HIV/TB counselling: Who is doing the job?

Time for recognition of lay counsellors

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Abbreviations

ANC	Antenatal care
APE	Agentes Polivalentes Elementares (Elementary trained polyvalent agents)
ARV	Antiretroviral (medication)
ART	Antiretroviral therapy
CAG	Community ART Group
CBO	Community-Based Organisation
CHA	Community Health Assistant
CHAI	Clinton Health Access Initiative
CHWs	Community Health Workers
EGPAF	Elizabeth Glaser paediatricAIDS Foundation
EHRP	Emergency Human Resources Plan
FHI	Family Health International
GFATM	Global Fund to Fight AIDS, TB and Malaria
GHI	Global Health Initiative
GHWA	Global Health Workforce Alliance
HRH	Human Resources for Health
HSA	Health Surveillance Assistant
HTC	HIV Testing and Counselling
HTCC	HTC counsellors
ICAP	International Center for AIDS Care and Treatment Programmes
IMF	International Monetary Fund
LC	Lay Counsellor
MDR-TB	Multidrug-Resistant Tuberculosis
MoF	Ministry of Finance
MoH	Ministry of Health
MoHCC	Ministry of Health and Child Care
MSF	Médecins Sans Frontières/Doctors Without Borders
NRL	National Reference Laboratory
NGO	Non-Governmental Organisation
NSP	National Strategic Plan
PEPFAR	President's Emergency Plan for AIDS Relief
PITC	Provider-initiated HIV testing and counselling
PLHIV	People living with HIV
PMTCT	Preventing mother-to-child transmission
PSC	Psycho-Social Counsellor
STI	Sexual transmitted infections
TB	Tuberculosis
VCT	Voluntary Counselling and Testing
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organisation

Definition of key terms

Community Health Worker	A health worker who is a member of the community where they work and is selected by the community. They have received standardised and nationally endorsed training outside of the nursing, midwifery or medical curricula and are supported by the health system but not necessarily part of its organisation [WHO 2007c, WHO 2013].
HIV counselling	A confidential dialogue between a client and a counsellor aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS [UNAIDS 1997].
Lay Cadre	Any health worker who performs functions related to health care delivery; trained in the context of the intervention, and having no formal professional or para-professional certificate or degree in tertiary education [Lewin 2010].
Lay Counsellor	A type of lay cadre involved in patient counselling and education tasks for HIV/TB, mostly performed at the health facility.
Patient Education	Education to help patients and their families understand the disease and the treatment, cooperate with health care providers, live healthily, and maintain or improve their quality of life [WHO 1998].
Peer Support	People with lived experience of a condition or illness (such as HIV/AIDS), who are generally not trained health workers, but empowered to provide specific services related to the care and support to others with the same condition [WHO 2007a].
Task shifting	A process whereby specific tasks are moved, where appropriate, to health workers with shorter training and fewer qualifications [WHO 2007a].

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Key recommendations

- Include standards for patient education and counselling in national HIV/TB guidelines.
- Define which staff are responsible for performing different counselling tasks, including HIV testing and counselling and adherence counselling at both health centre and community level and consider lay counsellors in performing these tasks in high disease burden settings or in settings that do not allow these tasks to be performed by existing cadres.
- Ensure a standardised job profile, training and supervision for lay counsellors, as well as adequate numbers of lay counsellors to perform counselling tasks.
- Align remuneration for lay counsellors with national standards.
- Develop a long-term strategy for human resources for health that specifically include counselling services, with donor support for planning, integration and financing whilst maintaining support for an interim solution.
- Upgrade and/or integrate lay counsellor positions within the national human resources for health establishment or establish other sustainable financing and contracting options, including through implementing partners.
- Ensure sufficient fiscal space, in particular for countries with high HIV burden, through dialogue with Ministries of Finance, donors and international financial institutions.

1. Executive summary

In settings with a high HIV/TB burden and significant shortages of human resources for health (HRH), task shifting strategies have relied on lay workers to provide HIV testing and counselling (HTC) and adherence support for HIV and TB treatments. While in some countries these tasks were integrated into the work of existing community cadres such as community health workers, new basic cadres have been created and trained in other countries, supported mainly through international funds. Agreements made with donors have mostly been to provide temporary support until a long-term solution was found. Unfortunately, there are few examples where Ministries of Health have been able to absorb lay counsellors into their health system or otherwise sustain their work.

In this report we aim to document the role of lay counsellors in HTC and adherence support and assess bottlenecks related to operationalisation and sustained support in selected countries. We compare the experiences around lay counsellors providing HIV/TB care in a convenience sample of eight countries across sub-Saharan Africa: Guinea, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Zambia, and Zimbabwe. Sources of information include literature reviews; review of national policies; annual reviews of health sectors in different countries; donor proposals; and key informant interviews with government staff and partners around harmonisation of approaches (including job profiles, training, supervision and entry criteria), inclusion in national strategies, and financing of lay counsellors.

This review finds that lay counsellors have played a critical role in scaling up HIV and TB services. In most countries, however, the work of lay counsellors is done in the absence of a supportive policy framework and is inadequately addressed by national HRH strategic plans. Countries have taken several steps in recognising lay counsellors and harmonising approaches to training, job descriptions and support, but formal integration of this cadre into national health care systems is limited. The current trend of reduced donor support for recurrent costs related to HIV programmes, such as salaries of lay counsellors, combined with lack of national prioritisation, threaten the sustainability of this cadre and the important support they provide to HIV and TB service delivery. Counselling services are critical to many of the recommendations put forward in the 2013 WHO Consolidated Guidelines on the use of ARV drugs, including viral load monitoring and early initiation of antiretroviral therapy (ART), and are also key to reaching the ambitious targets put forward by UNAIDS in 2014 (also known as '90-90-90'). This report aims to highlight certain trends, obstacles and solutions that can contribute towards recognition of and sustained counselling support in HIV/TB programmes.

Raul Mwandibozar from Changara, Tete province, Mozambique has been living with HIV since 2008. "I like my counsellor because he is giving professional advice to be adherent to my treatment and help to plan our treatment"

PART I Summary of findings

INTRODUCTION

The HIV/TB response in Sub-Saharan Africa

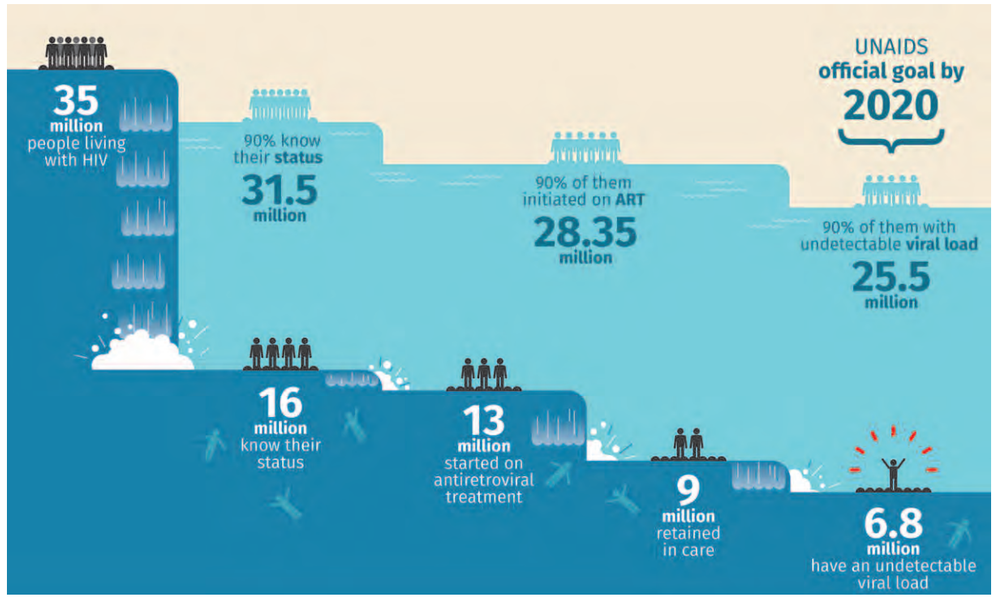
Today an estimated 35 million people are living with HIV (PLHIV). The scale-up of antiretroviral therapy (ART) has been tremendous in most countries, with nearly 13 million people on treatment by the end of 2013 [UNAIDS 2014a]. Despite the rapid increase of HIV testing, 19 million of the estimated 35 million PLHIV still do not know their status [UNAIDS 2014a]. Tuberculosis (TB) continues to be the main cause of death among PLHIV and evidence shows these two diseases are best tackled together in an integrated manner [UNAIDS 2014a, WHO 2013]. Countries have continued to adjust their HIV and TB targets in line with international commitments; for example, the 2011 United Nations General Assembly Political Declaration on HIV/AIDS aims to have 15 million on ART and reduce TB deaths by 50% by 2015 [UN General Assembly 2011]. The latest UNAIDS targets of '90-90-90' aim for 90% of PLHIV to know their HIV status, 90% of those diagnosed with HIV to be on ART and 90% of those on ART to achieve viral suppression by 2020 [UNAIDS 2014b].

To maximise the individual and population-level benefits of HIV treatment, it is essential that people are tested, those eligible for treatment are initiated on ART, and those on ART are retained in care and achieve sustained virological suppression. However, recent systematic reviews highlight substantial attrition rates in HIV services, as illustrated in figure 1. Over half (55%) of PLHIV in the world do not know their HIV status [UNAIDS 2014a] and only 41% of those diagnosed with HIV are linked to care. Another 45% to 56% are lost to follow-up before they are initiated on HIV treatment [Rosen & Fox 2011]. After being initiated on ART, almost a quarter of people (23%) interrupt treatment [Kranzer & Ford 2011] and a mortality rate of 39% has been reported in public ART programmes in sub-Saharan Africa among those lost to follow-up [Wilkinson 2015]. Another cascade shows similar challenges around TB and ART treatments for those co-infected with HIV and TB [Havlir 2013].

Interventions addressing the gaps in the HIV cascade

The quantification of losses in the HIV/TB treatment cascade have prompted programmes and health systems to identify effective strategies to address these gaps. Longer durations between antiretroviral drug refills, spacing of clinical visits, task shifting to lower cadres of health care workers, and decentralisation and integration of HIV and other services are a few examples of effective strategies to alleviate some of the health system barriers to access and improve retention in care [Govindasamy 2014].

Figure 1. ***Losses to follow-up in the HIV treatment cascade***



Other strategies such as patient education, counselling and peer support have also been shown to be successful in increasing access and retention in care, as well as adherence to treatment:

INCREASING TESTING: Increasing and strengthening entry points for HIV testing through the scale-up of provider-initiated HIV testing and counselling (PITC) and community-based testing strategies is effective in increasing the number of people who are aware of their HIV status. For example, community-based HIV testing and counselling (HTC) can achieve high rates of HTC uptake, reaching people with higher CD4 counts, and linking them to care [Suthar 2013].

IMPROVING ADHERENCE: Peer support and counselling following an HIV test and during the ART initiation process are recognised as important strategies to improve linkage and retention in care in the pre-ART phase [Govindasamy 2014]. Several systematic reviews indicate that counselling, treatment education and peer supporters improve adherence [Bärnighausen 2011, Thompson 2012, Chaiyachati 2014].

IMPROVING RETENTION: Experience from several countries in southern Africa shows that community-supported strategies for ART delivery improve retention in care for stable patients on ART [Bemelmans 2014a, Fatti 2012].

Global HIV targets have evolved from numbers of people on treatment to estimating the number of people receiving care along the cascade from testing to virological suppression. Patient education and counselling strategies will be critical to achieving the new ambitious 90:90:90 targets.

Who can perform patient education and counselling? The case for lay counsellor programmes

In sub-Saharan Africa, the centre of the HIV and TB epidemic, there remains a critical shortage of health workers and a large disparity in human resource distribution between rural and urban locations (Table 1) [WHO 2006 and WHO Global Health Observatory Data 2014].

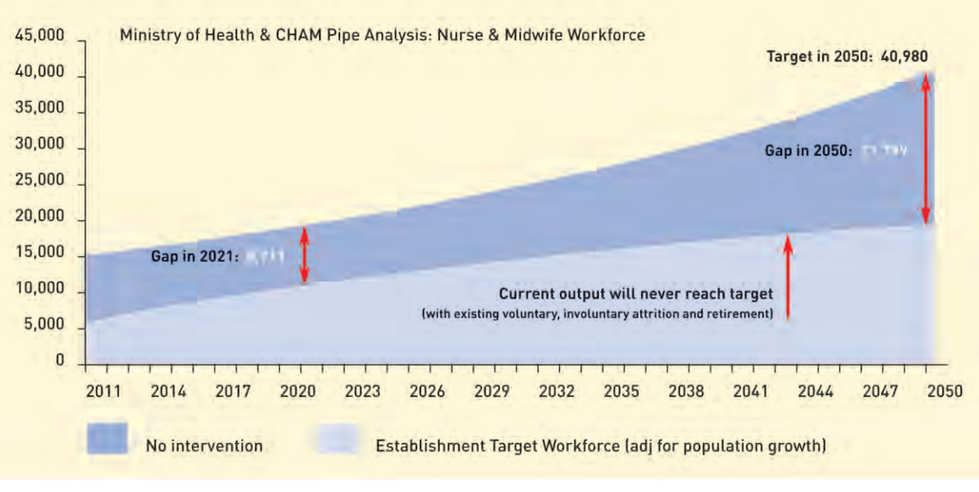
Table 1. ***Health staffing levels in selected countries*** *[website WHO Global Health Observatory Data 2014]*

Countries	Physicians / 100,000	Nurses / midwifes / 100,000	Health workers/ 100,000
Malawi (2009)	2	36	38
Mozambique (2012)	5	25	30
Lesotho (2003)	5	56	61
Zambia (2010)	7	78	85
Zimbabwe (2009)	6	125	131
Swaziland (2009)	17	160	177
South Africa (2013)	77	408	485
UK (2012)	279	883	1162
WHO minimum threshold*			230

* *WHO has defined a minimum accepted density threshold of 230 health workers (physicians, nurses, midwives) per 100,000 population, below which coverage of essential health interventions is deemed highly unlikely [WHO 2012b].*

There have been a number of initiatives to increase the health workforce over the past decade; however progress is slow. Figure 2 shows a projection of availability of nurses through to 2050 in Malawi, and the projected gap between numbers and need [MoH Malawi 2011].

Figure 2. ***Projected gap in availability of Nurses & Midwifes in Malawi*** *[MoH Malawi 2011]*



Task shifting to trained community health workers (CHWs), including lay providers such as lay and peer counsellors, has been recognised as one strategy to overcome staff shortages in high HIV burden contexts [WHO 2007a]. Due to the shorter duration of training and lower remuneration in comparison with professional health workers, the numbers of lay counsellors can be increased relatively rapidly at lower cost.

