



Transcript provided by kaisernetwork.org, a free service of the Kaiser Family Foundation¹
(Tip: Click on the binocular icon to search this document)

**XVII International AIDS Conference
HIV and Human Resources: Competing Priorities or
Interconnected Solutions?
August 3, 2008**

[START RECORDING]

DR. MUBASHAR SHEIKH: I welcome you all to this session which is jointly organized by the Global Health Workforce Alliance, UNAIDS and the National AIDS Society. The session which deals with HIV and Human Resources, completing the priorities or interconnecting solutions.

My name is Dr. Mubashar Sheikh, I am the Executive Director of the Global Health Workforce Alliance, an alliance which is a convener or an advocate which brings different stake holders and constituents together to discuss and deliberate and to address the issues related to the global shortage of health workforce in its broader terms within the functioning health system.

I am delighted and honored that I will be joined by Dr. George Alleyne, to co-chair this session of who is the United Nations [inaudible] special envoy on HIV/AIDS since 2003. He has a long and distinguished career in PAHO, which is the Pan American Health Organization including it's head from 1995 to 2003. He was knighted by the Queen Elizabeth II, and in 1990 for his services in medicines.

I would ask George if you want to say a few words to welcome the participants as well?

DR. GEORGE ALLEYNE: Thank you very much. Ladies and gentlemen, I would just join in welcoming you to this session. It is not really arrogance on my part to suggest that we will

be dealing with one of the most important issues in terms of the AIDS response. I look forward to hearing from you and to making a small contribution and I will turn you back over to Dr. Sheikh for continuation and to tell you what you are supposed to do during the course of these next two hours; welcome.

DR. MUBASHAR SHEIKH: We also are grateful that we are joined by an esteemed panel of speakers, over here among us on the stage, Dr. Peter Piot, who is the Executive Director of UNAIDS. We have Daisy Mafubelu, who is the Assistant Director General, Family and Community Health World Health Organization. We have Craig McClure, [misspelled?] executive director of the International AIDS society and we have Sigrun Mogedal, who is HIV/AIDS ambassador for the Norway and chair of the Global Health Workforce Alliance.

These distinguished speakers will take a few minutes to brief you on their thoughts and on the region in terms of the objectives and team of this particular session and I am sure we will greatly benefit from their contribution this morning.

Obviously, I am sure all of you will understand that we have a busy schedule here, so some of the speakers may not be able to stay with us for the whole duration of the session, but it is great and we are really grateful that they have joined us, and we also have with us, Dr. Jim Yong Kim, who will be the

moderator the entire session subsequent to the representations by the speakers.

Ladies and gentlemen, this session is facing a critical issue; an issue which goes directly to the heart of the team of this particular conference, which is the universal access to HIV/AIDS prevention, treatment, care and support.

We also know that there is a situation where we are facing a global shortage of health workforce. We know that there is a shortage of millions of health workers, more than 4 million, which is truly a global problem.

We also know that the greater problem is in Africa; in sub-Saharan Africa and in the developing world. We know that this issue is absolutely critical to overcome the shortage of health workers if we want to address this issue of universal access to HIV; its treatment, care and support. And that is why we thought this session will help us crystallize, understand and underline some of the key issues which emphasize the interconnectivity and the linkage and the synergies between the two issues.

We do hope that the speakers presentations as well as the two panel discussions, we will have the opportunity to learn a few more good practices, some of the issues, some of the challenges which you are facing in this particular area, but would also be able to have some kind of understanding that how we want to move forward, some of the key areas where we can

learn more, but really we can use this learning experience to move forward in addressing this global challenge, both in terms of shortage of health workers, as well as in terms of HIV/AIDS.

Just to give you a brief introduction while we are here, many of you might have joined us in Kampala in March 2008, where we had the first global forum on health workers. There, Dr. Peter Piot, who is sitting here, challenged us to take this agenda, because HIV/AIDS came forward very strong, in strong terms during the debate there. So he suggested that we should take this debate forward to Mexico, and I am glad that we could manage, and we are here to discuss exactly that particular issue.

I would not spend too much time on the technical side of the discussion, you have seen the objectives, and I am sure as we move along that they will be more clear. Because we are short of time, and we have to finish within the next two hours, I will just follow and make a brief introduction of the process which will follow in the next hour or so.

The session is designed in a way that we will have these four distinguished speakers. Each one will be requested to make a presentation of not more than five minutes, bringing different perspective of different constituencies. Then, we will request Jim to start moderating the panel discussions, where we have a very distinguished group of people. We have two sides, one is basically presenting the human health systems

and implementers group and others which are people and constituencies living and dealing with issues that are related to HIV/AIDS.

We hope that the two panels will be able to interact with each other on two specific themes. The first part of the panel discussion will look at the linkages between the health systems and in specific terms to shortage of health workers and HIV/AIDS. The two may be different tracks, but how do we need to come together, to work together to achieve the common objective of accessing and assuring universal access to HIV/AIDS in its specific dose, but also in the broader context of health system function and in terms of MDG's [misspelled?] and other related obligations.

But then the second half of the panel discussion will look into the area of stigma in terms of discrimination which are being faced by the people living with HIV, but also the health workers, from the peers and from the society at large. So these two discussions will follow one after the other, and we will be spending almost equal time on these discussions and requesting the panelists to share their thoughts and raise issues.

This will be followed by an interaction with the audience, all of you sitting here, so we will have about half an hour for that interaction. To make that interaction more meaningful, we are requesting that you please start writing

your question or query's and sharing with us. There will be people around from the secretariat who will go around and collect these questions, so please raise those questions, write down on a piece of paper which has been provided to all of you, and then we will collect them and obviously you will understand that it will not be possible for us to respond to all the questions, but we will try our best.

Jim I am sure will make an effort to respond to as many questions as possible with the help of the panelists, but just to assure you that even if we are not able to answer all of the questions, we will be able to include them in our report, and also maybe we can follow up with some of the discussion later on.

Very quickly, without any further adieu, let me start inviting the speakers. Our first speaker is Dr. Peter Piot, who is Executive Director of the UNAIDS. He is in this position since the creation of this body in 1995, and is also serving as the Under Secretary General of the United Nations. Drawing on his skills as a scientist, manager and activist, Dr. Piot has challenged world leaders to view AIDS in the context of social and economic development as well as security. Under his leadership, UNAIDS has become the chief advocate for worldwide action against AIDS. So Peter, would you please come?

PETER PIOT, M.D., PH.D.: Thank you very much Mubashar, and thank you for your leadership and for following up on what we indeed discussed at the workforce alliance meeting in Kampala, together with Sigrun Mogedal. It is really great because you can say it is normal to follow up on what we agree, but unfortunately, in the real world that does not always happen like that and I am very pleased to be on the podium with my good friends, the panelists.

I went to the meeting in Kampala because I am looking at where we are in the response to AIDS. It is very clear that when you take a long term perspective, there is no way that we can A) expand access to treatment, and B) that we can sustain what is being achieved without some serious investments in the health workforce.

The meeting in Kampala was not always easy because it is clear that we operate sometimes on different planets, those working in health systems, healthcare workers and those dealing with AIDS, but it is time to come together. And so it is the first time that I am aware of, that the International AIDS Conference is really addressing this issue, and it is long overdue and I am really happy with that and would like to thank the International AIDS Society for that.

We are definitely entering into a new stage in the response to AIDS in many, many countries with fewer people dying and fewer people becoming infected, although the AIDS

epidemic is not over anywhere in the world and it is going to be with us for many years.

On one hand, I can say that 3 million people are on anti-retroviral therapy in low and middle income countries, that is quite an achievement. On the other hand, there is double that number of people who do not have access; 6 million who are in need and do not have access. So we still have a long way to go, but it is the first time that a chronic treatment program is being implemented for resource environments.

In many cases, this achievement has come despite the fact that health systems are not really functioning, not because of them. It has really happened because there has been a movement. People have come together to demand treatment and to find ways to provide it.

It is really important to keep this achievement in perspective. AIDS is far from over yet. I think that it is the combination of the need for sustainability of the achievements to the need to expand treatment to those who have not had access to it yet, because the low-hanging fruit may be over. Thirdly, our understanding now that AIDS is really a long-wave phenomenon, and so we need to work on the structure and systematic and systemic issues that will guarantee a solid and sustainable response.

