² Within GAVI HSS, allowances and performance-based incentives are used much more extensively. For example, 100 percent of the Burundi grant is used for payments to staff members, and the entire amount is used to pay performance-based incentives to health workers. Salary payments are much less common (figure E.2).

A significant portion of payments to staff members in both GAVI HSS and GFATM grants are for frontline health workers. However, remuneration methods for these frontline health workers are different and suggest differences in the effect on the health workforce. More than 30 percent of GFATM grants have some share of their budget devoted to paying frontline health workers, and 36 percent pay administrative and managerial staff members. Five of the six GAVI HSS grants supported payments to frontline health workers. However, within GAVI, the remuneration payments to frontline health workers are mostly in the form of allowances, sometimes performance-based. Within GFATM, however, most of the remuneration to frontline health workers is in the form of salaries (figure E.3). This analysis suggests that GAVI HSS grants focus more on supplementing the income and improving the performance of the current health workforce, whereas the GFATM grants focus more on creating newly funded positions, thereby expanding the health workforce.

Depending on the aid modality, wage distortions can occur, resulting in unintended consequences regarding staffing. But good coordination can mitigate this outcome. When funding agencies pay salaries and allowances to health workers, such action can create large wage differences between

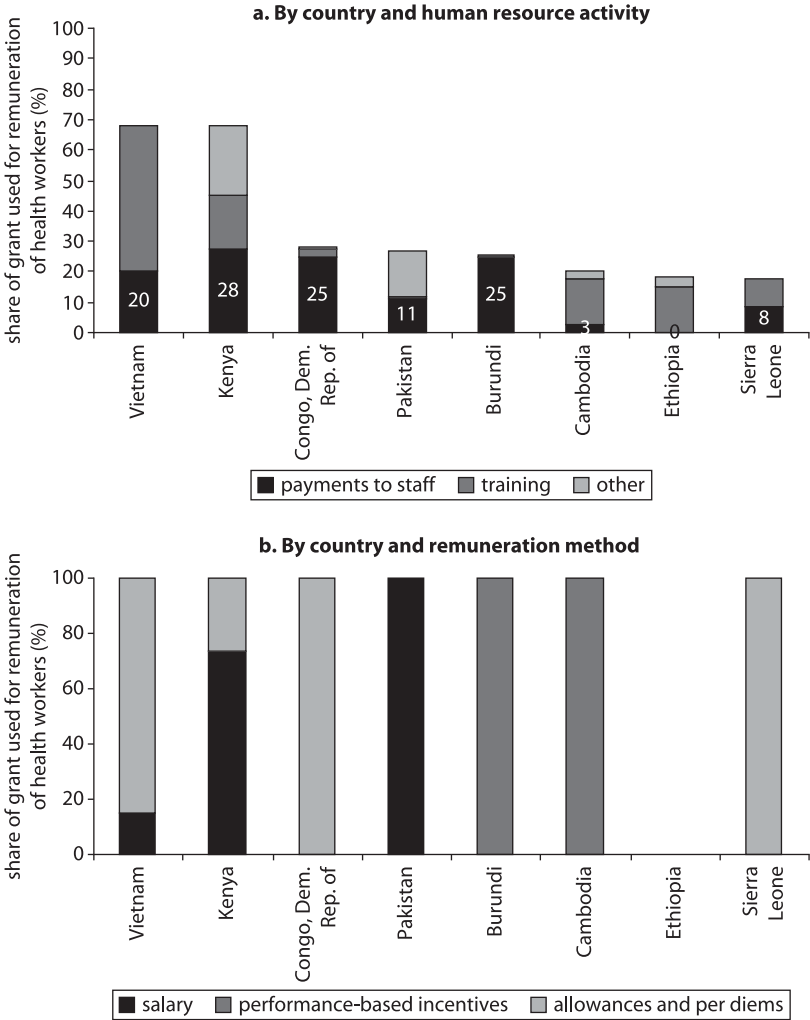
Figure E.1 Share of GFATM (Round 6) Grants Used for Remuneration of Health Workers



Source: Authors' analysis of GFATM Round 6 applications.