Community health workers in the context of HIV perform a wide range of tasks, including patient support such as counselling and patient education, home-based care and health service support such as screening, referral, drug refills and health service organisation [Mwai 2013].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Young girl from an HIV support group, Bulawayo, Zimbabwe.

Community health workers have been well recognised for their contribution in the uptake of HIV and TB services, contributing to shorter waiting times and lessening the burden on the health system by reducing the workload of professional staff [Mwai 2013, Ledikwe 2013, 10 Hermann 2009, Cohen 2009, Bemelmans 2010, Jaffar 2009, Kipp 2010, Torpey 2008, Topp 2011, Chandisarewa 2007].

In the context of this report we focus on lay counsellors, who are involved in patient counselling and education tasks for HIV/TB traditionally performed at the health facility level. Counselling tasks can be divided into a number of sub-activities:

- HIV testing and counselling (HTC) (including couples counselling)
- Linkages from diagnosis to HIV care & treatment
- Adherence counselling and patient education for:
  - Initiation and continued adherence support for patients on ART
  - Patients on medication for treatment of drug-sensitive TB and multi- drug resistant (MDR) TB, TB prevention (e.g. isoniazid preventive therapy) and contact tracing
  - Other common medication for prophylaxis (e.g. cotrimoxazole) and treatment (eg for noncommunicable diseases)
  - Pregnant and breastfeeding women
- Prevention through facility-based health education
- Paediatric and adolescent disclosure counselling
- Facilitation of community-supported models of ART delivery
- Support for monitoring and evaluation

Lay counsellors have been increasingly recognised as an enabling factor in the response to the HIV and TB epidemic, and have been recommended by WHO and others to support HTC, adherence support and the support of community-based ART delivery [WHO 2013, WHO 2014, WHO 2007b, Rasschaert 2014, Bemelmans 2014a].

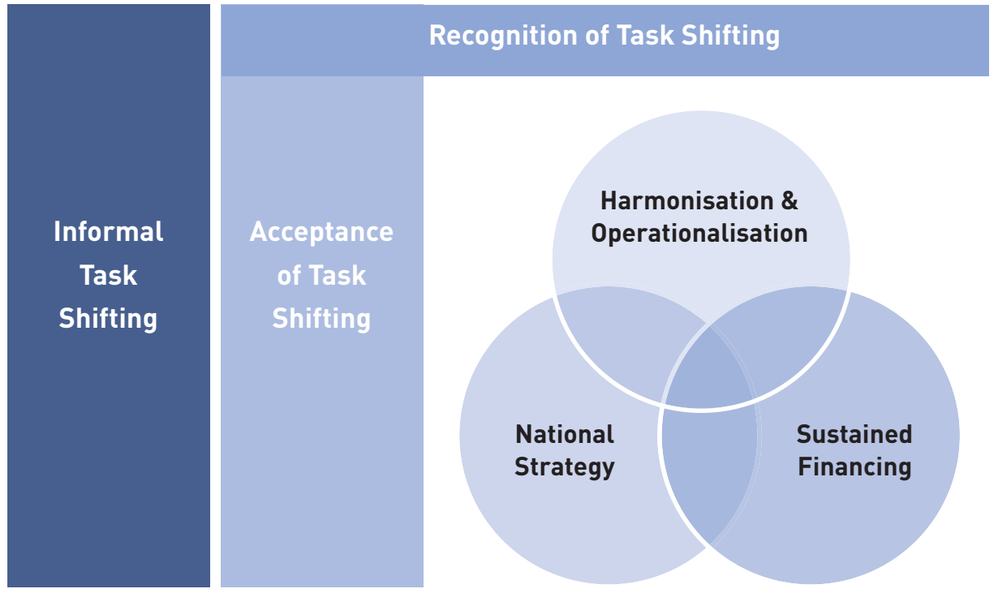
Optimising the role of lay counsellors and sustained support

Although there is widespread use of lay counsellors in HIV programmes, there is often a lack of recognition and financial, supervisory and training support of these cadres [Mwai 2013, Malema 2005, Dewing 2014, Bemelmans 2014a], despite regular calls by World Health Organisation (WHO) for support in these areas [WHO 2013, WHO 2007a, WHO 2012a]. A review of six HIV programmes using lay counsellors in Ethiopia, Malawi and Uganda showed that insufficient supervision and training may negatively impact on the quality of HIV programmes; the review concluded that a clear regulatory framework with remuneration and career prospects for lay workers was needed [Hermann 2009]. Other studies in Ethiopia, South Africa and Swaziland have similarly highlighted the fact that quality of care depends on the adequate training and supervision of lay health workers [Humphreys 2010, Assefa 2012, Bedelu 2007, Fairall 2012, Petersen 2014].

These challenges are not specific to HIV programmes: similar concerns around fragmentation of approaches, inconsistent support and non-integration of CHWs within the health system have been cited for other health programmes [Tulenko 2013]. Recently there has been an increased focus on CHW programmes resulting in a joint statement led by the Global Health Workforce Alliance (GHWA), with national governments and health development partners committing to harmonise approaches around CHW support, and align with country strategies [GHWA 2013]. A framework to operationalise this commitment was developed around three pillars: one national strategy, one authority to direct and coordinate and one monitoring and accountability structure [Mogedal 2013].

A number of countries in sub-Saharan Africa have taken steps towards recognition of lay counsellors, according to one or more elements of the support framework outlined in figure 3.

Figure 3. ***Road to recognition of lay counsellors***



In some settings, due to a shortage of professional health staff, informal task shifting of counselling has occurred in health facilities, without it being clearly supported by MoH or Non-Governmental Organisations (NGOs) [Cailhol 2013]. In other settings, task shifting of HIV Testing and Counselling (HTC) and adherence counselling is accepted and is in some cases a clear strategy embedded in a pilot programme supported by NGOs, while not being formally endorsed or coordinated by MoH. Based on country experiences as well as review of the literature [GHWA 2013, Mogedal 2013], three components were identified as necessary to realise formal recognition of lay counsellors.

1. National harmonisation of job profiles, training, education entry criteria, remuneration, supervision, plus operationalisation of these.
2. Inclusion of lay counsellors in national HIV/TB programmes and national human resource for health plans and/or a specific task shifting policy framework and programmatic guidance, plus operationalisation of these.
3. Sustained financing through domestic or international resources.

This report presents an assessment in eight sub-Saharan Africa countries of the role and status of lay counsellors. The selection of countries was based on predominantly high HIV/TB burden countries where Médecins Sans Frontières/Doctors Without Borders (MSF) provides support to national HIV/AIDS programmes. The report focuses on provision of HIV/AIDS services, but many of the findings can be applied to provision of TB and other health services as well.

Information was collected through a review of literature, including policy documents, national guidelines and publications in peer-reviewed journals together with interviews with representatives of Ministries of Health, Finance and Public Service, UNAIDS, WHO, donors such as PEPFAR and GFATM and implementing partners.

The first part of this report will summarise findings of progress in countries around these three components, while the second part will present detailed case studies from individual countries.

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HIV/TB co-infected patient at Ignace Deen National Hospital, Conakry, Guinea.

SUMMARY OF COUNTRY STUDIES

Table 2. ***General Country Profiles***

		Guinea	Malawi	Mozambique	Lesotho	South Africa	Swaziland	Zambia	Zimbabwe
General	Population (million) [1]	10.5	15.9	24.5	2.2	50.7	1.2	13.9	13
	GDP per capita (ppp/USD) [1]	990	226	861	1504	9678	5349	1423	424
	Human Development Index [1]	178	170	185	158	121	141	163	172
	Government resources allocated to health (% of total) [2]	7%	18%	9%	14%	13%	18%	16%	10%
	% of health budget coming from donors [2] (% of total)	90%	78%	57.8%	70%	2%	22%	68%	70%
HRH	Human Resources for Health (#doctors / nurses / midwives per 100,000 population) [3]	10 Dr 51 N&M (2005)	2 Dr 36.8 N&M (2009)	5 Dr 25 N&M (2012)	5 Dr 56 N&M (2012)	77 Dr 408 N&M (2013)	17 Dr 160 N&M (2009)	7 Dr 78 N&M (2010)	6 Dr 125 N&M (2009)
HIV/AIDS	HIV adult prevalence Number of PLWH (million) [4]	1.7% 0.13	10.3% 1.1	10.8% 1.6	22.9% 0.36	19.1% 6.3	27.4% 0.2	12.5% 1.1	15% 1.3
	ART coverage (2013) [4]	24%	51%	33%	29%	42%	49%	55%	51%
	Retention at 12 months (adults +children) [5]	72%	79%	74%	72%	80%	89%	80%	85%
	Population (aged 15-49) that received HIV test in the past 12 months [5]	1.1% (F) 2.7% (M)	31.3% (M)	25.9% (F) 14.2% (M)	42% (F) 24% (M)	45% (M/F)	21.9% (F) 8.9% (M)	18.5% (F) 11.7% (M)	33.6% (F) 20.5% (M)

* Country-specific references can be found in the individual country-based studies (part II)

1 UNDP 2013
2 WHO Global Health Expenditure Database 2014
3 WHO Global Health Observatory Data 2014
4 UNAIDS 2014a

GDP: Gross domestic product
PPP: Purchasing power parity
USD: United States dollar
M: Male
F: Female

Dr: Doctor
N&M: Nurse and midwife
PLHIV: People living with HIV

Table 3. ***Current strategies HIV/TB counselling – Harmonisation & Organisation***

Harmonisation and Organisation	Guinea	Malawi	Mozambique	Lesotho	South Africa	Swaziland	Zambia	Zimbabwe
Job title	Conseiller / Médiateur (counsellor or mediator)	Health Surveillance Assistant (HSA)	Lay Counsellor	Lay Counsellor	Lay Counsellor	HTC Counsellor (2 levels)	Psycho-Social Counsellor (PSC)	Primary Counsellor
Job Profile (JP) + Tasks	Not harmonised	Agreed JP with generalised tasks: related to PHC tasks	Agreed JP but not implemented and highly variable, depending on supporting partner.	Agreed JP HIV specialised	JP varies by province, HIV/TB	JP agreed by SNAP, HIV specialised	Agreed JP, HIV specialised	Agreed JP, HIV specialised
HTC		Yes	Yes	Yes	Yes	Yes	Yes	Yes
Adherence counselling		No	Yes	Yes	Yes	Yes	Yes	Yes
Health education		Yes	Yes	Yes	Yes	Yes	Yes	Yes
Paediatric Disclosure counseling		No	Yes	Yes	Yes	Yes	No	Yes
Facilitation of community supported models of ART delivery		No	Yes	No	No	No	No	No / in progress
Other PHC tasks		Yes	No	Yes	Yes – admin, data filing	Yes – filing, prepacking drugs	No	No
Numbers	unknown	Target 1/1,000 population but 10,073 available = 0.63/1,000	Target is 1,893 countrywide but only ~500 currently present = 0,02/1,000	Target 2-3 per health centre but number reduced from 487 to 165 due to lack of funding. Now 540 (= 0.25/1,000) proposed to GFATM	72,000 CHWs, including lay counsellors, countrywide = 1.4/1,000	~455 available	2-3 per HC	1 per HC
Training	No standardised training	12 weeks basic + 3 weeks HTC ~96% trained	HTC + adherence: 2 months agreed modules but in reality great variety depending on supporting partner	2 weeks	10 days HTC + additional modules	2 weeks classroom, 6 weeks practical	8 weeks	6 months (including 3 weeks classroom) recently increased to 9 months
Pre-education criteria	No fixed criteria	High school Most below this level	10th grade Most below this level	Secondary school. Most LC below this level	High school	High school	High school	Secondary school
Work location of lay counselors	Facility and community	Community originally but part-time facility based	Facility	Facility	Facility	Facility	Facility	Facility
Supervision	No fixed supervision	Senior HSA Nurse/Clinician in-charge	Nurse, Psychologist or professional counsellor	Nurse/clinician in-charge or Senior counsellor	Counsellor Supervisor and/or nurse/ clinician-in-charge	Medical in-charge and National Expert Client coordinator	Nurse/ clinician in-charge, professional counsellors	Nurse-in-charge
Professional body	None	None	None	None	None	None	Zambia counseling council	None

CHW: Community Health Worker
GFATM: Global Fund to fight AIDS, TB and Malaria
HC: Health Centre
JP: Job Profile
LC: Lay Counsellor
PHC: Primary Health Care
PSC: Psycho-Social Counsellor
SNAP: Swaziland National AIDS Programme

Table 4. ***Financing and National Strategy***

Financing and National Strategy	Guinea	Malawi	Mozambique	Lesotho	South Africa	Swaziland	Zambia	Zimbabwe
Remuneration (USD per month)	340 - 375	115 by government	117 MoH proposed 40 - 250 depending on supporting partner	70 MoH defined	90 - 335 Varies per province	360 - 550 Varies per partner	500. Varies per partner (100-300)	220
Staff establishment	Not absorbed	4,000 not yet absorbed majority government funded	Not absorbed – wage bill and administrative issues	Not absorbed – wage bill and administrative issues	Majority not absorbed – to avoid paying minimal civil servant package	Not absorbed	Absorbed but limited in number (800-1,000 out of 40,000 trained)	Not absorbed
Financing	100% partner	95% government	majority partner, some at local/ district contracts	100% donor/ partner	Most provincial budgets with some donor funds	100% donor/ partner	800-1000 paid by GoZ, remaining by partner/donor	100% donor (mainly GFATM)
Strategy								
Norms on patient education and counselling	HTC guidelines (2009) None on adherence support	Malawi HIV Testing and Counselling guidelines. Adherence counselling mentioned in HIV/ ART guideline	National strategy on psychosocial support and positive prevention (2014)	Unknown	HTC Guideline 2010 National adherence guidelines for HIV, TB and NCDs (in draft)	National Guidelines on the comprehensive HIV package of care for adults and adolescents in Swaziland (2010)	National HIV Counselling/ testing guidelines	Operational and service delivery manual for HIV care in Zimbabwe
Inclusion of counsellors in national strategic plans	None	Draft national guidelines on HSA's	Mozambique National acceleration plan 2013-2015	No, but mentioned in Annual Joint Reviews of Health Sector	National Strategic Plan	Task shifting Framework	No	Zimbabwe HIV Care and Treatment Strategic Plan 2013 – 2017
HRH plans on counsellors	None	None	None	None	PHC Re-Engineering Framework	None	None	None

GoZ: Government of Zambia
NCD: Non-Communicable Diseases
SNAP: Swaziland National AIDS Programme

DISCUSSION

Harmonisation, coordination and progress in implementation

In Guinea, task shifting for adherence counselling to nurse aids or volunteers that have received a training is applied by implementing partners (i.e. NGOs), but is not yet supported official policy. All other countries included in this report have progressed further in formally recognising the contribution of lay counsellors. In Lesotho, Mozambique and Zimbabwe, the MoH and implementing partners have worked to harmonise job profiles, training curricula, supervision structures and remuneration packages. The certification of training for staff providing counselling (HTC training in particular) and the standardisation of lay counsellors' job profiles have been put in place in Mozambique, Lesotho, Zambia and Zimbabwe. In Swaziland and some sites in Guinea, lay counsellors are specifically recruited from among PLHIV.