We really will need to keep up our efforts for decades to come. That is not very cheerful news, particularly not on the economic side, but it is the fact.

AIDS is often cited as the revealer of problems, and I think the health worker issue is a case-in-point. HIV does not spare health workers to start with. There have, and we will hear about that, but there are countries where there has been a real hemorrhage in terms of health care workers, because of the AIDS epidemic. No diploma protects you from acquiring HIV.

The problem is not new, it has been neglected for years saying that it is the AIDS efforts that would undermine the health system and healthcare workers is to say the least, and not supported by any facts and people with even a memory of 15 years would know better.

I think that the AIDS epidemic now where we are at this stage, offers a major opportunity to jump start long overdue action. In a number of countries HIV programs may be one of the only sources of funding available to address the workforce crisis. There are good examples. I am sure that Jim will speak about also what is going on in Rwanda for example, we see what is going on in Malawi, in Ethiopia, where in a very pragmatic way, one has been using the opportunity of the tragedy of AIDS to strengthen the workforce and to come up with innovative solutions.

Before ending, let me say that I think that are a number of lessons, or practices of the AIDS movement that could be very useful also for becoming really serious about the health workforce issue.

One is to set ambitious targets; you need to know what you are fighting for. Two is do not move without full involvement of civil society of the people who are most concerned. In our case, people living with HIV, vulnerable groups. That could also be true for healthcare force working. Have the rights-based approach, not being intimidated by the fact that there is no money, this is what is needed and then work towards that, and working across sectors.

The good news is that things start moving, that we are coming to bat and really, thanks to the coalition that the issue is now being tackled in a more systematic way and also, because I think we in the AIDS movement, we are reaching the limits of our ability to expand our efforts, particularly in the treatment and care area, and that is an objective reason to use that term why we should work together.

Thank you for putting it together. You can count on me and on UNAIDS, we will not be a central player on this, but we will make sure that we will join forces to resolve this health worker crisis which will illustrate again that with AIDS, not only are we a revealer of injustice and fault lines, but also a major opportunities to build a better world, thank you.

DR. MUBASHAR SHEIKH: Thanks Peter for your sustained leadership commitment and assurance that this issue stays high on the political agenda and we continue working together with all the challenges and still the problems we still face in this critical area of assistance.

Now let me request Daisy Mafubelu, who is the Assistant Director General of Family and Community Health of the World Health Organization. She has started her career in public health almost 26 years ago as a nurse and a mid-wife. She has had several positions in senior management within the South African public health sector, including Director of Human Resources, and later as a [inaudible] Director General of Health. Daisy, can I request you to please share your thoughts? Thank you.

DAISY MAFUBELU: Distinguished ladies and gentlemen, it is really my pleasure to be here and participating on this important topic. A topic which is very close to my heart and some of those people that have worked within various [inaudible] would know that the issue of human resources is very, very dear to my heart, and therefore, it is my pleasure to participate in this session. I believe the topic that we are looking at right now is one topic which in my view is long overdue.

The discussion of this topic which very few people would even venture to talk about is quite critical. So I am

happy that the organizers did really fit it into the discussions during the course of this AIDS conference. I definitely would like to share with you my thoughts on the question that we are talking about, on human resources and HIV/AIDS.

To me, human resources constrains, exemplify and amplify the tensions that we have between HIV and health systems, and yet, the two are inextricably linked together. There is no way that you can address, in my view, one in the isolation of the other. We are currently only less than two years away from the target date of achieving universal access to treatment care and support. This ambitious goal, in my view, cannot be achieved unless you address one fundamental obstacle, and that fundamental obstacle is human resources.

So, there is no way that we can really say in the absence of adequate human resources, we will be able to achieve universal access to HIV prevention treatment and care.

There is, in my view, no uncertainty that HIV and AIDS increases the burden of disease and I am sure that in your minds as well, you have certainty about that, that it increases the burden of disease. But what does that mean? It means that then the workload increases for the health workforce, but it is also a very well known fact that in many countries, especially the ones that are hard hit by HIV and AIDS, these countries have lost a high percentages of their work forces due to AIDS.

So that is an additional problem onto the problem that we are facing. The few that are remaining are also experiencing psychological stresses due to not only the heavy workload that they have to be working with, but also, just the stress of knowing that you are dealing with people that might be at the end of their lives, or you are only providing palliative care.

The mere fact of knowing that it is possible that you can save someone's life, but you do not have the means at your disposal to do that. That is a burden for most of our health workers. All of these things are happening against the backdrop of international migration of health workers. Unfortunately this migration is happening from the countries that are hard hit by AIDS.

The interconnectiveness is outlined between HIV and AIDS and human resources underscores therefore, the need for AIDS and health system movements to work together. I think that the two movements have to work together, there is no option but to work together if we really need to see progress. To provide a synopsis of health workforce crisis, we need to work together to highlight the HIV impact on the health workers.

We need to work together to clarify why human resources for health is part of the functioning health system...a fundamental for scaling up, and as I have mentioned on why they are so fundamental in achieving universal access. Not only

achieving universal access to HIV treatment, prevention, care, and support, but also to achieving the minimum development goals.

I think we need to work together as well to review ways to insure that a motivated work force is there to contribute to increased utilization of synthesis. Not only that, but making sure that they don't just add to this stigma and discrimination of people living with HIV and AIDS and those that are infected.

Most importantly, I think it is important for the AIDS and the health system movement to work together, to find interconnected solutions for the interconnected priorities.

As WHO are really committed to finding ways to how we could work with all these people and all the world peers, to make sure that we can really find these interconnected solutions to the two interconnected priorities. Thank you.

DR. MUBASHAR SHEIKH: Thank you Daisy. Your presence is absolutely critical and important because we know that the WHO has a critical role and important role to play, and your presence here, and reiteration of the commitment on behalf of WHO for continuance leadership and taking action to address these two interconnected issues is very important, and we really appreciate that you have been here and took the time to join us.

Now, I would request Craig McClure, who is the Executive Director of the International AIDS Society. Craig

has been working in the field of HIV/AIDS for the last 15 years, primarily in the areas of policy, advocacy and education. He has played a central role in the development of the 3 x 5 strategy, and I am glad that he has joined all of us here and is also co-sponsoring the session; Craig.

CRAIG MCCLURE: Thank you very much. I think we need more energy in this room to compete with the energy and enthusiasm of the room behind us, and certainly there is no issue in HIV that should stimulate energy than the issue of health systems strengthening broadly and the health workforce crisis specifically.

The International AIDS Society is a global association of HIV professionals, with about 12,000 members in 185 countries working at all levels of the response as physicians, and other healthcare professionals and public health and policy experts, and community practitioners. So the global health workforce crisis and the broader challenge of strengthening health systems are issues that are faced by most if not all of our members on a daily basis.

We put out a request to our membership for input on this debate and received a range of specific concerns facing HIV professionals in the field including, but not limited to the challenge of HIV infection amongst health workers themselves, the stigma and discrimination felt by them, including stigma and discrimination within the healthcare

system, the challenge of broadening the engagement of community members in provision of HIV prevention treatment and care, integration of HIV and other health services including primary care, pre and post natal care, maternal health, sexual and reproductive health as well as treatment of TB and other co-infections.

Also, the challenge of training and retaining health workers and specifically the loss of health workers in developing countries from the public sector to NGO's and faith-based organizations due to higher wages and better conditions and the need to integrate or at least regulate the quality of services provided by a range of different providers across the country.

A number of different analysis in reports of course, have been conducted recently examining these challenges and their impact overall on all health systems and suggesting ways forward. Just to mention a couple, the International Treatment Preparedness Coalitions report missing the target six, launched on the 29th of July, highlighted several positive effects of HIV scale-up, including relieving demand for hospital beds, emergency room services, motivating and expanding the capacity of healthcare workers.

However, the report also found that HIV scale-up had revealed fragilities in the health systems and created new challenges. This report reminds us that building

interconnected solutions between HIV and human resources will be necessary for achievement for universal access goals and health related millennium development goals, and will also be dependant on evidence informed policies and interventions.