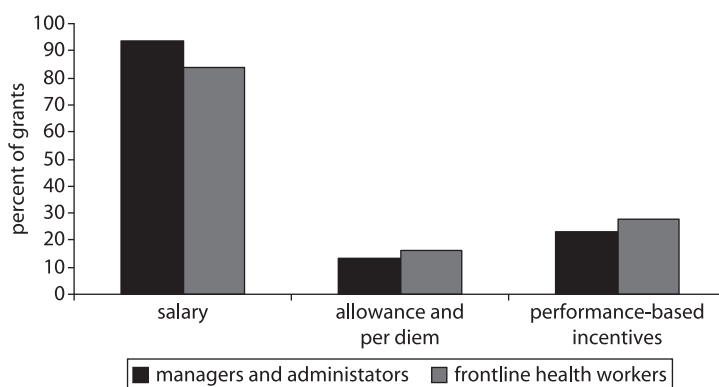
programs that are funded through external support and those that are not. Whether this outcome occurs depends crucially on whether funds are channeled through the government or, if they are not, on how closely the external funding agencies coordinate with the government. For example, if agencies agree to provide similar pay and benefits to health

Figure E.2 Share of GAVI HSS (Round 1) Grants Used for Remuneration of Health Workers



Source: Authors' analysis of GFATM Round 6 applications.

workers as those in the public sector, then wage distortions will be minimized. In fact, both GAVI HSS and GFATM, which are both highly coordinated with the government, are well positioned to avoid these distortions. Agencies such as PEPFAR, which primarily funds NGOs, are more likely to promote wage distortions. Recent experience in Kenya

Figure E.3 Method of Payments to Managerial and Frontline Staff Members within GFATM (Round 6) Grants

Source: Authors' analysis of GFATM Round 6 applications.

shows that when donors support hiring through pooled funds, use existing pay scales within the public sector, and agree not to recruit staff from certain agencies, the negative wage distortions are avoided (box E.1).

Some emerging evidence indicates wage distortions in some countries. However, further work is needed in this area. In Ethiopia, for example, a review of the GFATM experience suggested that jobs in HIV-related services became more attractive after GFATM resources became available (Banteyerga, Kidanu, and Stillman 2006). In Benin, evidence indicates that facilities supported through GFATM grants followed the government pay scale and had just as much trouble attracting staff as government facilities. Very little labor movement out of government facilities occurred (Smith and others 2005). A recent analysis of wages in several countries found that government salaries did not match those in the donor and nongovernmental sectors. For example, a driver for a bilateral agency in Addis Ababa was paid more than a professor in the medical faculty, and a government public health specialist could earn four to five times more by joining an international nongovernmental organization (McCoy and others 2008).

Key Considerations in Using GFATM and GAVI Funds for Remuneration

Donor funding of salaries can create contingent liabilities for the government's budget. If donor funds flow through the government budget and are used to hire health workers on permanent contracts, then when the

Box E.1**Examples of Countries Using GFATM Grants to Pay Health Workers****Ukraine AIDS**

Human resource costs represent 38 percent of the overall grant budget. These costs mainly support salaries and incentives for multidisciplinary teams performing prevention outreach (social workers, coordinators, psychologists, physicians, and nurses); for antiretroviral therapy and sexually transmitted infection programs (physicians and specialists); and for care and support programs (narcologists, infectionists, physicians, nurses, social workers, and counselors). The proposal will also engage personnel for overall project management (project directors, accountants, and office managers) and for local coordination and capacity building (municipal HIV/AIDS coordinators). The majority of these personnel will be engaged through NGOs, which will be responsible for fund-raising or securing funding from local governments for continuation of activities beyond the grant period.

China AIDS

Human resource costs represent 36 percent of the overall grant budget. These funds are mainly for paying health workers doing outreach, peer education, and counseling within grassroots NGOs. The grant has identified that sustainability for NGO projects and staff members is difficult to resolve. (No information is provided on how this issue will be addressed.)

Vietnam AIDS

Human resource costs represent 18 percent of the overall grant budget. Incentives to supplement government salaries will be provided for 202 staff members at the provincial level, 781 staff members at the district level, 784 mass organization volunteers and health care collaborators at the commune level, and 468 people living with HIV/AIDS collaborators. In addition, the grant will cover salary costs for 15 staff members working in the project management unit. (No indication is made whether the salary supplements will continue after the grant expires.)