Evolution of roles of lay counsellors beyond HIV care

In all of the assessed countries, the main reason for initially engaging lay counsellors was to scale-up HTC. Today it is appreciated that lay counsellors can also play an important role in adherence counselling, although this task is less well defined and nurses are mostly relied upon to provide this support. As a consequence, training curricula mostly focus on HTC but give little guidance on adherence counselling.

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HIV positive patient getting advice with MSF social workers in Matam hospital, Conakry

In all eight of the assessed countries lay counsellors are involved in HIV and TB adherence counselling, at least informally. It is expected that the management of other chronic conditions such as diabetes and hypertension will increasingly put a burden on health facilities in low resource settings, with the prevalence of such non-communicable diseases increasing in countries with high HIV prevalence [Reid 2012]. Building further on lessons learned for managing HIV and TB, it will be important to review the scope of practice, training curriculum and compensation for adherence counsellors to meet these additional responsibilities.

"The service provided in night clinics is crucial: many men don't want to go to health centres, so we go to meet them wherever they are. I know how to make them understand how to stay HIV-negative, or how to accept the result of a positive test.

I also prepare clients before they need to start antiretroviral treatment and make sure they understand what is at stake. This is key to help them avoid defaulting on their treatment."

Thokozile Dhodo, HIV counsellor, Zimbabwe

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Specialised versus generalised cadre

Most countries assessed in this report have a specific cadre dedicated for counselling and patient education at facility level. However in reality these specialised cadres often combine their core activities with other health service support tasks, such as general administrative tasks and drug refills. In such cases, clear job profiles are needed to avoid adding responsibilities at the expense of quality. In Zambia, where they opted for such specialisation of tasks, lay counsellors were reported to provide HTC services of consistent quality [Sanjana 2009].

Malawi opted to integrate HTC tasks into an existing national CHW cadre, the health surveillance assistants (HSAs), who also perform other activities such as basic health checks and health promotion at health facility and community levels. Despite clear advantages of an integrated approach, this may impact quality of HIV testing [CDC 2012]. More evidence is needed to inform decisions on the number of tasks that can be conducted while maintaining quality and defining what kind of supervision support is required in each setting.

Limited supervision

The supervision of lay counsellors varies by country. In Zimbabwe and South Africa the supervision is often delegated to the nurse in charge of the health facility. In Malawi senior HSAs provide support to their peer workers. In Zambia professional counsellors can either provide decentralised training and supervision to basic lay counsellors, or work in collaboration with basic lay counsellors at the health facility to support more complex counselling demands. In most settings supervision is reported to be limited and irregular due to other priorities and workload.

Adapting counselling as challenges evolve

At the beginning of the HIV epidemic, knowledge and awareness around HIV, ART and the main opportunistic infections among patients was low. Patient support focused on basic education and awareness about the disease as well as prevention of the sexual transmission of HIV. Nowadays counsellors are confronted with new challenges: for example, the increased availability of viral load testing allows for identification of patients at risk of treatment failure who need enhanced adherence support, but patients need specific counselling to be able to understand what the results of a viral load test means. Additionally, an increasing number of groups are eligible for immediate lifelong ART, including HIV positive pregnant and breastfeeding women and people in serodiscordant relationships. These new initiatives require adapted counselling. Some of these emerging counselling tasks and adherence challenges require additional training and on-the-job support for counselling cadres to be able to perform them. Training curricula need adaptation, as has been done in Western Cape, South Africa where lay counsellors go through specific modular trainings on paediatric treatment and how to address specific adherence challenges in pregnant and breastfeeding women living with HIV, allowing them to gain skills in comprehensive and new domains as they increase their work experience.

"My husband always refused to take ARVs and was buying all sorts of health supplements and herbal concoctions instead. It was only when I started working as a counsellor that I understood what could have been done to save him. But by then it was too late, he was already dead.

I too went through a serious case of denial of my HIV status – so much so that I infected my child by breastfeeding, against medical advice. This is what I always tell people: how denial cost me my family.

Now, as a counsellor, there is nothing that makes me happier than seeing someone I have helped recover. I really wish I had received the right information and support back then, before my husband died, before I infected my child. Things would not have turned out the way they did."

K, 33 years old, counsellor, Swaziland

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Edna Maulana, enrolled in a PMTCT programme, Malawi

Balance between facility- versus community-based counselling

Community-based HIV testing strategies and community-supported ARV medication refill strategies are recommended by WHO and implemented in an increasingly number of countries [WHO 2013]. In order to support these activities there is an increased need for lay counsellors to be present in the community as well as health facilities. Lay counsellors have been shown to play a critical role in the support of community-based models [Rasschaert 2014, Bemelmans 2014a, WHO 2013] and pilot projects are ongoing to provide counselling services that are traditionally performed at the health facility closer to patients' home, such as ART initiation counselling [MacPherson 2014]. Some countries have created specific community-based counsellors like the community health assistants in Zambia, while others have included HTC in the tasks and/or training of existing cadres (community health workers in South Africa and village health workers in Lesotho). Most countries in this report have a specific facility-based counsellor cadre; in Malawi these tasks are done by health surveillance assistants who spend approximately half of their time in the community. Attention needs to be paid to the continuity of care and it is important that realistic estimations are made about workload at both community and facility level.

Challenges in national strategies supporting lay counsellors

Lack of policy and implementation framework

National guidelines should stipulate the role of counselling and education services and supervision [Table 3]. Although most countries in this report have clear HTC guidelines, only Zimbabwe and Mozambique have a nationally agreed guideline stipulating minimal adherence support standards, procedures and tools. Mozambique's National Acceleration Plan for 2015 puts forward a target number of lay counsellors that are required to achieve national HIV targets. Swaziland has a specific task shifting framework detailing the scope of practice for certain cadres and their supervision and remuneration; however, implementation is limited because the document has not been formally endorsed for it to be functional.

Mozambique has estimated that 1,893 lay counsellors are needed in 1,414 health facilities [MISAU 2013], while Lesotho has stated that two or three lay counsellors are needed per health facility [Consortium of NGOs Lesotho 2009]. In many countries however national Human Resources Information Systems do not track community cadres. Strengthening the data available on the number of lay counsellors is critical for national human resource planning.

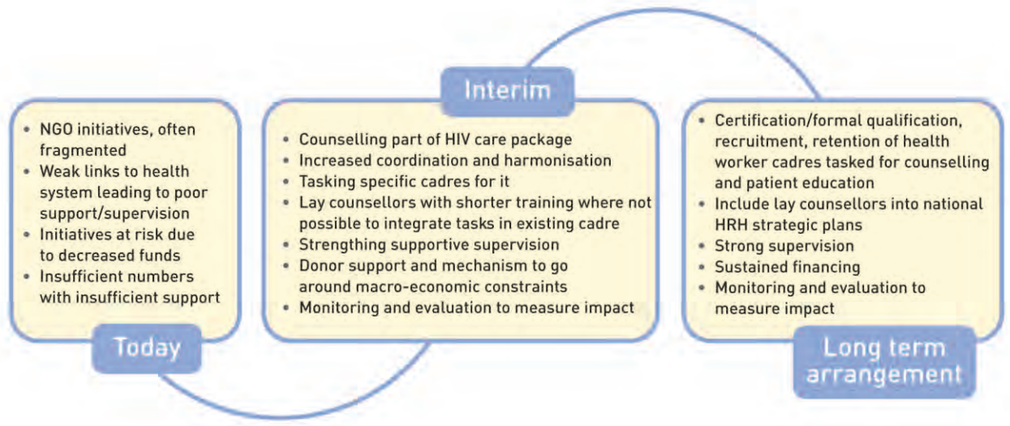
"As a nurse I am so busy that, I often don't have time to properly counsel patients. Counsellors are experts, and without them the ART programme would be compromised and we would lose a lot of patients. Counselling is taxing and demanding, so counsellors need to be motivated through capacity building and remuneration."

Fortunate Ncube, Nurse, Swaziland

Long-term strategies for lay counsellor support and integration

All countries assessed have gone through a rapid and major scale-up of both HIV and TB services, and have achieved high treatment coverage; however, further support is needed to ensure the long-term sustainability of progress to date [Table 2]. In line with the 2013 WHO Consolidated Guidelines on the use of ARV drugs, all countries have made ambitious scale-up plans and adopted part or all of these new recommendations. However, a long-term strategy for health staff support and financing is needed. Figure 4 illustrates three steps towards a sustainable solution. An interim solution could be to explicitly include adherence counselling and patient education as part of the MoH defined HIV and TB care package, with clear guidance on task allocation and lines of responsibility. Where the number and type of health staff do not allow these tasks to be performed by existing cadres, countries could recruit lay counsellors with relatively shorter training requirements. This solution could be enacted while continuing to work on long-term strategies, such as upgrading lay cadres or integrating tasks into community-based cadres and including them in HRH strategic plans. Ensuring standardised monitoring and evaluation that links the work of lay counsellors with MoH strategies is also important.

Figure 4. ***Strategies for lay counsellor support and integration***



Representation by professional bodies

With the exception of Zambia, most countries have no professional body that specifically oversees the work of counsellors. Zambia's Counselling Council has helped to establish psycho-social counsellors and provide mentoring and support to them plus other counsellor cadres, which allows for a certain level of professional status and recognition amongst the workforce. In other countries, there is scarce representation of lay counsellors or other CHWs within professional bodies. This stands in contrast with other professional health councils, such as the medical council or nursing associations.

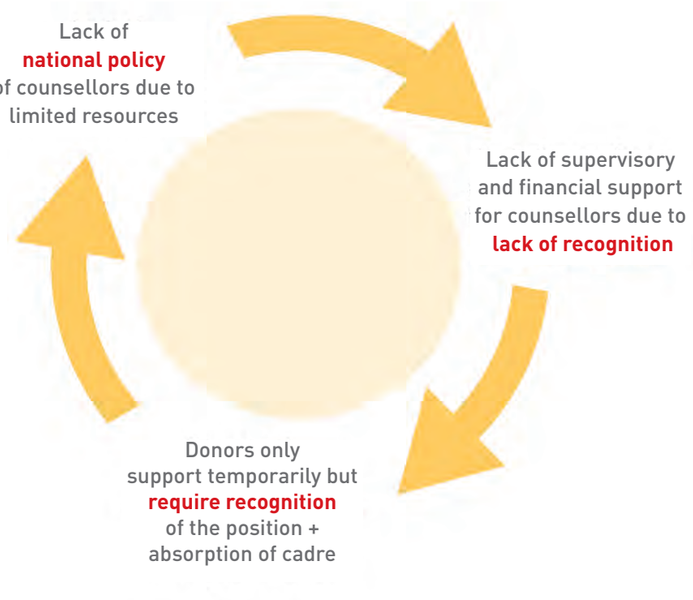
Sustained Financing

In the majority of the countries presented in the case studies that follow, lay counsellors are supported through international funds; global health initiatives such as the President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to fight AIDS, TB and Malaria (GFATM) and NGOs. Remuneration should be aligned with national standards. Packages for lay counsellors have in some countries been fixed by the MoH and vary between 70 USD per month in Lesotho to 220 USD in Zimbabwe and 500 USD in Zambia. However, since lay counsellors are not part of the staff establishment, Ministries of Health have little means to enforce such amounts, which in reality often end up dependent on the supporting partner(s) and can vary from 40-150 USD in Mozambique to 100-300 USD in Swaziland. In Swaziland this compares to 640 USD per month for the lowest level nurse and in Mozambique, the MoH proposed package for lay counsellors of 117 USD is about half that of mid-level nurses.

Donor support is usually focused on the short-term, whereas long-term country strategies need to be well defined. Despite recommendations to absorb lay counsellor positions within the national HRH establishment or find other ways to sustain them (e.g. delocalised contracts or contracting them to non-governmental or community-based organisations), most countries have so far been unable to do so. Only Zambia successfully integrated psycho-social counsellors into the MoH establishment but numbers financed by MoH are still few. This is primarily due to the challenges that Ministries of Health are confronted with when creating a new cadre, as well as the lack of strong evidence around their cost effectiveness, which would support prioritisation of their inclusion.

Reduced funding for lay counsellors has in some countries been associated with a reduction in key tasks. In Lesotho for example the number of counsellors decreased from 487 to 165 in 2012, with an associated decrease of facility-based HTC by 15%, from 253,994 in 2011 to 215,042 tests in 2012.

Figure 5. ***Vicious cycle of a lack of recognition and support***



* *Recognition is defined as the three pillars of harmonisation, inclusion in national strategies and sustained financial support.*

In the absence of long-term solutions for financial support within MoH, donors should not withdraw financial support, as this can hamper MoH in recognising these lay cadres due to financial and fiscal constraints (figure 5). Short-term international support needs to be coupled with a long-term strategy that supports sustainability from the outset. A national strategy related to civil servants, their training and remuneration would need to involve the MoH, the ministries of finance, public service and/or education.

Options for short- and long-term sustained financing

Different options for contracting and financing exist. While defining long-term options, short and medium-term financing must be ensured in order to allow for continuity of these cadres. National governments, for their part, need to strengthen efforts to sustain this initiative to work towards less dependence on external funds and may need to look into different strategies for remuneration and retention of these cadres of health workers.

The following examples of contracting and financing interventions were reported in the country studies:

i) Integration into the government staff establishment

There are often fiscal barriers with wage bill constraints, so donors are currently paying a large number of professional health staff, as is the case in Mozambique, Zimbabwe and Lesotho. There are also administrative difficulties on the part of the Ministry of Finance (MoF) to absorb additional positions that are allocated to health. Where health budgets are insufficient, established professional staff are generally prioritised. In addition, cadres with a shorter training duration or lay cadres often face constraints to be accepted as civil servant health staff, which normally requires at least a secondary school level of education. An option could be to offer an alternative civil servant package that allows lay counsellors to be integrated and upgraded according to required education criteria.

ii) Include lay counsellors and/or the counselling tasks into an existing cadre of CHWs

In Malawi lay counselling has been integrated into the role of the existing cadre of health surveillance assistants. However, in most countries in sub-Saharan Africa, CHWs still receive a significant part of their financing from international donors, thus a dependency remains if this option is to be chosen. Issues around "over-tasking" of this cadre, as described earlier, also need to be taken into account and sufficient numbers need to be in place in order to allow tasks to be addressed both at community and facility levels.

iii) Share responsibility for supporting lay counsellors between national MoH and local government

In South Africa, lay counsellors are employed on a local or regional government contract, financed both by government and partners. With this approach, national programmes need to put in place a nationally harmonised workplace policy, and define the core scope of practice and minimum job requirements. This option could be more sustainable if HRH management is further decentralised.

iv) Employ lay counsellors through community-based organisations (CBOs) and/or NGOs

In Mozambique, Zimbabwe, Lesotho, and Swaziland lay counsellors are supported through CBOs/ NGOs which in turn receive donor funds, while in South Africa government and donor funding jointly contribute to supporting CBOs/NGOs. Advantages of this model are that CBOs/ NGOs usually have a strong link to broader civil society and make the direct connection between services with patient needs. This option needs a strong coordinating NGO, adequate supervisory support and linkage with the formal healthcare delivery system. Still, funding for these CBOs/NGOs needs to be guaranteed either through domestic or international sources, and overhead costs for the MoH to provide supervision and general oversight need to be calculated.