Just to mention one other report, the 2008 WHO and UNAIDS progress report on scaling-up interventions in HIV in the health sector, towards universal access, shows that the increase in the number of healthcare workers receiving anti-retroviral therapy has not only saved lives and stemmed losses due to AIDS, but also reduced absenteeism and gained the health system thousand of health worker days. In addition, HIV programs are contributing to alleviating the health workforce crisis through task shifting models.

However, we still face the challenge of not having enough systematic evidence to inform the development of effective policies, based on what is happening on the ground. In addition, there is a general lack of systematic study beyond the documentation of strong case studies on how HIV interventions may be contributing to health systems capacity.

What is IAS's contribution to bringing the AIDS and health agendas closer together including human resources as a bridge? At the IAS pathogenesis meeting last year in Sydney, we launched what was called the Sydney Declaration, calling for an expansion of research for broadly, and specifically operations research in order to enhance essential research

systems, and generate strategic information needed for optimizing HIV interventions and improving the effectiveness of already stretched health systems, including the expansion and the sustainability in the health workforce.

This declaration was signed by over 5,000 people, and contributed to enhancing efforts and collaboration amongst partners including WHO, the Global Fund, the World Bank, UNAIDS, and the IAS, to push for an initiative on addressing knowledge gaps in the public health approach to delivering anti-retroviral therapy and care, and you will be hearing a lot more about this during the conference.

We also committed in 2007 to making health systems strengthening broadly, and the health workforce crisis specifically; permanent issues at the International AIDS Conference, and as Peter mentioned, this may be one of the first sessions on the issue, but there are a number of issues at this conference, exploring the challenges from a number of different angles.

To contribute to building a strong body of evidence, IAS is also participating in a World Bank led study in collaboration with WHO, The Fund, and UNAIDS, entitled Health Systems and HIV; a review, and analysis of the impact of international AIDS funding on the building blocks of country health systems, and recommendations for an effective and equitable global response.

For the next Pathogenesis Conference in Cape Town next year, operations research has been added as a fourth track to the conference. Really, the purpose of that is to really drive more research in this area to better understand how role out of HIV services is impacting health systems, so that we can better impact in a positive way, the health systems in the future.

Finally, as a founding member of the Global Health Workforce Alliance, we are working in partnership to expand attention to this issue and to try to find focused solutions to the problem.

Just in conclusion, the HIV movement has changed healthcare across all regions of the world, and even more dramatically in resource limited settings. The movement has created millions of empowered individuals involved in the management of their own health, literate in highly technical aspects of their own treatment, demanding services, helping to plan and design programs, demanding additional resources and challenging governments towards greater transparency and accountability.

The greater involvement of people living with HIV, and the communities most effected by HIV, provides us with a range of lessons to build on in supporting communities to raise awareness and claim their right for equal access to quality health services overall. Their engagement and their primary role in mobilizing societies is central to expanding human

resources and strengthening health systems through the AIDS response.

I want to stop there because I think the important thing is to have an interactive discussion about this. I just need to say that as the conference is opening tonight, I have a billion things to do, and my colleague, Jacqueline Bataringaya, who is the Policy and Advocacy Coordinator at the IAS, who is really doing the bulk of the work on this issue, will replace me in this seat in a few minutes, as I will need to move on, thank you very much.

DR. MUBASHAR SHEIKH: Thanks Craig, and we understand that you have too many things and too many commitments, but thanks for informing us about the initiatives and various activities being undertaken through IAS, and also emphasizing that despite considerable development, we still have serious challenges and serious issues to address and thanks for raising those issues.

Let me move on to Sigrun Mogedal, who is the Chair of the Board of the Global Workforce Alliance, and she has been the Norwegian HIV/AIDS Ambassador since 2005.

She is currently a board member of the Global Funds to Fight Against AIDS, TB and Malaria; The Board on Global Alliance for Vaccines and Immunization as well as the board on [inaudible]. From 2000-2001, she was also the State Secretary

of the Ministry of Foreign Affairs for International Development; Sigrun.

SIGRUN MOGEDAL: Thank you, and great to be here. I do not mind that Peter is going, we were together in Kampala, I can just echo his voice. We made this promise together and as long as the competing voices that are here, we are also happy that we are able to bring together the agenda around human resource and action on AIDS. We are comrades together, and it is a movement. I think we have actually a lot to be accountable for, and I have been thinking about that before this conference. It took us a long time to respond to HIV/AIDS. There was no lead for that epidemic to grow before the world started to recognize.

It has taken us a long time to be aware of what is happening in human resource. It is as if that has been on the sideline, recurrent expenditure, things that we just needed to know there. It was not a focus for how we needed to move forward. So we have a lot to be accountable for.

There is a movement now, and I am happy to be here representing the board of the Global Workforce Alliance, together with a number of other board members that are here, Medium [misspelled?], Swit I think is here, and some of them—Erick is here, [inaudible] this concern from something hardly anybody were really concerned about to now, a starting of a movement.

Let me just also say that as we talk about competing priorities, let's acknowledge that it is not easy to solve competing priorities. The world is full of competing priorities; daily life of a politician is full of competing priorities, National, I know Tedros would say the same sitting as a health minister in Ethiopia.

So we are not here to say there will be no more competing priorities, there will be no more competing voices. We are in the middle of voices and priorities, so the issue we are talking about is how can anyone make sense of a situation where we have to do many things at the same time and interconnect and make choices, and make them explicit and make them together, and make them in accountability to each other. That is what this is about, and that is also why the alliance needs to go beyond the usual suspects. It needs to go beyond WHO, it needs to go beyond donors, or national governments. Because in order to deal with this issue we have to work with professional associations, we have to work with private sector, we have to work with movements, NGO's, clinical trials research, what have you. There is a global shortage, and we are all competing to get workers to create results and to show that we can move forward.

That is what the Global Health Workforce Alliance is all about, to try to convene all these actors and try to make sense of all the things we need to think about so that each

priority is heard, so that each country in each locality can actually deal with the complexities of these issues. There is no global prescription. Linking up is the only answer, as we have just heard, and I could be just saying "amen". I just came from a session on faith, so I could have said here "amen" to all my colleagues.

Let me just say within all these competing priorities, there are also issues that is very hard to solve. We heard some of them around stigma. Definitely when you have a small pool of health workers, salary issues, how do you behave in markets, ethical recruitment across borders, but also huge privatization. What about the public and the private? We have the question, for instance on volunteers, nobody has mentioned that yet, should they be paid, should they not be paid? Numerous of those questions that we somehow have to face up to, and try to find solutions to together.

I do not need to say anything more to this issue now, because it will come, but closing, we cannot wait until all these things are fixed. That is also part of reality. We have to live with the complexity, we have to take a step at a time, and we have to do it together and in such a way that we want to make sure that we do not harm the other party. Because as we struggle together, as there are several streams of action side-by-side in the country or in the locality by different partners, let's at least find a platform where we convene the

actors and are accountable to each other. And I think that is also what this needs to be about, so thank you.

DR. MUBASHAR SHEIKH: Thanks Sigrun, thanks for highlighting again the complexity of the issues and the factors, but also emphasizing that it is an issue which needs involvement from everyone. It is everyone's business and it is everyone's contribution. So we hope that our discussion will take some of the points, some of the challenges which have been raised by the speakers. Jim and the panelists I'm sure will be able to, with this participation of the audience here, to discuss and raise these issues and deliver them in more detail. As I said earlier, we may be able to find some experimental [misspelled?], someone better understanding of what exactly needs to be done in concrete terms. Thanks everyone, to all the speakers once again.

Before I pass on to Jim to start the panel discussion and invite the panelists, I just want to say a couple of things. One is to please start—I requested all of you, if possible, wherever you were interested to raise questions and issues, so please raise your hands if you have a question and someone will be there to collect the questions.

I would also like to emphasize that Sir George Alleyne, my co-chair, at the end would have the difficult task to sum up and to share with us what exactly, hopefully we will be able to agree during the course of the next hour, and so Jim, I request

you to move to the panel discussion, but just to let you know that Jim, as I am sure most of you know, has 20 years experience in improving health in developing countries. He is the co-founder of Partners in Health, a non-profit organization that supports a range of health programs in poor communities world-wide.