Kenya TB

Human resource costs represent 28 percent of the overall grant budget. Most of the resources will be used to hire lab technologists, nurses, and clinical officers to

strengthen diagnosis and treatment of tuberculosis (TB) patients at the peripheral health facilities. Though the amount request to pay the staff is for five years only, the government of Kenya is expected to absorb these health workers after Round 6 funding runs out.

India TB

Human resource costs represent 27 percent of the overall grant budget. Additional human resources in the states are limited and cannot adequately undertake supervision, monitoring, and quality assurance activities. The program strengthens the states' capacity by funding recruitment of technical supervisory staff members on a contractual basis at the state, district, and subdistrict levels.

Lesotho TB

Human resource costs represent 25 percent of the overall grant budget. Resources will be used to develop a human resource development plan, including preventive measures to decrease staff turnover. Teams will be recruited to carry out activities at the district level as part of district health teams. Staff members will be paid monthly salaries, and the Ministry of Health will absorb the salaries after five years.

Source: Authors' analysis of GFATM Round 6 applications.

donor funding expires, the government will assume a financial obligation for remuneration payments. If, however, health workers are hired on short-term contracts, the government has more flexibility in adjusting staffing levels in response to donor aid flows because donor aid for health is volatile, unpredictable, and short term (for example, GFATM grants are for a period of at most five years). Short-term contracts are not extensively used in the public sector. Thus, the current donor aid architecture and the contracting arrangements within the public sector pose a challenge in not creating contingent liabilities for the government.

Some emerging practices are promising. In Kenya, resources from several donors were pooled and used to expand hiring of health workers through the Emergency Hiring Program. Health workers were recruited and paid according to the government pay scale, but they were hired on three-year contracts to match the term of the donor support. In Malawi, an initiative led by the U.K. Department for International Development provided significant resources to the government to increase salaries of health workers.

The resources were provided through direct budget support and for a period of six years—much longer than traditional commitments.

Within GFATM and GAVI HSS, sustainability issues surrounding payment of salaries and allowances to frontline health workers are not adequately addressed. Sustainability issues can be dealt with in several ways. Health workers who are paid salaries can be hired on short-term contracts. Allowances can be paid only during the time of the grants. The government can also commit to take over payment of salaries of newly hired staff members or pay allowances after grant funding runs out. The analysis of Round 6 applications shows that when GFATM resources are used to pay either salary or allowances to frontline health workers, in 56 percent of cases there is an assumption that the government will absorb the salary and allowance payments at the end of the grant period, but the government makes no explicit agreement to do so.³ In no cases has the government made a formal pledge to set aside the necessary budget resources, and in only 9 percent of cases are short-term contracts matching the term of the grant used exclusively. Within GAVI, the issue of sustainability is not dealt with adequately either (Health System Strengthening Independent Review Committee 2007).

Sustainability, the likely success of the intervention, and links to an overall national HRH strategy are some of the main reasons more GAVI and GFATM funding is not used to pay health workers. Within GAVI HSS proposals, one of the main issues identified was the sustainability of staff incomes—either in the cases where staff members will be hired into a separate project management unit or where incomes of frontline health workers are being topped up in various ways (Health System Strengthening Independent Review Committee 2007). The report of the Technical Review Panel for Round 6 of GFATM found that the overall quality of the HRH interventions is poor (GFATM 2006). The panel did not see that they were based on a clear government strategy for overall human resources for health. Sustainability is very important. Funds are for three to five years, but whether the hiring is short term or long term is not clear. The panel suggested the following points be taken into account in guiding future proposals for the funding of remuneration: proposals for salary support and premiums within the public sector and NGOs (a) should take into account the overall human resource policy of the relevant institutions, (b) should use existing salary scales, (c) should minimize negative impact on other aspects of the health care system, and (d) should plan to shift the

salary costs to the national budget and provide a clear timetable for doing so. There is also a need to better demonstrate clear benefits to treatment of diseases of GFATM and for immunization in case of GAVI.

Notes

1. At the time the data were collected, it was not possible to know which applications had been approved. The analysis did not look into differences in human resources for health content between approved and rejected applications in both GFATM and GAVI HSS.
2. The breakdown of the budget by salary, per diem, allowances, and the like is not available in GFATM applications, but by reviewing the description of activities funded, one can determine whether salaries, allowances, or performance-based incentives are paid.
3. Given the emphasis on sustainability in the GFATM guidelines, this figure is likely to be much higher among approved applications. All applications were examined for the analysis in this report.

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