Table 5 summarises the advantages and disadvantages of the various options, and the countries that currently apply one or multiple strategies.

Table 5. ***Contracting and financing options***

Contract Types	Advantages	Disadvantages	Countries - Funding
A. Create new cadre and integrate in MoH staff establishment	• Strong link to health system • Career path • Sustained support • Easier supervision	• Fiscal, administrative and financial constraints	**Zambia** – Government of Zambia + GFATM/ partners
B. Integrate counselling tasks within existing CHW cadre	• CHW an accepted cadre • Renewed international and national interest in CHWs	• Increasing job profile without increasing basic training • May overburden CHWs in settings where they are already multi-tasked with a 'full plate', poorly remunerated or acknowledged. • Tasks may require additional training • Work in both facility and community is needed • Often still donor funded	**Malawi** - Government of Malawi **South Africa** – Department of Health (DoH) and partners
C. Local/regional government contract	• Local flexibility according to needs • Link to health system	• Dependent on local government priorities • Works best in mature health system decentralization process • Vulnerable to hospital budget trends and dependability	**South Africa** – DoH and partners **Zimbabwe** – GFATM **Mozambique** - partners
D. NGO/CBO contract	• If strong NGO/CBOs quality management • Generally strong connections to patient and community needs • Potentially community mobilization to demand and access services	• Vulnerable to donor trends and dependability (domestic funding not usually given to NGOs for this role)	**Mozambique** – NGOs, GFATM **Lesotho** – GFATM, NGOs **Swaziland** – NGOs At provincial level in **South Africa**: local NGO – combined government / partner

International Monetary Fund (IMF), the World Bank and Ministry of Finance

The integration of lay cadres into Ministries of Health is challenging. Any increase in human resources for health within a country is usually defined by the wage bill, which is a maximum budget set by the Ministry of Finance to the Ministry of Public Service, who then ensures recruitment and remuneration of civil service staff. A wage bill ceiling was previously a condition for loans at the IMF or the World Bank and led to limitations when hiring health staff or improving their package to assist in recruitment and retention of good staff. Since 2007 these restrictive policies were softened for most countries: although no longer considered strict conditions [IMF 2009], they remained recommendations [CGD 2007, Kentikelenis 2015]. However, the Ministry of Finance often still adopts these conditions.

In several of the countries assessed, the lack of involvement of the Ministry of Public Service lead to delays in absorbing 'non-official' positions. The weak negotiating position of the MoH to increase the allocation of the wage bill to health is another constraint. Freezes on civil servant wages, as recently applied in Lesotho and Mozambique, lead to recruitment and staff retention challenges as well as constraints in increasing necessary health staff numbers and maintaining quality of care. International funders have generally been reluctant to fund staff salaries unless a clear plan on absorption of staff into the government's civil servant bill is presented [McCoy 2008, Ooms 2007, GHWA 2013, Leach 2005]. Within these limitations, countries with severe shortages of health staff put priority on absorbing professional staff rather than lay cadres.

The importance of allocating additional staff numbers to the health workforce is strongly recommended and has already been highlighted by WHO.

> *"...recognising that fiscal constraints present a challenge for countries coping with HIV epidemics, there is a need to create fiscal space for the health workforce which will require relevant stakeholders to engage productively with ministries of finance, donors and international financial institutions..."* [WHO 2007a].

Cost-benefit of lay counsellors

Counselling has shown to contribute to a higher uptake of services and retention in care in HIV/ART programmes [Thompson 2012, Chaiyachati 2014]. Lay counsellors have also played a pivotal role in the formation and facilitation of Community ART Groups (CAGs) in Mozambique, a model that reported good patient outcomes in terms of retention in care [Rasshaert 2014]. In order for MoH to make the case for financing and supporting lay counsellors towards the MoF and donors, more data on cost-effectiveness is desired.

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People waiting for their viral load test at the HIV department of Arua Regional hospital, Uganda

The documented clinical and programme benefits associated with the employment of lay counsellors may lead to cost savings. These include improved adherence and retention in care that limits the development of ARV drug resistance and associated morbidity, plus the need to switch to expensive second-line ARV drugs [Stricker 2014]. In addition, lay counsellors can be involved in identifying stable patients suitable for simplified HIV care, requiring clinical assessments just once a year (and only drug refills in between), which can be associated with lower care costs for both patients and the health system. In some countries rapid 'scale up' of lay counsellor involvement is possible at low cost in comparison with higher professional staff salaries and training, and allows the latter to concentrate on patients with complex needs that require more frequent clinical visits and clinical expertise [Mwai 2013; Ledikwe 2013; Hermann 2009]. For instance, in the Western Cape Province of South Africa, according to PERSAL (the government personnel database) records, 5.3 counsellors can be employed for every professional nurse. Also, lay worker-led adherence clubs were highly cost-effective compared to the nurse-led standard of care [Bango 2013].

A study reviewing evidence on cost effectiveness of task shifting, including shifting of tasks from health professionals to lay providers, found that it resulted in significant time saving for physicians and therefore cost savings in ART provision, making it a cost-effective strategy. However, most of the reviewed studies were relatively small and overall cost-effectiveness data were limited [Mdege 2013]. It is therefore important to continue to collect data that show the cost-effectiveness of these interventions, which can assist Ministries of Health in making a stronger case to Ministries of Finance in order to receive an appropriate allocation of health care staff needed to meet their goals, including counsellors.

CONCLUSIONS

Patient support activities performed by lay counsellors have been documented as being an important component of successful HIV programmes, with positive impacts on patient health and programme outcomes. There is also some evidence of worsening programme outcomes when lay counsellor capacity is reduced. Their role may need to be expanded in the coming years to address the rise in non-communicable diseases and adherence to life-long treatments for HIV, including both first- and second-line ART regimens.

Lay counsellor programmes can only function optimally if they are supported with training, supervision and sufficient remuneration. Despite the fact that counsellors and their scope of work have not been fully integrated within the health system in most settings, several steps have been taken in the countries assessed in this report that have allowed progress toward their recognition and support.

At the international level, it is important that lay counsellors be included in the broader human resource for health agenda aimed at harmonising and recognising community health workers [GHWA 2013]. Donors should assist Ministries of Health in recognising these resources as an essential part of quality ART delivery and assist MoH in their planning and financing to allow them to make a strong case to their respective Ministries of Finance for adequate funding.

Low-income countries facing a high HIV/TB burden and severe HRH shortages will continue to rely for some time on external donor funding. Continuity of support for health system strengthening with a specific focus on human resources for health must therefore be guaranteed, including developing appropriate curricula, and training for supervisors.

Countries should be supported to share experiences and support the development of recommendations on the numbers of lay counsellors required to support HIV and related services, recommendations on minimum quality standards, tasks, a supervision framework, training needs, and to define priority areas that require further evidence and research.

Though this review report focuses on lay counsellors in HIV and TB care, the issues of harmonisation of job profiles, training and increased recognition are just as valid for other lay cadres, e.g. community health workers. The framework defined by development partners in support of harmonised approaches around CHWs recommends clearly that MoH and partners work towards one national strategy, aligned to a national monitoring and evaluation structure, and means of support [Mogedal 2013]. It is therefore important to advocate on a wider scale for several groups who face similar issues.

PART 2 Country Studies

Lesotho
Malawi
Mozambique
South Africa
Swaziland
Zambia
Zimbabwe
Guinea

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LESOTHO

A harmonised profile for lay counsellors, but lack of long-term funding

Table. ***General country indicators for Lesotho***

General / macroeconomic	Population:	2.2 million (72.7% rural) [UNDP 2013]
	GDP/capita (ppp/USD):	1504 USD [UNDP 2013]
	HDI:	158 [UNDP 2013]
	Wage bill:	18% of GDP [World Bank 2010]
Health	Government resources allocated to health (% of total government budget):	14% [WHO GHED 2012]
	% of the health budget coming from donors:	70% [WHO GHED 2012]
Human Resources for Health	5 doctors, 56 nurses/midwifes per 100,000 [MoHSW 2013a]	
HIV response	HIV prevalence:	22.9% as of end of 2013 [UNAIDS 2014a]
	ART coverage according to WHO 2013 Guidelines:	29% [UNAIDS 2013]
	Retention at 12 months in 2012 (adults + children):	72% [UNAIDS 2013]
	Population (aged 15-49) received HIV test in the past 12 months of 2012:	42% (F) / 24% (M) [UNAIDS 2013]

USD: United States dollar; HDI: Human development index; GDP: gross domestic product

Background

Lesotho has the second highest HIV adult prevalence in the world at nearly 23%, and AIDS remains the primary cause of death among adults [MoHSW 2013a]. The country faces severe challenges due to a lack of health staff, especially in rural areas where less than 20% of health workers are deployed to provide care to 77% of the population [MoHSW 2013b].

From 2006 onwards, Lesotho applied a decentralised ART model with nurse-led ART initiation and HTC and adherence support provided by lay counsellors. Data between 2006 and 2008 showed satisfactory results with 80% retention in care on ART at 12 months among adults and lay counsellors having been reported to facilitate the ART scale-up, i.e. through HIV testing and preparation of patients for ART initiation [Cohen, 2009]. Today all 197 health facilities provide ART.

Lay counsellors received short, task-specific training and were deployed to enable rapid ART scale-up. Lay counsellors were financed and managed by international donors and NGOs. However, at present, the future existence of this cadre is at risk due to a decrease in funding and lack of prioritisation.

Harmonisation of strategies and operationalisation

Lay counsellors are recruited from the community, often from the existing pool of village health workers, to work at their closest health facility [MoHSW 2011]. The approach in Lesotho was for a long time fragmented in terms of remuneration, training and job title, which was dependent on the supporting NGO/partner. However in 2009, a consortium of international NGOs[1] came together in an effort to harmonise approaches. Policy recommendations to the MoH were developed and adopted in 2010. A pre-education criterion for lay counsellors is fixed at secondary school level, but in reality most have only finished primary education; for example, in Roma catchment area where MSF supports HIV care, all 41 lay counsellors have finished primary education only. This is due to low overall levels of education, especially in rural areas [Consortium of NGOs 2009]. A standardised job profile was created for lay counsellors with tasks including HTC, counselling for ART initiation, adherence support and assisting in other activities such as patient registration, drug distribution and health education. A two-week training on HTC, pre-ART care and adherence support was accredited and coordinated by the MoH and remuneration was decided on ~ 70 USD per month. Health facilities were to have two to three lay counsellors each but the basis for these projections are not clear and evidence is lacking on the appropriate number of counsellors needed in Lesotho. Supervision at health facility level was to take place through the nurse in-charge, and through punctual mentorship visits by a psychologist or senior counsellor at district level.

A rapid workload analysis of lay counsellors was conducted by MSF in 2013 in three health facilities in the Roma catchment area. The assessment reported an average of 77 working hours per month or approximately 5 hours per day per lay counsellor. The method relied on self-reporting and reported a fairly low number of working hours, presumably due to underreporting, involvement in a number of other tasks that were not reported, as well as the fact that clinics usually become much less busy beyond two o'clock in the afternoon. Lay counsellors were found to considerably reduce the workload of professional health staff [Bemelmans 2014b].

National Strategy

Despite lay counsellors not yet being part of any national strategy, they are mentioned and evaluated in the Annual Joint Reviews of the Health Sector in Lesotho [MoHSW 2013a, MoHSW 2014].

Lesotho also has village health workers, a well-established cadre whose role is described in the Lesotho Primary Health Care Revitalisation Strategy 2011 – 2017. Certain lay counsellors have been recruited from this pool and trained in HIV counselling and testing for Lesotho's 'Know Your Status' Campaign that was launched in 2006. Recruitment criteria for the village health workers that became lay counsellors include knowing how to read and write in English and Sesotho, with the minimum qualification required being a Junior Certificate. They are not paid but sometimes given some incentives from partners. They report to the HIV Senior Counsellor and Public Health Nurse [MoHSW 2011].

Financing

Lay counsellors were donor funded through NGOs or directly through the MoH from 2006 and by 2011 a total of 480 lay counsellors had been deployed country-wide. Over half of the lay counsellors have been financed by the GFATM. A specific agreement was made between GFATM and the Government of Lesotho that the funded lay counsellors would be absorbed by the government as of the end of the grant agreement in 2012. Despite their contribution to HIV care and increased recognition in Lesotho, MoH did not succeed in making lay counsellors part of the staff establishment due to fiscal and administrative constraints. In 2009 Lesotho had one of the highest wage bills in the region with 18% of their GDP spent on civil servants; however only 7% of the budget for civil servants is spent on health workers [MoPS 2013]. As a result of the high wage bill, Lesotho put in place a 'freeze' on recruitment and increase of salaries. With a significant number of professional staff still not absorbed within the establishment, lay cadres such as the counsellors have not been a priority.

1. The consortium included Baylor College, CHAI, EGPAF, MSF, ICAP, Ontario Hospital Association, Partners in Health, SolidarMed, and University Research Council.

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Women at MSF supported health centre of Ha Seng, Lesotho.

In 2012, when it became clear that the MoH was not able to absorb lay counsellors into their staff establishment, several organisations (i.e. CHAI and GFATM) stopped or reduced their funding for lay counsellors. The MoH started to look for alternative solutions, including integrating counselling tasks into the already established village health worker cadre. There have since been discussions again to create a separate cadre, as proposed by the MoH. During delays of GFATM funding in 2012, the MoH bridge-funded shortages in funding for lay counsellors, but by the end of 2012 only 165 lay counsellors out of the initial 480 were still working. Renewed agreements have since been made between the government of Lesotho and GFATM on the funding of 540 lay counsellors until 2017.

The reduction of lay counsellors had a major impact on HIV- and TB-related activities. During the same year, ART coverage[2] decreased from 61% to 51% and facility-based HTC decreased by 15%, dropping from 253,994 tests in 2011 to 215,042 tests in 2012 [Bemelmans 2014b]. Lesotho's Annual Joint Review of the health sector ascribed the worsening national HIV programme outcomes partly to the failure to retain or support lay counsellors [MoHSW 2013a].