In 2004 and 2005, Dr. Kim served as the Director of World Health Organization in the HIV/AIDS Department, including leading the 3 x 5 initiative. He is currently leading a new Howard University based initiative in global health delivery, which is designed to discover and widely share knowledge about the effective implementation of health programs in poor communities. So Jim, please help us move forward, and I also want to welcome and once again thank the distinguished panelists who have joined us for this discussion. Thank you very much once again.

DR. JIM YONG KIM: Thank you very much everybody. I go to two sets of meetings, the HIV meetings and the tuberculosis meetings, and at the tuberculosis meetings we never have to compete with singing, but it kind of a good thing, and if we just speak in rhythm with the singing, we will be fine.

We are really thrilled to have a fantastic panel here. Sigrun Mogedal you met, we also have Anandi Yuvaraj, from the Asia-Pacific region, representing the community of people living with HIV. We have Gregg Gonsalves, from the AIDS Rights

Alliance for Southern Africa, and we have Jacqueline Bataringaya from the International AIDS Society.

We also have the honorable minister, Tedros Adhanom Ghebeyesus, Minister of Health of Ethiopia. We have Tesfa Ghebrehiwet, representing the World Health Professions Alliance. We have Pat Daoust, from the Health Workforce Advocacy Initiative, and Julio Frenk, from the Group of Carso Health Initiative, but also, soon to be Dean of Harvard School of Public Health, and soon to be my boss.

So I want to start by giving a sense for how this debate has evolved. The debate has evolved in sometimes very intense and even angry terms. Let me read you some positions that have been taken. These are positions that have now come out in writing. Roger England writes "throwing money at countries through disease specific global programs might make good press, but it is not the way to help Africa. Money for combating HIV/AIDS is the worst. This now exceeds the whole health budget of many of the recipient countries such as Uganda. It distorts countries efforts to deal with their problems because most of this new aid is delivered off budget, resulting in separate plans, operations and monitoring all in parallel with government systems."

Our friend Stuart Tyson from the British Department for International Development has written, or has said, in talking about Zambia, has said that they have—this is the Zambians—

"they have to get so many people on treatment by the end of year two, year three, year four, how do they do it? They put an advertisement in the paper in Musaka [misspelled?], and they hire 400 health workers. Where do they take them from? They move them from one part of the health system where they are delivering children and providing general health services looking after kids to work just on AIDS. This is a no win/no win situation. It is robbing Peter to pay Paul."

On the other hand, Rafael Sauder [misspelled?] and Elaine Abrahams, from Columbia University, have written that "we postulate however, that if the resources available for scale-up of HIV care was utilized for the design and implementation of HIV programs with attention to benefiting the broader health services, this effort may catalyze the transformation of health services into more effective and responsive ones that are capable addressing the health needs of all individuals in these communities."

Lincoln Chen, my colleague from Harvard who really started with the joint learning initiative on human resources for health, has increased attention to human resources has written "priority disease control programs usually deploy workers through vertically integrated systems with strong support and supervision. In many situations, this deployment can improve health systems, producing new energy, more

resources, motivated workers, better information and higher demand among clients."

So for our panel, and let me start with honorable Minister Tedros from Ethiopia, you face these challenges, these trade-offs, these difficulties every single day, can you tell us from your perspective, how you deal with these kinds of situations?

DR. TEDROS ADHANOM GHEBEYSUS: Thank you Jim, first of all I would like to thank the organizers for giving me this chance to participate in this very important discussion.

Yes, I have to admit that because of political or specific programs, you know, the other fellow's programs are being affected. Like for instance moving some people from the general to the specific, but I think we need to understand what are the root causes for this. I do not think that it is because the money, which is coming from FRO Global Fund is actually the root cause of this problem. The root cause of this problem is there is underinvestment in training actually our workforce or in producing.

When this problem had happened actually, what we tried to do is, we tried to assess our internal situation. We tried to understand the root cause of the problem, and what we found out was that there was a shortage of professionals, and this is because we do not produce enough. So it is because there was a short supply, and that is why we were competing.

So we did two things. One, when we talk about human resources, we should not lump sum it; it is not just one problem, and the solution cannot be one. For instance, for HIV/AIDS, the major strategy is prevention. For prevention, it is I think primary healthcare which is the major vehicle. The human resources required for primary healthcare is low-level and mid-level health professionals. To complain about mid-level and low-level health professionals is I think wrong. If there is any problem, it should be the problem of the country, because the mid and low level health professionals actually are not affected by brain drain. So for any country using the opportunity which is coming, we need to really produce enough [inaudible] for the primary healthcare, because most of the things with preventive or curative can be done actually at the primary healthcare level.

So that is how we tried to address the problem. We tried to identify the human resources we need based on the programs we have, based on the priorities we have and we tried to train in and of that, which is not really a problem in terms of brain drain.

For instance, in Ethiopia, for the primary healthcare, we identified a cadre of health system workers, full time paid, and we have targeted to train 30,000 and we have trained and deployed 24,000. The remaining 6,000 will be trained by December 2008.

So this cadre will work on the prevention, not only for HIV actually, for either programs as well. We use the HIV money, the money that [inaudible] and Global Fund, to use this cadre of professionals and they are actually serving their communities. When you go higher, training nurses and health officers is also going well in Ethiopia. This will cover the first curative services and more than 90% of our patients actually need the attention of health officers and nurses. They do not need really highly skilled professionals. So that is why I say when we complain about human resources, when we lapse on at like 4 million, I do not accept it, because we are not talking about one category of health professionals and we have based on the need, based on the level of services we give, we need different categories of health professionals and we are going to complain about health professionals, we can complain about the highly skilled, but the remaining can be handled by the country and of course, whatever is coming for vertical programs can be used horizontally.

So I do not think it is a good idea to undermine what is being provided by Path Fund and Global Fund as something for the press, because I am a witness and it is making a huge difference in Ethiopia in terms of addressing actually the human resources, so we can train enough mid-level, we can train enough low-level, we can train enough even up to duties we have in increased [inaudible] in order to address it, and we may

have a problem with highly skilled ones, which are not actually in terms of providing services to the majority who do not have actually a huge impact, so we need to categorize it.

So in summary, what I would like to say is, whether you keep the balance or not, how can you keep the balance when you have the funding, how can you use that as an opportunity to address it in the general health? Not only for human resources, for instance, the money we are getting from Path Fund and Global Fund and the [inaudible] we are using it to build our health centers. Because when we talk about universal access, you talk about geographic access, you talk about actually the [inaudible], the time, you talk about affordability, of course treatment is free, you talk about cultural and social issues, the stigma and so on, and you cannot actually do any specific program activities without the health systems, because the geographic access, the [inaudible] can only be addressed using the health system. That is the only way you can address them. That is why we say we do not actually take them as a separate, you know, specific and the health systems are one-in-the-same, and one can beat the other one, and one cannot exist without the other one, because we only put business specific programs just to show that there are priorities because they are the major killers, because they are the majority contributors to morbidity and mortality. The only thing is we need to really balance it, but we cannot work

without priorities, we cannot work without focus, and that is why we have business programs. We horizontally link by strengthening also our health systems. Thank you.

DR. JIM YONG KIM: Dr. Julio Frenk, Dr. Frenk you have done some of the seminal work in conceptualizing health systems, and many people would think of you as a health systems person. You have certainly been a thought leader in that area. But you have also talked a lot about getting away from discussions of horizontal and vertical and thinking about the diagonal. What does that mean?

DR. JULIO FRENK: Well, first of all, also as the Mexican on this panel, I want to extend everyone a very warm welcome to my country. I had the privilege of working very closely a few years ago with the IAS to secure the honor for Mexico of hosting the International AIDS Conference and it is really a great thrill for all of us to see this moment come. So welcome, welcome to Mexico. I hope you enjoy your week here and that this conference is as big of a success as we all expect it to be.

On the particular subject of this satellite session, I think we need to rephrase and reframe the question. Because it is not an issue of AIDS against health systems. Any priority operates through a health system; even a fragmented health system that would be completely skewed in itself a health system. So it is not that there is something apart from health

systems that we call treatment and prevention and care for HIV/AIDS. All of those activities always operate through a health system.

This debate that was exemplified in the quotes that Jim started with is a very old debate between the idea of having explicit priorities, which we tend to call the vertical approach, and then the strategy called the horizontal strategy of strengthening the health system in general, but without explicit priorities.