Table. ***Recognition of lay counsellors in Lesotho***

Pillars Recognition of Lesotho counsellors	
Harmonisation	• Job profile: agreed • Remuneration/stipends: MoH defined: $70 monthly • Training: 2 weeks accredited • Supervision: nurse/clinician in-charge or senior counsellor • Pre-education criteria: secondary school, most are below this level
National Strategy	No, but mentioned in Annual Joint Reviews of Health Sector
Financing	100% partners/donor

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2. ART coverage defined as according to the 2010 WHO guidelines that were being recommended at that time.

MALAWI

Integration of HIV testing and counselling tasks within an existing CHW cadre

Table. ***General country indicators for Malawi***

General / macroeconomic	Population:	15.9 million (84.2 % rural) [UNDP 2013]
	GDP/capita (ppp/USD):	226 USD [World Bank 2013]
	HDI:	170 [UNDP 2013]
	Wage bill:	5.3% of GDP*
Health	Government resources allocated to health (% of total government budget):	18% [WHO GHED 2012]
	% of the health budget coming from donors:	78% [WHO GHED 2014]
Human Resources for Health	2.0 doctors in 2010 36.8 nurses/midwives per 100,000 in 2009 [WHO 2014]	
HIV response	HIV prevalence:	10.3% (1.1 million PLWH) [UNAIDS 2014a]
	ART coverage according to WHO 2013 Guidelines:	51% according to WHO 2013 eligibility criteria [UNAIDS 2014a]
	Retention at 12 months in 2012 (adults + children):	79% [UNAIDS 2013]
	Population (aged 15-49) received HIV test in the past 12 months of 2012:	31,3% (M) [UNAIDS 2013]

* [http://timesmediamw.com/malawi-civil-servants-trade-union-insists-on-salary-increment/

USD: United States dollar; HDI: Human development index; GDP: gross domestic product

Background

With the ninth highest HIV prevalence in the world, Malawi has made great progress in scaling up HIV treatment, with ART now available in all of the country's 694 public health sector facilities. Malawi has one of the highest coverage rates in the region, providing ART to 486,795 of an estimated one million PLHIV in need, based on eligibility criteria in the 2013 WHO treatment guidelines [MoH 2014a].

This significant scale-up in ART treatment coverage was largely made possible in Malawi by the country's public health approach to the epidemic. task shifting to lesser trained cadres such as community health workers was one vital aspect in the context of a critical human resource shortage as shown by a 61% vacancy rate for clinical staff in 2010 [MoH 2010].

Harmonisation of strategies and operationalisation

In Malawi there is no specific counselling cadre and only those tasks related to HIV testing and counselling have been integrated into the job profile of the existing cadre of Health Surveillance Assistants (HSAs) since 2006. Patient counselling and education tasks related to ART are still to be done by nurses as part of their job description. However, the high workload of nurses brings into question the feasibility of quality ART counselling.

The cadre of HSAs was initially created in the 1960s as a community cadre focused on preventive activities, as well as to contribute to disease outbreak responses, and became an official established cadre in 1984 [Kok and Muula 2013]. Over time and especially with the rise in HIV cases, tasks for this cadre have expanded to include supporting activities such as taking blood pressure, weighing patients, and dispensing drugs, due to their widespread presence.

© Marco Longari/MSF

Mother enrolled in PMTCT B+ programme

A total of 10,073 HSAs are currently employed in Malawi [personal communication Mr. Precious Phiri, Primary Health Care (PHC)/HSA National Coordinator, MoH, August 2014]. The HSA basic training course is 12 weeks in duration, followed by a three-week training on HIV testing and counselling, all coordinated and certified by the MoH.

There have been tensions around the use and tasks of this cadre. While the cadre was originally charged with community-related health promotion activities, HSA tasks expanded over time with changes in disease burden and the existence of severe HRH shortages, as well as the influence of supporting NGOs. HSA tasks now include more HIV and TB care such as ART refills, TB treatment refills, health education and promotion, collecting specimens for testing (e.g. dried blood spot specimens for early infant diagnosis of HIV, viral load testing, and sputum for TB microscopy), defaulter tracing, ART data management, HIV testing, and counselling [Puchalski Ritchie 2012]. An evaluation in Thekerani, a health centre in the rural district of Thyolo, showed that HTC takes up only 7% of an HSA's workload. In addition, HSAs are expected to be present in the community as well as in the health facility, dividing their time equally between the two. Quality issues arise due to this wide scope of tasks and frequent rotation through health facility and community [MSF 2013]. A recent review on quality of HIV testing done by CDC reported a high number of incorrect diagnoses, spurring debate within the HIV department to "specialise" a number of HSAs, keeping them facility-based and focused on HTC [CDC 2012]. However, the draft "Guideline for the management of task shifting to HSAs in Malawi" does not promote this idea of specialisation. The job description of HSAs has been under revision since 2012 and it is likely that most of the tasks that have been gradually incorporated into the work of HSAs will be formalised as part of their job description.

District coordination and supervision of HSAs is done through the district level based Environmental Health Officer, a diploma level cadre with three years of study and part of the national preventive health department. There is a cadre of senior HSAs for overall supervision of HSAs at both community and facility level; for activities directly related to clinical work at facility level, HSAs are supervised through the nurse or medical assistant incharge. However, due to time constraints, this is not always done in a satisfactory way. Remuneration of HSAs is approximately 56,000 Malawi Kwacha per month (equivalent to ~120 USD) and HSAs are considered part of the civil servant staff establishment.

National Strategy

A further improvement in ART coverage is expected following the adoption in 2014 of the most recent WHO recommendations. In addition, Malawi is aiming to achieve the '90-90- 90' targets put forward by UNAIDS for 2020 [UNAIDS 2014]. In order to reach these targets, a need to focus on three pillars has been identified: scale-up of HIV testing, initiate and retain people on ART and long-term adherence support. For all of these services, counselling will be vital [MoH 2014d, Jahn 2014]. Proposals are underway to consider introducing a separate cadre specifically for testing ("HIV diagnostic assistant") in order to help increase the country's HIV testing capacity. Although these ideas at national level are still in the early stages, the intention is to create a cadre that can be contracted at lower costs than HSAs (i.e. requiring even less training and lower salaries). The plan on how to support adherence and long-term retention in care through education and counselling remains unclear. For now, MoH plans to develop national guidelines to regulate and rationalise the operation of the HSA cadre.

Overall, national ART guidelines recommend limited patient education and counselling for people living with HIV but do not specify which cadre is to perform this task.

Financing

In 2003 Malawi made a special agreement with the International Monetary Fund (IMF) for a ceiling on the government wage bill. With the declaration of HRH shortages as a national crisis in 2004 and the setting up of the Emergency Human Resource Plan to increase the size of the workforce, IMF agreed that the ceiling could be adjusted upward or downward by the full amount of donor-funded supplementary wages and salaries for the health sector that is greater or lesser than the programme baseline [IMF 2006, Ooms 2007].

Due to the shortage in skilled and trained health care workers, HSAs became the single biggest health worker cadre, representing 55% of the entire health workforce. HSAs have been described as the backbone of the HIV care service delivery [DFID 2010]. In 2007, the cadre increased from approximately 5,000 to 11,000 with the rationale being to rapidly increase HSA numbers in order to contribute to the HIV and TB response. The plan now is to further increase this number to 13,500, aiming for a ratio of one HSA to serve a population of approximately 1,000. Funding has come from the GFATM and an agreement between GFATM and the Malawi Government was made to absorb HSAs additionally recruited over time.

One of the five key elements of the Emergency Human Resource Plan was to improve incentives for recruitment and retention of Malawian staff through a 52% salary 'top up' for 11 professional cadres [DFID 2010]. The government of Malawi has since sustained the 52% salary top up to all health workers, as well as the absorption and payment of salaries for the additional HSAs recruited under GFATM. Despite all 10,073 HSAs being paid through government funds, 4,000 are not yet part of the staff establishment and not yet enjoying the full package of benefits. According to MoH sources, there is an informal agreement to date among the Ministry of Health, Department of Human Resource Management and Developmen and Ministry of Finance to allow for still more recruitment of health workers, as the health worker vacancies that have been filled continue to be below the number of established posts. MoH continues to face funding gaps for salaries for health workers and is in some cases still restricted by national budget constraints.

Malawi has been functioning on a 'zero aid' national budget, which is based on taxation revenue and funds raised within Malawi and does not include direct budgetary support from donors (who temporarily suspended their support after serious issues around cash flow and accountability); this has however had a crippling effect on all expenditure, including health care. The country is currently experiencing hyperinflation due to further currency devaluations, so the financial outlook and prospects for improvements in the HRH vacancy rates is bleak.

Table. ***Recognition of counsellors in Malawi***

Pillars Recognition of Malawi counsellors and absorption of HSAs	
Harmonisation	• Originally generalised PHC tasks • Expansion of tasks on official job profile is currently under revision. Mainly HTC included, not adherence support. • Remuneration by government – 115 USD per month • Basic training of 12 weeks + additional 3 weeks for HTC • Pre-education criteria: High school but most are below this level. • Supervision by Assistant Environmental Health Officer, senior HSAs (at community level) and nurse/medical assistant (at HC level) • No professional body, since the Medical Council of Malawi will only certify and cover the cadre if they undergo a minimum academic training period of one year
National Strategy	In progress: National guidelines on the management of the task shifting and use of the cadre are presently being finalised and discussions on the idea of a new cadre are ongoing.
Financing	95% Government

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A group of HIV-positive actors perform at the Mikolongwe health centre, Malawi

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MOZAMBIQUE

From acceptance to first steps in recognition

Table. ***General country indicators for Mozambique***

General / macroeconomic	Population:	24.5 million (68.8% rural) [UNDP 2013]
	GDP/capita (ppp/USD):	861 USD [UNDP 2013]
	HDI:	185 [UNDP 2013]
Health	Government resources allocated to health (% of total government budget):	9% [WHO GHED 2012]
	% of the health budget coming from donors:	57.8% [MISAU 2014a]
Human Resources for Health	5 doctors, 25 nurses/midwifes per 100,000 (2012) [WHO GHO 2014]	
HIV response	HIV prevalence:	10.8% (1.6 million PLWH) [UNAIDS 2014a]
	ART coverage according to WHO 2013 Guidelines:	33% at end of 2013 [[UNAIDS 2014a]
	Retention at 12 months in 2012 (adults + children):	74% [UNAIDS 2013]
	Population (aged 15-49) received HIV test in the past 12 months of 2012:	25.9% (F) / 14.2% (M) [UNAIDS 2013]

USD: United States dollar; HDI: Human development index; GDP: gross domestic product

Background

Mozambique, a high HIV burden country with one of the lowest health staffing levels, has made less progress compared to other countries in the region in terms of ART coverage, HIV testing rates and retention in care (e.g. 57% ART retention rate after 24 months versus 70% in the region) [UNAIDS 2013]. By 2015, almost 1 million people will be eligible for antiretroviral therapy (ART) according to the latest WHO treatment guidelines [MISAU 2014a].

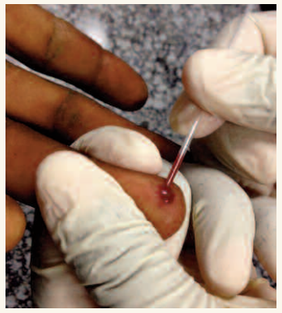
Initiatives around supporting HIV/TB lay counsellors are fragmented and lay counsellors are not included in the payroll of the MoH. Their presence depends on financial support from donors through NGOs and is constantly endangered during this time of funding uncertainties. Nevertheless, different steps have been taken to achieve recognition of this cadre.

Harmonisation of strategies and operationalisation

Mozambique currently has 501 lay counsellors who have received basic training and are employed by various international NGOs that focus on HIV, including EGPAF, FHI, ICAP, MSF, and national NGOs such as CCS (Centro de colaboracão em Saude) or ARIEL (Foundation ARIEL Glaser); these counsellors are facility-based, scattered throughout the country and have different job profiles, supervision structures and diverse remuneration packages. In most sites supported by NGOs, lay counsellors perform important work related to HTC and adherence counselling, as well as paediatric disclosure counselling.

A positive impact has been reported in models that involve lay counsellors. For example, rates of loss to follow-up after 12 months on treatment in Chamanculo varied from 3% to 13%, well below the national loss to follow-up rate of 24% [Bemelmans 2014c, PEPFAR 2014]. A retrospective workload analysis of lay counsellor tasks in 2013, assessing 24 counsellors in six MSF-supported health facilities in Maputo, showed that counsellors perform 13 sessions on average per working day, resulting in a significant workload reduction for professional staff [Bemelmans 2014c]. They are also recognised for their key function in forming, monitoring and facilitation of innovative community supported models such as community ART groups (CAGs), which report a very high retention rate of patients (e.g. 91.8% at 48 months on ART). CAGs are now part of a nationally rolled-out strategy whereby stable patients on ART from the same geographical area take turns collecting ART refills for their group of ~6 people, such that an individual patient only has to come to the health facility twice a year for clinical consultation and monitoring blood tests. However, the current uncertainty around the recognition of lay counsellors and their continued financial support has been identified by stakeholders as a threat to the continuation of the CAG model [Rasschaert 2014].

In 2011 a task force was created involving a number of organisations[3], which looked at increasing lay counsellor recognition through harmonisation of job descriptions, training, entry criteria, supervision and remuneration. As a result, a national job profile for counsellors was agreed and approved by the HIV department of the MoH in 2012. Lay counsellors' tasks agreed upon in this national job profile included HIV testing and counselling, adherence counselling, facilitation of support groups, and counselling related to TB and PMTCT. Modules for a two-month training were put together and consisted of HTC, adherence support and other counselling related activities, with a pre-education entry criterion of a 10th grade education. With the input of the task force, the MoH led the development of a national psycho-social strategy that was endorsed in 2014. Supervision was recommended in this document to be performed by one of the following members of a multidisciplinary team: psychologist, another counsellor or a psy-chiatry assistant [MISAU 2014b].



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HIV testing at night in Gutu, Zimbabwe

However the task force has become less active and implementation of these agreed standards is threatened due to less partner support, as well as MoH budget deficits related to staff. Moreover, different views of stakeholders have developed: for example, PEPFAR has supported NGOs that utilise peer educators, a cadre with a reduced set of tasks that includes health education and tracing but not counselling. A clear vision of complementarity of roles between lay counsellors and peer educators does not currently exist. Not only that, but peer educators are mostly PLHIV that work on a volunteer basis, which potentially hampers common efforts for harmonising the counsellor profile and ensuring recognition.

National Strategy

The lay counsellor workforce is currently defined as one of the factors required to reach targets set out in the national HIV response action plan. The MoH estimates that a total of 1,893 counsellors are needed to help increase access to HTC, provide 80% of eligible adults and children with ART, and achieve a 70% retention rate among people on ART care at 36 months by 2015 [MISAU 2013]. However, a concrete roll out plan has not yet been defined, nor has a budget been foreseen for training and remuneration.