I do not think that is a solution either, because health systems that do not specify priorities invariably end up catering to the needs of the better off. Those are health systems that end up over investing in tertiary hospitals in the urban areas and not taking care of the problems that affect most of the people.

This is why my colleague Hymas [inaudible] calling this idea, extending the metaphor, the geometric metaphor that neither of those two approaches is good, neither are the purely vertical that looks at one priority at a time, nor are they strictly horizontal that looks to strengthen the health system without a clear sense of priority, but that we should move to a diagonal strategy.

The diagonal thinking means that you use explicit priorities according to the realities of a country to try to be the driver, the trail blazer for generic improvements in the

health system that then spill over to the care of other health requirements. And I think Singrun proved it very well the problem is not health systems versus AIDS, the problem is what is the mix, the appropriate mix of priorities in a country and the degree of integration between those multiple priorities into a unified, integrated health system. That is the real issue.

Let me just tell you that this is a possibility. There are countless examples of health systems that have achieved such integration. I can give you the example of my own country during my six years as Minister of Health here. We realize that the main challenge, very much like Minister Tedros is saying, was the insufficient investment in overall infrastructure and the work force. We decided that many people were paying out of pocket catastrophic expenditures, and that that was a major barrier. So the big push here, the big policy change was to introduce universal health insurance. Now that was a generic structural transformation of the health system. But when it came to selecting those deliverables that people could relate to the abstract notion of health insurance, the first priority that came out was HIV/AIDS. And the first priority that was selected for what we call accelerated universal coverage was HIV/AIDS. A) because of the burden it represented in Mexico, B) because with the appearance of anti-retrovirals, that is where we were witnessing huge financial

barriers, and C) because it gave us the political example to relate abstract notions of insurance and investment to a concrete deliverable, so we could garner political support from civil society, from the congress legislature to actually pass that piece of reform.

Today, this happened in 2003, there is 22 million people enrolled in this insurance program. The overall budget for HIV/AIDS grew 14 times, as part of this major drive-through universal insurance and it would not have happened if we did not have the trailblazer condition that AIDS represented. But it generated a structural reform that is now transforming the health system in a general form for everything else.

This I think is the essence of the diagonal strategy, and I think this is the solution out of this false dilemma in which we really must avoid falling.

DR. JIM YONG KIM: Thank you Julio. Let me ask Gregg, Gregg Gonsalves, Gregg, you know, some of these statements, these are the written ones, but the ones that you hear off the side is that people like you, especially you Gregg, specifically, have been too successful. That by advocating so strongly for HIV/AIDS, even if we can make those compromises, that AIDS is just too big. There is too much money going in, and we should not make decisions based on the loud voices of a few troublemakers like you. What do you say to that?

GREGG GONSALVES: I do not know what to say to that. I mean I do think the debate is artificial, and the honorable minister, next ministers I think have got it. I do not feel like we should be on separate sides of this debate. But I do think Roger England, and Stuart Tyson are raising issues for a reason. I do not think it is about AIDS versus health systems, I think it is a red herring. I think it is the difference between selective primary care and comprehensive primary care, about achieving the goals and alma atta of health for all.

We are going back to the 70's and 80's where health systems stagnated under chronic underinvestment and structural adjustment policies that really destroyed health systems. So I think Stuart and I think Roger are basically saying you know what? It is AIDS fault. They do not say it is the donor countries who are not investing properly in overseas development aid, including health. They blame the AIDS activists, but yet none of them spoke up when structural adjustment policies destroyed public sectors all over the world, not just in HIV, but in education and in other social services.

So I think Roger and Stuart represent a return to the past. It is a return of the repressed. These were the people who where against treatment in 2000.

I get care in a public clinic outside of Cape Town in a township. It is a public hospital, primary care is given

there, I get my care in the context of general medical care. I know that for me and for the millions of people on treatment that the success for treatment for the 3 million that are on it now and the ability to extend it, is to build comprehensive primary care. Because I am going to live hopefully to a ripe old age to get diabetes and get other health conditions that are going to have to be managed just like my chronic illness is with HIV. And so I do not see any choice for us to do that. We need to hold the feet to the fire, donor countries to say you need to invest in health and other social services that need to be done. You have to use activists like me and Anandi and others to drive demand from the ground up for health services and accountability at the national level.

A lot of the talk right now is about the international health plan, where governments talk to governments again, and civil society is left off the table. That is a way to close the doors and make decisions in backrooms and one of the things we have done in AIDS is been able to hold people's feet to the fire, to provide accountability, transparency from a local, national, and regional, and international level and we want to take that forward with health systems and primary health care. So let us not let Roger and Stewart get us off track. I think we have a partnership to build here. We are going to do it. I think a lot of the stuff that is going to come out of this conference is going to talk about how we build that movement

together and we are all partners in this. You know what [applause]? If that is what they want to call me, they can call me anything they want but we are going to keep moving forward.

DR. JIM YONG KIM: Thank you [applause]. Let me go right to Anandi. Anandi, what does the health workforce crisis look like from India and what would you say in the midst of this debate, these claims that we have heard going back and forth? What has been your perspective?

ANANDI YUVARAJ: From India perspective like where I kind of come from, the epidemic is concentrated and we do not see or come across or have this debate of what the health care crisis in terms of the HIV but we often, we come across the issue of stigma is the major issue that our health care system where people living with HIV are accessing, are confronting and that is the most challenging for our part of the world. Stigma is the major issue.

DR. JIM YONG KIM: We will get to that. We will get to that in just a second. Let me turn to Pat. Pat, you are part of an advocacy initiative for the health workforce. How do you see the debate as it is taking shape?

PAT DAOUST, M.S.N., R.N.: Well, like some have said already, I do not really think this is a debate per say here in this room. I think it is time to have a really worthwhile effective discussion of how we can draw our common knowledge

and our common ground together. As Peter said, I think AIDS is a revealer of problems. I also think that the AIDS response is a revealer of solutions. How we responded to the AIDS pandemic has shown the strength of our activist voice and our activist voice includes health care professionals. I am also a nurse. I have worked in HIV for many years both domestically in my own country and throughout Africa. I do think by empowering the voices of health workers and allowing them to first understand the situation, be part of the solution at the table with the activists is part of the way to effectively respond to this question.

One of the quotes that Roger England [misspelled?] had in his article was the exceptionalism of HIV or AIDS and he said is the death of millions of young children from pneumonia not an exceptional situation? Is maternal mortality rates not an exceptional situation? My answer is yes; these are all exceptional and need to be responded to in exceptional manners. I think this is where we can bring our expertise to the table and the exceptional should be the norm.

It should be standard. Our response, we have learned, the lessons learned here are invaluable and once again, it is a major issue of funding limited resources. So let us not look to take away from AIDS. Let us use the lessons learned, add to the overall resource pool, bring the activists to the table. Allow them to address the Global Fund. We are having round

nine is coming up. Let us look at the voices of the learned and say let us start encouraging countries to invest in health system strengthening.

Part of this initiative is a civil society-led initiative, advocacy initiative and it is internationally, our membership is internationally renowned and we are actually looking at funding issues. That is not about HIV specific although when you look at the table, most of us are there because of our work in HIV. So I urge each one of you to learn more about the initiative and join us in our voice and in our common response to this situation.

DR. JIM YONG KIM: Jacqueline, from the international AIDS, it is very exciting that your governing council identified human resources as a major issue and how do you see this going forward? You are talking about working in partnership, what would you like to see come out of this particular session and this particular meeting at AIDS? What would you like to see us do to take real action on the problem of HIV or the relationship between HIV and human resources?

JACQUELINE BATARINGAYA, M.D.: Thank you Jim. I will start with an anecdote from my own experience as working as a district health medical officer and also when I just graduated from McCarron [misspelled?] University. At that time, I was earning \$50 U.S. and most of, per month regardless of the hours I worked and the workload, and also my friends, at the time,

were looking to leave the country to find better pay, better working conditions and I think the situation, as described in the Global Health Workforce Alliance, and at the district, we accepted the situation the way it was, weak health systems and the challenges of shortages of health workforce. We did not question that, that perhaps they could be a different scenario and then HIV came along and it changed the dynamics completely. I imagine if I was a district medical officer again, I would not accept to go to health facilities that have drug cupboards that are empty, that have nobody working there, that have patients that cannot say anything. I would not accept that and I thank HIV for that.