3 CDC, USAID, ICAP, PSI, EGPAF, FGH, JHPIEGO, CARE, UNICEF, WHO, MSF, Pathfinder, FHI, CHAI

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Counselling session, Maputo, Mozambique

Financing

Given the variation in remuneration depending on the supporting NGO (between 40 - 250 USD per month), a salary of 117 USD/month for lay counsellors has been proposed by the MoH, which is about half that of mid-level nurses. It has also been recognised that training costs are significantly lower for lay counsellors [Bemelmans 2014c]. Today, lay counsellors in Mozambique are mostly recruited, financed and managed through NGOs and largely funded through PEPFAR or other international partners. However uncertainties around continued donor funding have put such initiatives at risk, and require that a longer-term solution be found. In certain provinces, NGOs have agreed with the local MoH to employ counsellors through a local or regional government contract, often under a different but existing job post, though mostly still financed through the NGO. But this approach may lead to considerable regional fragmentation and job insecurity since there is no official position for counsellors yet. If counsellors are hired as administrative assistants or cleaners, they are obviously drawn into different responsibilities other than counselling.

Fiscal barriers prevent the government of Mozambique from integrating this cadre into the government staff establishment. There is already a large number of professional health staff (~4500) currently paid by donors that will be difficult for the government to absorb due to civil servant wage bill constraints, administrative difficulties to absorb positions allocated to Health by the Ministry of Finance, as well as an insufficient health budget to allow new cadres into the staff establishment [MISAU 2014c]. In addition, lesser trained or "lay" cadres cannot be accepted as civil servant health staff according to current standards, as government entry criteria require 1.5 to 3 years of specialised education (i.e. after grade 12).

There has been some discussion about allowing integration of lay counsellor tasks into the Mozambican equivalent of CHWs, the Agentes Polivalentes Elementares (APEs), who are trained for 18 weeks and given a limited stipend of approximately 40 USD per month; APEs are mainly funded by the World Bank and UNICEF, but managed by MoH. HIV is not included in their current job description, and care would need to be taken not to 'over-task' this cadre at the expense of quality. In addition, there needs to be an appropriate balance between presence at community versus health facility, since counselling needs require sufficient facility-based human resources. Moreover, some tasks that require more advanced counselling skills might not be able to be performed by the generalist APEs.

While the national psycho-social strategy mentions the need to advocate for funds for counsellor positions in the new financing model of GFATM, and the inclusion of the cadre of counsellors in the national strategic HR plan 2015-2017, counsellors have not been included in the new GFATM proposal. This is because they are not considered a priority, especially since it is not clear that absorption into government staffing structures is possible and the process for potential inclusion in the Mozambican health establishment is slow. It is worrying that there is currently no budget identified to increase the number of counsellors. This presents a vicious circle in that as counsellors are not officially recognised as one of the MoH cadres and there is therefore reluctance for donors to finance this health resource. Other challenges ahead are to implement the developed standards of training and job description, whilst ensuring good supervision.

Table. ***Recognition of counsellors in Mozambique***

Pillars Recognition of Mozambique lay counsellors	
Harmonisation	• Agreed job profile but needs updating • Remuneration: 117 USD proposed by MoH but high variance in remuneration/stipends (40 - 250 USD/month). • Training for HTC lasts 2 weeks; modules prepared for a 2-month training in HTC/adherence • Supervision through nurse, psychologist or NGO supporting the counsellors • Pre-education criteria defined at 10th grade, but currently great variety and mostly not 10th grade
National Strategy	National ART Acceleration Plan 2013 National Psychosocial Strategy 2014 (soon to be endorsed) Implementation of national strategy not yet happening. 501 counsellors currently supported by NGOs; accepted but not yet harmonised
Financing	Majority international (NGOs), but some health centres pay lay counsellors through local/district contracts.

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SOUTH AFRICA

Counsellors and CHWs financed at provincial level but lack of clarity on tasks and remuneration

Table. ***General country indicators for South Africa***

General / macroeconomic	Population:	50.7 million (37.6% rural) [UNDP 2013]
	GDP/capita (ppp/USD):	9678 USD [UNDP 2013]
	HDI:	121 [UNDP 2013]
Health	Government resources allocated to health (% of total government budget):	13% [WHO GHED 2012]
	% of the health budget coming from donors:	2% [GHED 2012]
	% of the HIV budget coming from donors:	22% [NDOH 2014]
Human Resources for Health	77 doctors, 408 nurses/midwifes per 100,000 (2013) [MoHSW 2013a]	
HIV response	Adult HIV prevalence:	19.1% (6.3 million PLHIV) [UNAIDS, 2014a]
	ART coverage according to WHO 2013 Guidelines:	42% at end of 2013 [UNAIDS 2014a]
	Retention at 12 months in 2012 (adults + children):	80% [UNAIDS 2013]
	Population (aged 15-49) received HIV test in the past 12 months:	45% [HSRC 2014]

USD: United States dollar; HDI: Human development index; GDP: gross domestic product

Background

South Africa has a generalised HIV and related TB epidemic: 19.1% of adults are living with HIV and there is a reported TB incidence of 1,003 cases per 100,000 [WHO 2014]. The country has the largest ART programme in the world [UNAIDS 2014a] and to date the government had expanded ART to 3 million people. In addition, the ART eligibility criteria are progressively expanding in South Africa, with the CD4 count threshold rising from 350 to 500 cells/µl in January 2015 [Minister of Health 2014].

A 10-year improvement in average life expectancy at birth has been observed for South Africans since the early 2000s, when ART access was scaled up [MRC 2013]. However, there are still around 200,000 HIV-related deaths per year, since HIV and related opportunistic infections (especially TB) remain the leading burden of disease in the country.

4. Personal communication relaying internal audit findings conducted by National Department of Health with support from National Treasury, 21 Oct 2014.

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Counsellor organising an adherence club, Khayelitsha, South Africa

South Africa has an inequitable distribution of health workers with health workers primarily based in the private sector and urban areas, resulting in large inequalities in access to health care [McIntyre 2009]. For example, the Western Cape, a rich, urban province has over triple the number of doctors per capita than four of the most rural provinces [Ashmore 2013]. These inequalities, which mirror inequalities of income and service access across South and southern African society, are important drivers of the need for task shifting to achieve ambitious HIV and TB treatment targets.

South Africa has a model whereby lay counsellors fall under the umbrella of community health workers (CHWs), yet are facility-based and focused on HIV/TB counselling. Financial and supervisory support is delegated to the provinces and takes place through mixed funds from both (provincial) government and donors.

Harmonisation of strategies and operationalisation

HIV Testing and Counselling (HTC) has been primarily performed by lay counsellors in South Africa. This has been the case since the government rolled out its mass testing campaign in April 2010 that also involved Provider-Initiated Testing and Counselling (PITC) or 'opt out' testing. In Limpopo, lay counsellors were already providing voluntary counselling and testing (VCT) for PMTCT as early as 2005 [Malema 2005].

The National Department of Health's (NDOH) HTC guidelines [NDOH 2010a] generally allow for CHWs to provide HTC, but at present it is rare for CHWs to perform HTC in South Africa except through pilot projects and home-based care programmes. Lay counsellors, meanwhile, generally work full time in clinics and conduct all HIV tests, including those referred by nurses and doctors. Their other tasks include sometimes counselling related to ART initiation and adherence support.

Lay counsellors are grouped with CHWs, a cadre that has faced issues around clarity of roles and lack of support and recognition [Schneider 2008]. There are currently around 72,000 CHWs, including 10,000 counsellors working in South Africa [personal communication Director of Care and Support National Department of Health, HIV/AIDS and TB]. Ideally CHWs should take on certain HIV/TB-related community tasks such as door-to-door HTC, tracing of clients who have missed appointments and supporting community models of care such as 'ART clubs[5]' that are run in community venues; however, these activities are not routinely conducted.

Counsellors in some provinces (e.g. KwaZulu-Natal) only focus on HTC, even as adherence counselling and patient education remain neglected areas. This is contrary to what happens in other provinces such as the Western Cape and Eastern Cape, where adherence counselling is standard practice among counsellors. More specifically, in Western Cape Province, there are different HTC counsellors and adherence counsellors. CHWs are in some cases managed only by the Department of Health, while in other cases they are managed by multiple government departments. This points towards a lack of standardisation of the practice and management of lay workers – both counsellors and CHWs – and the need for clarification of guidelines.

Provinces in South Africa are expected to implement counsellor and CHW plans without specific budgets for this purpose, and to make matters worse, there is little guidance on appropriate numbers, roles and responsibilities from the national level. The integration of HTC into other PHC diagnostic services is planned for at the national level, and could be expected to improve retention in care, but implementation is a challenge at lower levels.

Several challenges have been observed in different sites across the country, related to supervision of and reporting by counsellors. Supervision is normally performed by counsellor supervisors; due to gap filling however, supervision activities often do not take place. If not supervised properly, lay counsellors are often obliged to do other tasks such as administration, data filing and driving. Counsellor supervisors are generally employed outside of the government by multiple NGOs and having dual reporting lines can create a problem if neither the NGO nor the government take on the responsibility for lay counsellors or the quality of their performance. Lay counsellors are provided with ten days of standardised training that focuses on HIV Testing and Counselling; in Western Cape province, the AIDS Training, Information and Counselling Centre (ATICC) provides additional modules on PMTCT and paediatric counselling.

In the town of Eshowe in KwaZulu-Natal (KZN) province, CHWs are not allowed by the Department of Health to provide HTC. This is despite use of this cadre having been shown to be highly feasible at 'scale up' of testing and highly effective at targeting individuals being tested for HIV for the first time or infrequently, when employed in an MSF-supported project there. Meanwhile, government-employed CHWs can be overburdened with a list of tasks, which is partly the result of being managed by several departments, including the Departments of Education and Social Development (social services), in addition to the Department of Health. It has also been demonstrated in Eshowe that adherence counsellors can reduce the need for a switch in ART regimen in those at risk of treatment failure (i.e. those with high viral loads) through suggesting potential cost savings [Shroufi 2013].

National Strategy

The national government has set policy regarding counselling and testing through a number of guidance documents: the National Strategic Plan (NSP), 2010 HCT Guidelines and a Primary Health Care Re-Engineering Framework [SANAC 2011, NDOH 2010a, NDOH 2010b]. In addition, the government is finalising an integrated Adherence Guideline for HIV/TB and noncommunicable diseases, along with additional guidelines for HTC that will inform the reinvigorated HTC campaign in which lay counsellors are utilised. In order to support the implementation of an expanded set of skills NDOH should work with Treasury to earmark funding for the counsellor and CHW programme and give clear advice around the role of all lay workers, along with standardised tools for harmonising and monitoring HTC and adherence counselling in all provinces.

5. ART adherence clubs (ART clubs) are a long-term retention model of care that caters for stable ART patients. They meet at health facility or community level and are facilitated by a non-clinical staff member who provides quick clinical assessment, referral when necessary, peer support and group distribution of pre-packed ARV medication every 2 months. Once a year, a clinician provides clinical management. This concept originated in Khayelitsha, Western Cape, South Africa in 2007 and Global Fund is currently funding national scale-up [Bemelmans, 2014].

Provinces need to be held to account on the implementation of lay health worker projects, for HTC and for other standard activities. This can be achieved through audited performance and business plan reporting, by the Office of Health Standards and Compliance, and through active engagement with civil society monitoring organisations.

An unprecedented scale up in counsellor- and CHW-supported HIV testing and counselling will be required to realise the goal in the HIV/TB/STI National Strategic Plan [SANAC 2011] to test 30 million people per year in South Africa by 2016, as well as NDOH plans to almost double the number of people on ART (currently 3 million) by 2019 under the new 2013 WHO ART guidelines [NDOH 2014]. While ART targets continue to be ambitious, HTC targets have been revised downwards by NDOH and currently sit at 10 million per year over the three year Medium Term Strategic Framework [Mabuto 2014].

Financing

The salaries of CHWs or counsellors range from ~90 USD per month in Mpumalanga province to ~200 USD in Gauteng province and ~335 USD in Western Cape. There is little harmonisation of approaches to training, monitoring and evaluation, and tasks across provinces such as services and management are delegated from national to provincial level. For example, five provinces employ lay workers indirectly through NGOs, which is less expensive but delays the professionalisation of HTC services; the remaining four provinces employ lay workers directly through government payroll [Mail & Guardian 2014]. There is an ongoing debate at national level over whether counsellors and CHWs should be absorbed into the government's payroll or employed by NGOs. This is primarily a budget debate since several of the provinces are already in large amounts of debt, which has resulted in freezes on hiring of new health staff. Treasury is therefore reluctant to promise any new money, given that CHWs and lay counsellors would become eligible for significant additional benefits if made civil servants.

In KZN province, health authorities have decided to phase out the use of counsellors from the health facilities, while proposing to finance additional studies for lay counsellors in order to become nurses. As a result, the number of counsellors has been reduced in the clinics without a clear plan to fill the gap that is created and ensuring that HTC, ART initiation and adherence counselling continue to be available. The aim of professionalising counsellors and integrating services is praiseworthy, but poor planning can also result in poor service delivery on the ground.

Table. ***Recognition of counsellors in South Africa***

Pillars	Recognition of South African facility-based lay counsellors
Harmonisation	• Job profile varies per province; some separate HTC and adherence counsellor • Remuneration/stipends: varied according to province; 90-335 USD per month • Training: basic training of 10 days for HTC but differs by NGO. Additional modules on TB, PMTCT, etc are not standardised nationally. • Supervision: by counsellor supervisor or nurse/clinician in-charge, but often lacking and dual reporting lines • Pre-education criteria: high school
National Strategy	HTC Guideline 2010, NSP and PHC Re-Engineering Framework
Financing	Mostly provincial budgets with some additional donor funds

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Community Health Agent, doing door to door HIV testing. KwaZulu Natal, South Africa

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SWAZILAND

task shifting policy framework exists, but lacking implementation since the country is still working on it.