The International AIDS Society, a few years ago, started to discuss the expansion of the discussion around HIV to better integrate a public health agenda. As Gregg said, this is something we would like to see more and more of so that HIV is discussed in the context of the realities on the ground just like Pat said. A woman might be HIV positive but also be pregnant looking after children. So we would like to see more and more of this coming through country presentations, coming through the research and placing HIV within that reality but the exceptionalism has to continue, as Pat said also, reflecting all these challenges as they come.

The second is that we, I think, this discussion has gained momentum simply because of treatment but when people

were dying and there was no treatment, I did not hear these people speak up and I think that we need to challenge them on that, that pre-treatment and the post-treatment has changed this discussion that we need to take note of but I think that more and more like some of us, as scholars of the distinguished panel here, HIV has even started to go beyond simply saying how is scale-up happening to look more at social health protection and we hope within this conference and subsequent conferences, we can start to ask are the most vulnerable people accessing health services and how are they able to pay? Are they actually getting to pay out-of-pocket and finding themselves more impoverished.

So all the aspects of the health system or the six components, as WHO would have described them, we would like to see more of that research and discussion happening. So we hope that this is the first of many debates where HIV is at the center but this continuously looks at the dynamics of human resource, at financing, at infrastructure, and at lab services, at everything because for HIV, for us to achieve universal access goals, all these other aspects also have to be working well. We know, as patients or people living with HIV, we will not stop unless we have access not only to ARVs but to other aspects of our health care. Thank you.

DR. JIM YONG KIM: Thank you very much. Tesfa, you represent the International Council of Nurses but also you are

here representing the World Health Professions Association, doctors, nurses, pharmacists. What are some of the ways that you see we could begin to solve this problem of human resources? Dr. Tedros, Minister Tedros mentioned some of the ways that they have been doing it in Ethiopia but there are a lot of issues on the table, task shifting. What are you doing in these organizations to try to help support the needs for more health workers in countries?

TESFA GHEBREHIWET, PH.D., M.P.H., B.SC.: Thank you very much Jim. I also feel the argument of attempting to divide the issue into vertical, horizontal, I think is very artificial. I think this will divert us from the main issues of optimizing the performance of health systems, optimizing the production of health care workers. So whether we opt for a vertical system or a horizontal system, they all require human resources. At the moment, we face a crisis, a double crisis I would say. We have the crisis of numbers, a shortage of doctors, a shortage of nurses, a shortage of if you like, everyone else.

We also face the other crisis of moral, the other crisis of motivation, the other crisis of willing to stay in our own countries. So these other burning issues I think that we should address because if we have adequate numbers, if we have competent health professionals at home where they are needed, it does not matter if we have vertical or horizontal

programs. I think we will be able to start them. Perhaps vertical programs are an admission of failure perhaps. Perhaps people are going vertical because they feel that is the low hanging fruit perhaps.

So like my colleague, like Gregg was saying, I think a sensible way to go is a comprehensive primary health care approach rather than a fragmented approach. So what are the health professions doing? Obviously the health professions are deeply concerned by the current crisis, crisis in numbers and crisis in the moral and motivation of the health workforce.

Many of us health professionals here would agree that if you ask the young person who is going to medical school and to nursing school and ask them why do you want to be a doctor, why do you want to be a dentist, a nurse, they will tell you they are out to save the world.

The same person, the very person, if you ask him the same question six, seven years down the road, has become a burned out demotivated human being. Why is that? I think part of it is the health system that is more or less dysfunctional. I think part of it is health policies that are not supportive of the health workforce.

So in moving forward, I would echo what the honorable minister, Minister Tedros was saying. We need to train in adequate numbers. I know sometimes that can be an issue because that can be a deep pit that never fills but I think if

we train adequate numbers in all countries in developing and developed by the way, because if the developed countries have adequately trained health workers, there is no room for poaching. There is no room for the pull-push factors that are pushing and pulling health care workers from their countries.

So we need to train in adequate numbers and here, what are the health professionals doing? We are lobbying. We are advocating, the governments, advocating international organizations, but we are also working in partnership with the Global Alliance, for example, to address human resources issues.

For example, the International Council of Nurses has established what we call International Center for Human Resources in Nursing, which is really documenting the movement of nurses, the availability of nurses, the issues that are affecting quality of care delivery, and sharing this information with governments in an online way, sharing this information with governments and with others.

Many of our colleagues in the other professions are doing the same but I must admit it is a very serious issue and I think we should not be deflected from this issue by artificial discussions of vertical, horizontal, and so on.
Thank you.

DR. JIM YONG KIM: So thank you very much Tesfa.

Seeing that we have very little disagreement on this topic, let

us move on to something that maybe we can find some disagreement on. Anandi, tell us about the experience of stigma again and tell us what it has been like to try to get services. Go ahead.

ANANDI YUVARAJ: Okay. Thanks Jim. My memory around the stigma that I experienced is still fresh in my mind. I want you to take way back to ten years when I was diagnosed HIV positive in 1998 and then I did not disclose my HIV status. I was comfortable with my status and then I did not have any problem but then I got an opportunity to work with the NGO and then finally I thought that this is where I need to work because I am HIV positive and I see many of my fellow people in HIV have been experiencing, they have been stigmatized and discriminated and I felt that need to work in the field and then I updated my skills on counseling. I became a counselor in one of the medical college. So that is where the story is going to start.

I will be very brief. Then I joined as a counselor but I did not disclose my HIV status within the medical college where I was working as a counselor. I had to go for my dental scaling and one of my doctors who knew my status, HIV status, told me that he [inaudible 01:15:48] treating people in the HIV and he is taking people of, he told me okay, go to the so and so doctor dentist but do not reveal your HIV status because he

may [misspelled?] send you back and he will not treat you. We have not [inaudible] anyone for dental problems.

So I was confused because I was very new within the health system, within the medical college so I thought I was confused [inaudible] and I spoke to this dentist and I was just, I introduced myself. My doctor already informed the dentist that the counselor from the HIV/AIDS clinic is coming for some treatment. I asked him, [inaudible] him, I said that I am a counselor and I am a recent [inaudible] and NGO has recruited me within the [inaudible] for the vertical program.

So I got this opportunity. So I said, I am the HIV/AIDS counselor and he was happy. He said okay, what is your problem? What is it that you want? I said you know, I have my dental, this thing and I was curious and I wanted to check basically really challenge why he is not treating and I was like because I wanted to confront the situation, how I would be treated if I might disclose my HIV status. I took that opportunity. I thought okay, I asked him like do you know, have you treated HIV positive people and no, no I have not come across anyone and said then I said okay. Are you using the universal precautions for everyone? I do not use the universal precautions. I do not use gloves.

So then you assume that everyone is not positive? Then you are giving the treatment? What if somebody comes and tells you that they are HIV positive and will you treat and he was

confused? He did not know how to address that question, how to really. I said then you know that if you use gloves and you will not be infected. You will not have that risk of exposure to HIV. Yes, he nodded his head and then I said will you treat me? Yes. I said I am HIV positive. Will you use gloves and treat my problem? He was really taken aback and he did not know what to do but he admired my, I challenged him and I was talking to him. I engaged him in that dialogue. So he said yes and then but give me one day and you come tomorrow. I will treat you. I did go but eventually he treated me and that is when he said the first time, I have treated HIV positive and demanded and using the universal precaution, the gloves.

He was so thrilled also like I must say he was so happy but what I am saying is like that was the thing and I also, at the same time ten years back, and one of my colleagues who was not, her husband got admitted at the hospital and they later on diagnosed him as HIV positive. They went to her and the medical college asked her to go for HIV test mandating and she was also HIV positive. She was diagnosed HIV positive. Immediately, they removed her from the main health care [inaudible]. They put her in isolation ward where they are taking care of people in HIV since she was asked to take it of all the people in HIV and she was not included into the main [inaudible]. So that is the kind of experience that is ten

years back but situation if you ask me whether it has changed, it has not really changed even now because why I am saying is.

I moved to Delhi [misspelled?] to work and one of my colleague who works with the positive network, she went to a super, super-specialty hospital in Delhi and like how much government money has been invested in super, super-specialty hospital and she went for her TB treatment and she was asked to stand in the cue and then she was asked [inaudible] time until her turn comes and she was asked to go back and stand in the cue. When she asked like okay, we will wait. We will come to you until we were finished everybody and we will come to you. Then when everybody, the doctor and the paramedics, they took care of everybody else and then like when her turn came, she asked why she was asked to stand so long and why she was waiting and why they made her to wait and they said we know that you are HIV positive. We can use gloves and we can treat you.

So that is the kind of the situation even now. I just want to...

DR. JIM YONG KIM: Let me go to Sigrun for a second. Sigrun probably has visited more HIV programs than anyone. Let me ask you this, we have committed to universal access. How are we going to ever get there? Tell us about what you have seen and what we need to do about stigma if we have any hope at all of reaching universal access.

SIGRUN MOGEDAL: That was a hard, good question but if I first could say is this stigma affecting health care in Norway because I have also visited in Norway. I know a lot of my HIV positive friends in Norway experience similar things. In Norway, where it is not a matter of throwing money at the system, where it is not a matter of lack of health workers, but it is a lack of knowledge. It is not being familiar but also somehow being scared and facing up.

I think that some of the countries with a heavy load where this is something that we gradually get to know how to address. Some of those are examples of how one can change attitudes within health systems. I think that we have a lot to learn also from south to north. When it comes to stigma, it is global. I wish that health workers associations, training institutions, would really start to address what are the root causes there because I do think that stigma is a major barrier to universal access.

If it is so that health workers are burned out and demotivated, if it is so that HIV, treating HIV is down on the list, if it is so that chronic diseases and having patients in a separate part of an institution means that health workers do not be part of the bigger system, then we need to address it.

I think throwing money at health systems, yes, I am sitting in the Global Fund, I am part of a government where we both fund national systems like we heard about earlier wanting

governments to set priorities and so on but we also fund the Global Fund and we think that we have to work, pull these forces together and actually use that energy that is there in some of the movements for AIDS because bureaucracies are not in movement.

Bureaucracies may get money, they can account for money but it is stuck there. It does not come out. So that urge of making results and bringing in the various stakeholders is what can create universal access. I do not dare come with special examples but that is my passion. Thank you.

DR. JIM YONG KIM: Gregg, you are involved with lots of different organizations of people living with HIV/AIDS. Can you give us some examples of what you have been hearing out there in the field?

GREGG GONSALVES: Well let us not talk about HIV stigma. Let us talk about drug users in Eastern Europe and Central Asia. Health care providers and it is not just health care providers, it is NGO workers like me and Anandi and other people in this audience have utter disdain for drug users and contempt for them.

We will talk about them behind their backs and I am sure I do a lot of work with the drug users but I am sure it is the same for sex workers and gay men. So for anybody who is working in the health care profession, whether it is medical professionals, nurses, health officers, counselors, NGO

workers, I think it is not just about HIV stigma. It is about drug use, sex, and other things that are going to drive people away from the health care system and leave them left behind in universal access.

So I mean it as part of talking about health system strengthening, I think we have to confront those issues of stigma not just of HIV but about drug use, sex workers, men who have sex with men, and do it in a really concerted way.

DR. JIM YONG KIM: Pat, is it just about discrimination against people living with HIV who are trying to get services? What about within the health professions?

PAT DAOUST, M.S.N., R.N.: I think as we sit here and talk about the need to increase the numbers of health care workers and standardize training and as we try to scale-up health workers in many, many countries, part of the challenge will be to integrate into this curriculum particularly in pre-service, health as a human right, a rights-based approach so that all have equal access to health care [applause]; So it is not just about HIV and it is not just disease-specific and it is not just about the most marginalized but equal access across the board.

If health care workers have the opportunity to learn, become desensitized to the fact that many of the discriminatory feelings that health care workers hold, they are not even

aware. A values clarification session within one classroom can show you how divided a health care worker group can be.

So I think we have a challenge in front of us. So when we are going to scale-up and over the next few years, increase our health care workforce by 2.6 million to meet the four million deficit, we have got to look at the curriculum, look at the training. So I challenge the countries all of our countries, including my own, to really look at health care as a human right within the health care profession itself. Then I think we might be able to begin to address this issue.

DR. JIM YONG KIM: Dr. Frenk, how have you been dealing, how did you deal with the problem of stigma here in Mexico?

JULIO FRENK, M.D., PH.D., M.P.H.: Well I believe when it comes to the relationship with the health workforce, that people are motivated by what one could say are three Is, Information, a lot of what we are calling stigma is fear from health workers that are actually disinformed about modes of transmission, who are actually not provided with the necessary tools to reduce their own risk and to fulfill their mandate, their ethical obligation.

The second is incentives. We need to change the way we hire and promote, and remunerate health workers so that they become responsive to the needs of patients not just HIV patients but in general and part of this reform I was talking

about did involve new incentives for achieving targets of treatment and other incentives to health care workers.

So we may solve some of the structural problems of poorly remunerated and poorly motivated health workers who do not see any advance, even if they perform in a very positive way.

The third I is internalize values. I think mostly through the occasional system, I fully agree, internalizing the values that are embedded in our codes of ethics, but if you just think that, that last I and changing people's health is going to transform reality, I think that is not it.

We need to also work on the other Is and solve the systemic issues that sometime constrain the best performance that a health worker could achieve.

I think those are some ideas and, of course, there are lots of examples from around the world that we need to disseminate through best practice.

DR. JIM YONG KIM: Great. Honorable minister, let me ask you, you have been more serious or at least as serious as anyone in Africa about reaching universal access. Not only do we have problems of stigma against people in the community trying to receive services but there is stigma within the health workforce. Health workers who have HIV feel especially stigmatized and we have heard horror stories. How are you going to reach universal access through, how are you going to

work through the problem of stigma on your way to reaching universal access?

DR. TEDROS ADHANOM GHEBEYSUS: Thank you very much. I think in our case, what we are trying to do is through education actually our communities, our health workers to actually address the problem. We are using all means or outlets to educate our communities and health workers.

The other issue is I think we are partly responsible for the stigma, the health sector itself because in hospitals, we tend to have like ART clinics and we treat HIV like a different health problem but it is like any other illness. We have to recognize that and what we are doing now is we are making all our health institutions process-based like we have in-patient services, outpatient services, emergency services and then any patient, it could be HIV or it could be TB, malaria, or any other illness, goes through this process like any other health problem and we are actually are abandoning the issue of this ART clinic and so on.

We have just started it and we are using the business process re-engineering to have this model implemented into our hospitals, I think has been successful in some countries. Through that process actually, we are cutting even waiting time of patients because from triage center where they do the initial check-up, medical records, they are paying and so on and then they move straight to case teams where they have the

examinations, [inaudible] of minor procedures, and so on almost all taken care of through the pharmacy, then they are out. They stop just in three places and cut by several like more than 60 persons actually of waiting time.

So I think we have to see it as health system, one system in general and trying to address it within that. Then we can reduce the stigma because we have admitted actually we are the source of stigma. Thank you.

DR. JIM YONG KIM: Tesfa, so you represent doctors, dentists, nurses, and pharmacists. In some senses, we could say that the people you represent are the source of the problem. So we have heard about educational initiatives, structural initiatives, what can those health profession's organizations do to really make an attempt at reducing stigma?

TESFA GHEBREHIWET, PHD, MPH, BSC: Thank you Jim. I think one of the challenges the health system itself. We have health systems that are dysfunctional in a way. At the end of the day, health workers are people like the rest of us. So they see that health systems do not care about them.

You have an elegantly trained professional and he or she is put in an inelegant and terrible situation. Some of you have seen, all of you have seen the working conditions of many of the health professionals.

There is no excuse to stigma, by the way. There is no excuse at all but we know the health system itself and the

current stigma in the health system it self is contributing or perpetuating the stigma itself because health care workers are asking themselves if I get HIV, if I am the next person in that bed then I am going to receive all that stigma that I see.

So that fear, I think, is perpetuating this stigma. There has been lots of talk about stigma but little action and we believe [applause] the health professions believe it is time to act. The big challenges are how could we make health professionals become the trendsetters? How could we create health systems that are stigma-free or that are friendly to people living with HIV/AIDS?