Table. ***General country indicators for Swaziland***

General / macroeconomic	Population:	1.2 million (78.8% rural) [UNDP 2013]
	GDP/capita (ppp/USD):	5,349 USD [UNDP 2013]
	HDI:	141 [UNDP 2013]
	Wage bill:	14% of GDP [IMF 2014]
Health	Government resources allocated to health (% of total government budget):	18% [WHO GHED 2012]
	% of the health budget coming from donors:	22% [WHO GHED 2012]
Human Resources for Health	17 doctors, 160 nurses/midwifes per 100,000 (2009) [WHO GHOD 2014]	
HIV response	HIV prevalence:	27.4% (200,000 PLHIV) [UNAIDS 2014a]
	ART coverage according to WHO 2013 Guidelines:	49% [UNAIDS 2013]
	Retention at 12 months in 2012 (adults + children):	89% [UNAIDS 2013]
	Population (aged 15-49) received HIV test in the past 12 months of 2012:	21.9% (F) / 8.9% (M) [UNAIDS 2013]
	TB incidence rate:	1380 cases per year per 100,000 inhabitants [MoH 2012]
	MDR-TB:	estimated 200 cases yearly [MoH 2012]

USD: United States dollar; HDI: Human development index; GDP: gross domestic product

Background

Swaziland has the highest HIV prevalence rates in the world with an adult prevalence of 27.4% [UNAIDS 2014a]. By the end of 2013, 100,138 people were receiving ART and 9,522 (84%) of the 11,307 HIV-positive women were receiving PMTCT services (84%). The percentage of HIV-infected infants born to HIV+ mothers decreased from 12% in 2011 to 3% (at age 6-8 weeks) as of the end of 2013 [MoH 2013].

Swaziland is the only country out of the eight assessed in this report that has developed a detailed task shifting framework that accommodates lay cadres. However, there have been challenges and delays in its implementation and the framework is not yet officially launched.

Harmonisation of strategies and operationalisation

In recent years Swaziland has introduced a number of positions requiring less training compared to traditional health workforce cadres. These lay cadre positions include basic HTC counsellors and Adherence Support Workers (collectively referred to as Expert Clients), 'Mothers2mothers' (also known as 'Mentor Mothers'), and TB expert patient and community treatment supporters.

1. **Expert Clients (ECs)**

   Adherence officers are collectively known as expert clients. There are 452 ECs in Swaziland, which includes both government- and NGO-managed staff. These are HIV-positive community members who work on a full-time basis in different facilities throughout the country, seeing an average 20 clients per day [MoH staffing report]. They are responsible for adherence counselling and patient follow-up, as well as psycho-social support for HIV-positive clients, all of which should improve retention in care. In addition, ECs provide assistance to nursing staff by retrieving patient files, pre-packing certain medications and taking basic anthropometric data from clients. The Adherence Support Workers are generally not trained to provide HTC[6], but are trained specifically in working with patients at risk of treatment failure (i.e. those having a detectable HIV viral load), PMTCT Option B+ counselling, paediatric disclosure counselling, and patient support for those with MDR-TB.

2. **Mothers2mothers**

   Mothers2mothers (m2m) is a donor-funded organisation. The 'Mentor Mothers' are a group of HIV-positive women who are based in clinics that support PMTCT activities. They provide pretest and ongoing HIV counselling for pregnant women receiving PMTCT interventions, and support nurses in early infant care. The programme began in 2008 and there are currently 61 sites across the country, in which 29 site coordinators and 94 Mentor Mothers work. On average, they see 30 clients per day [mothers2mothers 2015].

3. **TB Expert Patient and Community Treatment Supporters**

   TB Expert Patients are supported by MSF and are community-based workers in Manzini and Shiselweni. They provide adherence counselling and support to clients who have multi-drug resistant tuberculosis (MDR-TB), conduct home visits to TB clients on treatment and work in collaboration with rural health motivators to ensure adherence and improve out comes for clients.

There are two levels of HTC counsellors in Swaziland: the more qualified nursing assistants and diploma holders in a health science-related field or social science and referred to as HTC counsellors (HTCC), while the lay HTC counsellors have a basic high school education. In order to be certified as a HTC counsellor, both levels must undergo the standard HTC training.

Training of HTCCs is provided by the Swaziland National AIDS Programme (SNAP) and the National Reference Laboratory, in collaboration with HTC implementing partners. Currently there are two government-accredited organisations, Population Services International and The AIDS Information and Support Centre offering HTC training, which consists of two weeks of theory and six weeks of a practical training attachment. Training is harmonised through the use of a country specific curriculum. The national Expert Client Coordinator and the national HTC Counsellor Coordinator ensure regular field visit support and supervision. In addition to this, HTC counsellors receive further on-the-job training plus refresher trainings provided by their technical supervisors, who are usually health care workers with higher educational qualifications (e.g. nurses).

6. An exception exists in Shiselweni region, where MSF has trained Expert Clients to conduct HTC services.

Recruitment of Expert Clients, both HTC Counsellors or Adherence Support Workers, takes place through the catchment area of a health centre; applicants need to be HIV-positive and ready to disclose their status to be an expert client. The current recruitment criteria and job description from the MoH are in line with the nationally defined, but not yet endorsed, task shifting Framework of 2011.

Given that there are currently no staffing norms in Swaziland related to health infrastructure, whether it is for traditional positions such as nurses and medical doctors or for newly proposed positions from the task shifting framework, allocation of lay people to health facilities is done based on need, as defined by partner organisations or on the availability of funding. In theory, although needs assessment should be done by the MoH and proposed to the Ministry of Public Services, the latter is currently not involved in this allocation, so official absorption of HTCC positions is not yet taking place. The development of staffing norms was planned for 2013 according to the Human Resources for Health Strategic Plan 2012-2017, but has not yet been finalised [MoH 2011a].

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Mother and child at pharmacy, dispensary counter. Swaziland, Matsapha industrial area

National Strategy

In 2011 Swaziland developed a task shifting Implementation Framework, a product of joint efforts between the MoH, professional regulatory bodies, professional associations, training institutions, NGOs, health cadres and development partners [MoH 2011b]. This framework outlines guiding principles, goals and objectives of task shifting. Although not yet officially launched, it recommends tasks to be shared between the different health cadres and provides a process for implementation, including a roadmap and proposed supportive measures such as supervision and mentoring, monitoring and evaluation, advocacy and resource mobilisation.

With regards to shifting of non-medical tasks from nurses to lower level staff members, the framework proposes that patient education on disease prevention, HTC, sputum collection, defaulter tracing, contact tracing, adherence counselling and follow-up at community level should be shifted from nurses to 'Health Motivators', levels 1-3. Health Motivators are described as follows:

1. **Health Motivators, level 3 (HM3)** include Rural Health Motivators, Home Based Carers, Adherence Treatment Supporters and Community Volunteers who have completed their O Level (secondary) education and have attended a 12-week MoH Health Motivators' training. They serve as a liaison between clinics and communities and are responsible for conducting health promotion and education, defaulter tracing, as well as providing home-based care, first aid, and other related primary health care activities.
2. **Health Motivators, level 2 (HM2)** are qualified HM3s with additional specialised training. These consist of Mentor Mothers, Expert Clients, Community Based Communication Agents, Peer Educators, Adherence Officers, Male Circumcision Recruiters and Cough Officers. Serving as liaison between clinics and the communities, their responsibilities include conducting community health talks and distributing information, education and communication (IEC) materials and condoms, defaulter and contact tracing, establishing community support networks, and making clinic referrals/linkages.

3. **Health Motivators, level 1(HM1)** are Lay Counsellors, Social Counsellors, HTCCs and Community Based Educators. They are HM2s with an additional five weeks of specialised training. HM1s are responsible for pre-and post-test HIV counselling (including preventative counselling) as well as ongoing counselling as described in the National HTC Guidelines. HM1s also provide health education, counselling to orphans and vulnerable children, and make clinic referrals/linkages.

To date, the task shifting Implementation Framework has not been implemented. There are constraints at policy level with a lack of clear implementation and operational plan, including costing and budgets. Nonetheless, task shifting has been informally taking place in Swaziland for a long time.

Given the increasing task shifting practices that are occurring at different levels of health care delivery in the country, implementing partners have been pushing for related policy change. The MoH realises the urgency to formalise the task shifting Framework as appropriate. The HRH Strategic Plan 2012-2017 highlights the application of this Framework as one of the key HR management issues to be addressed. The MoH started implementing the strategy and addressing issues related to absorption of donor-funded positions including some positions created as part of the task shifting strategy. The absorption of HTC and Adherence support staff remains a challenge, as there are no corresponding posts within MoH and the Ministry of Public Services.

The two ministries have however agreed in principle on the need to absorb these positions and are currently engaging on the issue.

Financing

At present, all HTC counsellors and Adherence Support Workers are remunerated by partner organisations, mostly by PEPFAR-funded NGOs and GFATM. Their remuneration varies per organisation: the salaries of HTC counsellors range from 360 - 550 USD per month including benefits. Adherence Support Workers, on the other hand, receive a monthly allowance of not more than ~110 USD.

Table. ***Recognition of counsellors in Swaziland***

Pillars Recognition of Swaziland counsellors	
Harmonisation	• Job profiles are developed for three levels of lay cadres • Remuneration/stipends not clarified, great variety: 360 - 550 USD per month • Training recognised by the MoH, 2 weeks classroom, 6 weeks practical • Supervision by Medical staff in the facilities • Pre-education criteria: high school
National Strategy	Swaziland task shifting Framework 2011 (not endorsed) Small chapter in the Human Resources for Health Strategic Plan 2012 -2017
Financing	All partner funded

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MSF staff addressing the community during community testing campaign in Shiselweni region, south of Swaziland

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ZAMBIA

Final steps towards full operationalisation of MoH-recognised counselling cadre

Table. ***General country indicators for Zambia***

General / macroeconomic	Population:	13.9 million (60.4% rural) [UNDP 2013]
	GDP/capita (ppp/USD):	1423 USD [UNDP 2013]
	HDI:	163 [UNDP 2013]
Health	Government resources allocated to health (% of total government budget):	16% [WHO GHED 2012]
	% of the health budget coming from donors:	68% [WHO GHED 2012]
Human Resources for Health	7 doctors, 78 nurses/midwifes per 100,000 (2010) [WHO GHOD 2014]	
HIV response	HIV prevalence:	12.5% (1.1 million PLHIV) [UNAIDS 2014a]
	ART coverage according to WHO 2013 Guidelines:	55% at end of 2013 [UNAIDS 2014a]
	Retention at 12 months in 2012 (adults + children):	80% [UNAIDS 2013]
	Population (aged 15-49) received HIV test in the past 12 months of 2012:	18.5% (F) / 11.7% (M) [UNAIDS 2013]

USD: United States dollar; HDI: Human development index; GDP: gross domestic product

Background

Zambia has a similar population and HIV prevalence as some of the assessed countries, but has a higher GDP and higher number of available health staff compared to some of the other countries in the region (e.g. Malawi). The country has managed to scale-up HIV care and treatment to reach 55% of people with ART by the end of 2013 [UNAIDS 2014a].

Zambia seems to be the only country of the eight countries assessed in this report that has managed to absorb lay counsellors, recognising counselling as an important aspect of HIV care.

Harmonisation of strategies and operationalisation

Today in Zambia, there are several cadres of health care workers involved with counselling. The first group are the lay counsellors that were introduced and paid (or incentivised) through the different partner organisations as part of the HIV testing scale-up, providing 70% of the counselling and testing services at health facilities in 2008 [Sanjana 2009]. Lay counsellors at facility level initially focused their work on HIV services, mainly HTC, as well as ART preparation and adherence counselling; additional general clinic tasks, as well as mental health counselling responsibilities, were added over time, in line with the move towards integration of HIV care into general health services [Simbaya 2013]. None of the lay counsellors are currently funded by the Zambian Government.

Work on establishing a new formalised counselling cadre started in 2009 with an official request from MoH to the Ministry of Finance (MoF). Dialogue was organised at the national level between MoH and partners after observation of significant fragmentation in management of lay counsellors and the risk of disruption of vital services due to a lack of long-term funding for these lay cadres.

Different levels of counsellors with different requirements and remuneration packages were defined. Actual recognition and absorption into the establishment took approximately two to three years; a new cadre of psycho-social counsellors (PSCs) was introduced and their absorption into the MoH staff establishment was finalised in 2011.

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Lay counsellors can still continue their work on HTC and adherence counselling through support of NGOs but PSCs are the preferred facility-based lay cadre. The target is to have three PSCs at hospital level and two to three PSCs at health centre level depending on the patient load.

The MoH certified training for PSC which is a standardised eight-week training, with two weeks of theoretical classroom training and six weeks of on-the-job-training. This training package had already been implemented for the lay counsellors before actual full recognition of the PSCs, and was conducted through MoH with support of its partners such as USAID, Society for Family Health/PSI (SFH) and the Center for Infectious Disease Research (CIDRZ). Whereas LC training had a main focus on HTC, the PSC training is now a more integrated training package linking to other chronic diseases as well.

The minimum educational requirement for PSCs is 12th grade (secondary school level). Those LCs already deployed by partners were given preference for the PSC training, such that a number of LCs have now become PSCs. LCs or PSCs are sometimes PLHIV themselves, but not necessarily and are mostly recruited from the catchment area of each health centre.

The remuneration package for PSCs has been defined by the MoH at 500 USD per month; in comparison, the lowest level nurse receives ~640 USD/month. However, harmonisation in remuneration has not yet taken place for NGO-supported LCs and PSCs (i.e. those not yet absorbed by the MoH), whose package varies between volunteer work and 150 USD per month.

LCs and PSCs initially fell under the home-based care/HTC Programme of the Ministry of Community Development Mother and Child Health but they transitioned in early 2014 to become under the Mental Health Department of the MoH.

Those who have previous training, either a diploma in social work or any social or health field, and participate in the eight-week PSC training, plus an additional 'training of trainers' course, couples counselling or counselling for children and adolescents, are considered para counsellors; this cadre is considered to be one level higher than that of the PSC. A para counsellor could for example be a nurse with additional training in counselling. Depending on the person's initial qualifications and position in the MoH, the individual is remunerated accordingly. Para counsellors often act as a reference person or undertake supervision to PSC and LC from hospital or district level.

Day-to-day supervision of both PSCs and lay counsellors in the clinics takes place through the nurse or clinician in-charge. Overall coordination of PSCs and lay counsellors at district level is to be performed by a professional counsellor, with a degree in either social work or pastoral care and after having gone through a certified short course in PSC. The aim is to have at least one professional counsellor per district.

Community HTC and counselling activities are increasingly being taken up by members of the community, who either volunteer their services or are paid by NGOs. A new cadre of community health workers, called "Community Health Assistants" (CHAs), was introduced into the Zambian health system in 2010 with the aim to provide HTC services at Health Post[7] Level, as well as provide a link between the community workers doing testing and the health centre [Zulu 2014]. The target was to have 5,000 CHAs but their integration into the establishment has been stalled; due to limited resources, only approximately 650 CHAs have completed their training and been deployed so far. They would at least have to earn the new minimum wage and receive similar conditions as other civil servants. They are at present being funded by Department for International Development (DFID) and receive a monthly stipend of ~100 USD/month. Not only are CHAs seen as a form of career progression for lay counsellors, but they could also go on to become nurses or clinical officers.

The table below summarises the different levels of counsellors based at different locations in the Zambian health care system and depending on their background and training.

Table. ***Counselling cadres in Zambia***

	Pre-Education Level	Length of counselling training	Remuneration (per month)	Tasks and Location within the health care system	Recruitment
Lay Counsellors	Read & write, preferably 9th grade	8 weeks	Varies depending on organisation with whom they work; from 0-150 USD	HTC / adherence support. Meant to be in community but still mostly based at Health Centre (HC).	From the community; usually selected by HC nurses and community leaders.
Psycho-social Counsellors	Grade 12	8 weeks	500 USD if on Govt. payroll; if with an NGO, it varies between 100-300 USD/month	HTC / adherence support and other chronic diseases. Based at urban and rural HC level	From the community; 18-45 years
Para Counsellors	Diploma or degree in any field plus certificate in any counselling training	8 weeks of PSC, plus duration of certificate training	If with MoH, usually paid a salary based on initial qualifications	Advanced counselling and supervision. Based at high patient load HCs, hospitals and supervisory bodies (Ministry/DHMT)	Open advertisement through individual application
Professional counsellors	Counselling or social discipline related degree	8 weeks of PSC, plus duration of diploma or degree	If with MoH, usually paid a salary based on initial qualifications	Overall coordination and supervision. Based at hospitals and supervisory bodies (Ministry/DHMT)	Open advertisement through individual application
Community Health Assistants	Grade 12	1 year	~100 USD at present	HTC at community and other health tasks. Based at Health post / community	

7. A Health Post is generally referred to as a rural site where primary health care services can be provided, smaller in size and with fewer trained health staff than a health centre.

Lack of supervision of counsellors has been mentioned as a challenge (personal communication with representatives of the Ministry of Community Development Mother and Child Health because partners supporting PSC/lay counsellors do not usually support the recruitment and remuneration of supervisors. The national set target is to have two or three PSCs per health facility. Currently, as there is not yet a sufficient number of PSCs, there is a mix of PSC, lay counsellors and community volunteers, totaling two to three per health facility. This mix consists of mainly lay counsellors and community volunteers at rural sites versus mostly PSCs and professional counsellors in urban areas [personal communication with implementing partners CIDRZ and SFH]. Even though lay counsellors are now to be based mostly at community level, there is still a high level of rotation through the health facilities.

National Strategy

There is a National Community Health Worker Strategy in which the role and position of CHAs is defined [MoH 2010] as well as national guidelines for HIV counselling and testing, both general as well as specific for children [MoH 2006, Zambia National HIV/AIDS/STI/TB Council 2011].

Professional body

Since 1996, Zambia has a professional body for counsellors, the Zambia Counselling Council (ZCC), initiated by the MoH, that protects them as a cadre, ensures counselling standards are in place and adhered to, as well as provision of mentorship and guidance. After certification, any lay or professional counsellor is to register with ZCC that issues them annual practising licences to work at clinic or community level. The Council's added value is that it provides a certain level of professional status and recognition amongst the workforce. It has the ability to regulate the professional conduct of its members and will in the near future have statutory powers. The ZCC is invited to attend all policy revisions to ensure the rights of its members are observed and/or taken into consideration. One of the prerequisite requirements for recruitment of psycho-social counsellors in the MoH or any other organisation is that they must be registered with ZCC, being an important step in the recognition process of psycho-social counsellors in Zambia.

Financing

Until recently, all lay counsellors and PSCs were supported through international donors and in particular NGOs supported by PEPFAR. The government of Zambia is now able to include a limited number of PSCs within their official staff establishment, between 800-1000 out of the ~40,000 that have been trained thus far [personal communications with Mr. Friday Nsalamo, department of Mental Health, MoH]. Every year new positions continue to open but the process is slow.

Partners mostly involved in the support, including training of the cadre and curriculum development, are Family Health International (FHI), CIDRZ, SFH, World Vision and USAID.

Table. ***Recognition of counsellors in Zambia***

Pillars Recognition of Zambia psycho-social counsellors	
Harmonisation	• Agreed job profile, focus on HIV • Remuneration defined by MoH: 500 USD/month, but in practice varies between NGOs (100-300 USD/month) • Training: 8 weeks coordinated by MoH, paid by partners • Supervision through nurse/medical in-charge • Pre-education criteria defined at 12th grade
National Strategy	National Strategy National HIV Counselling and Testing guidelines Financing GoM slowly absorbing an increasing number of positions within their payroll
Financing	Government of Zambia slowly absorbing an increasing number of positions within their payroll (800-1000), but majority still paid by partners

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ZIMBABWE

Full recognition but 100% dependency on external funds

Table. ***General country indicators for Zimbabwe***

General / macroeconomic	Population:	13 million (60% rural) [UNDP 2013]
	GDP/capita (ppp/USD):	424 USD [UNDP 2013]
	HDI:	172 [UNDP 2013]
	Wage bill:	68% of GDP (MoF 2013 in New Zimbabwe)
Health	Government resources allocated to health (% of total government budget):	10% (MoF 2012)
	% of the health budget coming from donors:	70% [WHO GHED 2012]
Human Resources for Health	6 doctors, 125 nurses/midwifes per 100,000 (2009) [WHO GHO 2014]	
HIV response	HIV prevalence:	15% (1.3 million PLHIV) [UNAIDS 2014a]
	ART coverage according to WHO 2013 Guidelines:	51% at end of 2013 [UNAIDS 2014a]
	Retention at 12 months in 2012 (adults + children):	85% [UNAIDS 2013]
	Population (aged 15-49) received HIV test in the past 12 months of 2012:	33.6% (F) / 20.5% (M) [UNAIDS 2013]

USD: United States dollar; HDI: Human development index; GDP: gross domestic product

Background

Zimbabwe has achieved a relatively high coverage of ART, even after fully adopting the WHO 2013 treatment guidelines. Decentralisation and task shifting have played a crucial role in the scale-up of HIV services. Zimbabwe is doing better than some of the other countries in the region regarding availability and education level of health staff, albeit with an unequal distribution of staff between urban and rural areas and with the country having a very high wage bill.

Counsellors have been recognised by the MoH in Zimbabwe with clear roles and lines of supervision, however funding has been 100% dependent on donors, particularly the GFATM.

Harmonisation of strategies and operationalisation

In 2006 a cadre called primary counsellors (PC) was created in Zimbabwe. Due to a lack of domestic funding and the existing high wage bill, they have not yet been put on the government payroll. This cadre was a response to the need for additional staff for the HIV response and was initially meant to fill a critical gap in HTC. Their tasks presently include group HIV education, pre- and post-test counselling,

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Counselling session to switch a patient to second-line treatment. Buhera district, Zimbabwe

ART initiation and adherence support for adults, children and PMTCT, plus counselling for TB/MDR-TB, as well as other general health service support [Sibanda 2012, MoHCW 2014]. During an assessment of the PITC system in Zimbabwe, nurses reported that PCs helped to relieve workload significantly and enabled nurses to focus on clinical tasks and quality of care [Sibanda 2012].

PCs are recruited by the District MoH, sometimes together with the supporting NGO, from the clinic's local community with recommendation from the local leaders. Educational requirements are at least 5 O levels. Training for PCs is coordinated by the Provincial Training Coordinator and the National level HIV Testing and Counselling Department. The training used to take six months, with two weeks of in-class training, followed by a period of practice in the health facilities. After the practical experience, they go back to class for another week at the end of the six-month period. The minimum duration for this cadre to be absorbed into the MoH staff establishment was extended from six to nine months in 2013 to also accommodate other areas on counselling, i.e. TB/MDR-TB, PMTCT 'Option B+[8]' and HIV virological failure. The content however is still mainly focused on HTC as in the previous six month curriculum. Training was mostly coordinated by the Zimbabwe Association of Church Hospitals and MoHCC (Ministry of Health and Child Care) and financed through GFATM, PEPFAR, European Union (EU), Expanded Support Programme on HIV ESP (2007-2012 this was a consortium of DFID, CIDA, SIDA, Norwegian Embassy, Irish AID).

The nurse in-charge, responsible for their supervision, undergoes a one-week supervision training; however, the nurse is usually overwhelmed by regular clinical work to spend sufficient time on supervision. At district or national level the PCs do not yet have a representation, which adds to the challenges in their supervision and overall technical coordination. At national level, PCs fall under the HTC department of the HIV/AIDS and TB Unit.

MoHCC aims to have at least one full time PC per facility providing ART, independent of the actual workload.

Remuneration had been harmonised and set at 170 USD monthly. MoHCC would like to increase this amount to 300 USD but lack the resources to do so. In 2014 the GFATM has agreed to increase the amount of support to 220 USD monthly.

8. PMTCT Option B+ refers to triple ARV therapy for the entire life of all HIV-positive pregnant and breastfeeding women.

National Strategy

Guidance on whom and how to perform patient counselling and education is defined in the operational and service delivery manual for HIV care in Zimbabwe. PCs are included in national strategic plans which include The Zimbabwe National HIV and AIDS Strategic Plan 2011 – 2015 (ZNASP II), Zimbabwe National Guidelines on HIV Testing and Counselling in Children, and Zimbabwe HIV Care and Treatment Strategic Plan 2013 – 2017 [NAC 2011, MOHCW 2008]. The PC cadre was adopted by the MoHCC as part of the national health system. Zimbabwe also included PCs as a needed source for PITC, part of the essential minimum package of HIV care in their national HIV plan and operational and service delivery manual [MOHCW 2014].

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Young boys from a support group of rural area of Tsholotsho. Zimbabwe

Financing

PCs have been mainly funded by GFATM, with a small number supported by a few NGOs. MoHCC has proposed to absorb them into their establishment but due to the general freeze on staff and the high wage bill, this is very difficult and not feasible in the short term. The high dependency on donor funds puts a serious strain on continuity, as there are often delays in disbursement, which in turn cause delays in salary payment. GFATM as the main donor has only agreed on a salary of 220 USD per month, not the increase to 300 USD/month as requested by MoHCC, which led to dissatisfaction and demotivation among this group of staff, leading some to look for other job opportunities.

Table. ***Recognition of counsellors in Zimbabwe***

Pillars Recognition of Zimbabwe primary counsellors	
Harmonisation	• Agreed Job profile • Remuneration: 220 USD/month • Training: previously 6 months (3 weeks in the classroom, the remainder on-thejob) but now extended to 9 months • Supervision: nurse in-charge • Pre-education criteria: 25- 50 years old, 5 O levels (= secondary school), from the community
National Strategy	National Strategy Operational and service delivery manual for the Prevention, Care and Treatment of HIV in Zimbabwe [MOHCW 2014], ZNASP II [NAC 2011]
Financing	Mainly GFATM 72.2 million USD, with some by other partners – UNICEF, WHO, CDC giving a total of 89.4 million USD (MoF 2013).

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GUINEA — From acceptance towards recognition

Table. ***General country indicators for Guinea***

General / macroeconomic	Population: GDP/capita (ppp/USD): HDI:	10.5 million [UNDP 2013] 990 USD [UNDP 2013] 178 [UNDP 2013]
Health	Government resources allocated to health (% of total government budget):	7% [WHO Global Health Expenditure Database]
	% of the health budget coming from donors:	90% [WHO Global Health Expenditure Database]
Human Resources for Health	10 doctors, 51 nurses/midwifes per 100,000 (2005) [Global Health Observatory Data, WHO]	
HIV response	HIV prevalence:	1.7% (130,000 PLHIV) [UNAIDS 2014a], 2.7% urban*
	ART coverage according to WHO 2013 Guidelines:	24% at end of 2013 [UNAIDS 2014a]
	Retention at 12 months in 2012 (adults + children):	72% [UNAIDS 2013]
	Population (aged 15-49) received HIV test in the past 12 months of 2012:	1.1% (F) / 2.7%(M) [UNAIDS 2013]

* [2013 Annual Report of the Aids Treatment in Guinea (121 951PLWH) (spectrum 2013)

USD: United States dollar; HDI: Human development index; GDP: gross domestic product

Background

Guinea Conakry in West Africa has a prevalence of 1.7%, which is similar to other countries in the region. It has a relatively higher number of health professionals compared to Southern Africa. Scale-up of HIV care is limited to urban areas, with 90% of HIV services being offered in Conakry and Boke, Kankan and N'zérékoré, the four major urban areas within Guinea [UNGASS, 2010]. Decentralisation to primary health care settings and task shifting of ART initiation to nurses has not taken place in this context. ART coverage is estimated at 24% according to the national HIV programme [UNAIDS 2014a, PNPCSP 2013]. The country adopted the WHO 2013 guidelines in terms of national policy, but has not been able to implement them so far. More than half of the 27,792 patients on ART in the country are under the care of the Ministry of Health with the technical support of a NGO called Solthis, while other NGOs such as MSF and GIZ (German Development/Deutsche Gesellschaft fűr Internationale Zusammenarbeit) are responsible for the HIV care of around 11,000 patients. A counselling cadre, as implemented by NGOs, is accepted but not recognised by the Ministry of Health. Attempts are currently ongoing by partners to standardise initiatives involving counsellors.

Harmonisation of strategies and operationalisation

According to the national guideline on "Norms and Procedures for HIV Testing and Counselling" and the "Manual for Counselling and Psycho-social support for STI/HIV/AIDS", doctors, midwifes, nurses, nurse aids, 'agent technique de santé' (technical health agent) and volunteers that have gone through a training can perform HIV testing and counselling [CNLS 2009, CNLS 2014].

Several NGOs providing HIV care have recruited staff or volunteers to perform HTC, adherence counselling, and counselling for specific at-risk groups (e.g. children and pregnant women). MSF works with salaried staff having a diploma in social sciences who offer counselling services, plus volunteer PLHIV who get an incentive to perform health talks, provide peer support and support linkage to care. Other NGOs like Dream and GIZ work with volunteers from networks of PLHIV who receive incentives of between 340 – 375 USD per month to provide similar services.

Standards for HIV testing and counselling have been defined, but a standardised training package for counsellors does not exist. First steps towards harmonisation of counsellors were made in 2014 through the organisation of a workshop by the implementing partners, which clarified the tasks counsellors should perform, plus recruitment criteria, training and supervision required.

National Strategy

The national strategic HIV framework 2013-2017 gives neither guidance on strategies to ensure adherence and retention in care, nor guidance on who can support these strategies. The Ministry of Health is willing to look into these and has asked partners for help in developing such guidance.

Financing

In round 10 of the Global Fund, a subvention is foreseen for volunteers of networks of PLHIV who provide counselling in health structures. There is budget requested for 41 volunteers and peer educators already integrated in the care of PLHIV in health structures, who should receive 10 USD per month. This nominal amount is meant to cover the transport costs of volunteers to the health facility.

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Table. ***Recognition of counsellors in Guinea***

Pillars Recognition of Guinea counsellors	
Harmonisation	• No agreed job profile, recruitment criteria, training and supervision • Remuneration defined by partner between 340 – 375 USD/month
National Strategy	National Strategy Not defined, MoH willing to develop
Financing	Financing Round 10 subvention for volunteers requested (for transportation costs)

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HIV treatment distribution in a Community ART Group, Thyolo District, Malawi