I think we need to start by engaging in a dialogue, in a campaign, sustained campaign with people who are living with HIV/AIDS. We need to engage that group I think. Just as that group has been able to mobilize resources and energy towards HIV prevention and care, I think we could mobilize that resources also working with the health professions and the people living with HIV/AIDS and activists towards creating health systems that are stigma-free.

I think most of all, we need to create positive environments for health care workers because we have settings, at the moment, where the average health worker does not get a glove, where the average midwife is delivering babies bare hands and do not tell me that midwife should not be afraid or

do not tell me that midwife should not protect, that nurse should not protect herself.

It is just a normal human instinct despite all the ethics, despite all the commitment, and the compassion to care. So while there is no excuse to perpetuating stigma in health systems, we believe that the health care workers are also facing a daunting challenge in that they are not supported.

One activity that the health care workers have taken seriously, the health care profession associations have taken seriously is what we call positive practice environment, working with the Global Health Workforce Alliance, the WHPA, the World Health Professions Alliance, and others.

We are working towards improving the environment in which health workers are working. In this way, we hope to optimize their performance, to retain them, to recruit others who are probably migrating into other professions, or migrating into other countries. So care of the care provider, the classical analogy, metaphor that comes is [applause] we have all flown to come here from wherever we live and hostess, the [inaudible] and crew always tell us to put the mask on ourselves before helping others. I think we need to embrace that kind of analogy in health systems if we are going to combat stigma and discrimination. Otherwise, we are going to talk and talk and perpetuate stigma.

Care of the carer, that person, that nurse, that physician, that dentist who is working day and night, when he or she gets HIV, often stands on the same line, on the same cue as the patients that he or she serves. I mean how unfair could the health systems be? Many health workers are telling us if the system does not care, why should I?

This is typically a sign of burned out health professionals. Burning out, I think, is not an intentional effort that we bring on ourselves. I think it is systems that burn us out. It is health systems. So we need to strengthen health systems. We need to create positive practice environments. We need to care for the carers as a matter of priority. For example, access to ARV, access to counseling, access to testing. We need to provide protective equipment, gloves and others but equally important, we need to engage with people who are living with HIV/AIDS and learn from them what are we doing wrong? We also need to exchange best practice, what works and I think that is why I was saying there is much talk but little action, little data. We need to share this data. What works, let us say, in fighting stigma?

My colleague here was saying, Pat was saying value clarification. The ICN is working in this area, training nurses in many places. We know there is a short-term effect for example but we do not have evidence if it has a sustained, long-term effect. We need that evidence. We need to invest in

combating HIV just in combating stigma, just as we have to combat HIV/AIDS. Thank you.

DR. JIM YONG KIM: Thank you. This is just a extraordinary panel. Unfortunately, we are running out of time. So I would like to invite the Deputy Director General, Madame Andayi Anduro [misspelled?] to make a brief comment and representing the International Organization of Migration.

MADAME ANDAYI ANDURO: Thank you [inaudible]. I would like to congratulate all the panelists but I would like also to contribute a little bit on this debate because today we are effectively facing some competing priorities and the most critical priority that the African countries in particular, the developing countries in general, is facing is the one of the shortage of human resources to make the health system work and to make some development because we will have some obviously some healthy people to lead our development process.

Now IOM, because I work with [inaudible] since ten years after having been Minister of Development Social in my country during ten years, I know that this brain drain of persons in that [inaudible] is asking for taking into account at the policy level is something very, very important.

As far as we will not provide some solution, some answer to the going out of all these people by developing our own policies in our country, it will be more and more dramatic.

Now we are looking at additional resources and additional human resources for the health system might be health workers outside the countries or the [inaudible] outside Africa want to help to develop a more sustainable, a more normal health system like this gentleman talked about later on, before me.

I would like to say that the African [inaudible] health workers would like to enter [inaudible] in their own country of origin and the problem they are facing is a problem of policy. How can we reform our policy in the countries of origin that can integrate those health workforce that are outside and that want to come in and contribute to the development of this country?

This is the contribution we would like to bring in this debate. How can we scale-up the health system of our country by bringing in the competencies, the expertise of [inaudible] health workers living abroad? It is possible but as far as we do not reform our national health system to integrate them, to have a multisectoral approach to deliver a service of health, we will of course face this kind of shortage.

This is what we would like to share with you and please take into account in your delivery statement or in your conclusion this kind of additional forces that we can bring in the human resources taskforce we have to undertake in our countries. Thank you.

DR. JIM YONG KIM: Thank you very much. We will only have time for two questions. The first is we will ask Miriam Ware [misspelled?], is Miriam in the audience somewhere? Yes, right here. Yes?

MIRIAM WARE: Thank you very much sir and thank you very much the panel, you have really kept us awake [laughter]. My question is can we request the countries, the 57 countries, especially the 57 countries that got a human resource crisis to report at the next meeting at least one district in their country, which has put into practice all the good ideas that we are hearing so that we do not come back and just talk in generalities. I think my [inaudible] have the whole country by then but can all the other [inaudible] at least have, at least one country, at least one district so that we make it a requirement? That is my...

DR. JIM YONG KIM: Let me ask Jacqueline to comment on that first and anyone else who would like to.

JACQUELINE BATARINGAYA, M.D.: Thank you very much. I think that is a fantastic proposal. I am sure there are members attending this conference who would agree that have been pushing for greater accountability from countries. I think this is where to add to what you have said, I would like to add a couple of Is to what Honorable Julio Frenk mentioned before. and that is on the information.

Many times, we read about health care workers that are affected, about 20-percent may have been lost due to AIDS in some countries. A study from South Africa where there was comparable rates, prevalence rates, and then it is kind of goes quiet. So I think we would like to see this becoming more integral to how we look at this issue as part of being able to develop effective interconnected solutions.

The other I, I would like to add is just to underscore the issue of infection control because as a competing priority, we have got other issues like TB where TB/HIV becomes integrated and also becomes a source of fear but there are other issues that come in and then affect this issue profoundly. I hope that we can add infection control as to one of the priorities that we have to address in the response going forward.

Then a couple of final points. One is that of empowerment. We have learned in this movement that you have to empower the most affected communities. I think for health care workers, one of the forms of empowerment will be understanding, better understanding how to manage their own health. The assumption is the health care workers, so they know how HIV is treated and I think that is a wrong assumption. Yes, the clinical researches and the AIDS experts may know but while others may be involved in delivering care, they may not have even the knowledge that Gregg has or the complexities of first-

line, second-line, when to start, when to switch that some people in the peer HIV movement have acquired over the years. You think they got PhDs and are professors of medicine.

So I think we need to extend this to health care workers and make sure that they are also empowered and I think that will come to deal with stigma over time.

Then finally, to encourage that we take this message perhaps through the Alliance and through the partnership and call on countries that are making progress to work with normative agencies to really document their experience and conduct strong analysis and perhaps we see this more and more coming through the next international AIDS conferences. Thank you.

DR. JIM YONG KIM: So why not ask Freddie Perez to come up. Marion, here is how I hear that. So at the next meeting, representatives of all 57 countries that have a human resources crisis will be invited to come and there will be a special and IAS will pay for their transport completely, and they will be invited to come not just to present but to talk about what they have done and then begin to share just like we have talked, that let us turn IAS into a place where at least once every two years, we come and compare notes, teach each other, and then leave the conference linked together in our efforts to solve the problem of human resources.

So thank you very much for that commitment. We will find the representatives. Let us turn this meeting into a working meeting where people actually compare notes and share notes in a way that will be helpful back home. Is Dr. Freddie Perez? No, okay. George, let me just say a couple of quick things.

Mark Dybul has sent his apologies. He very much wanted to be here with us. Logistics prevented him from doing it and we would now like Sir George Elaine [misspelled?] to wrap this all up and explain to us what we need to do to go forward. Thank you.

SIR GEORGE ELAINE: Thanks very much. It is fascinating to me sitting as a [inaudible] bystander. When the proposal is put to me that which I should make a summary at the end of this meeting, it seemed to me that there were two kinds of issues. One of the problems is how you bring these two issues together and I have to confess on beginning that I start as a confessed optimist. I am a confessed optimist.

What I want to start with is the idea that we should all be clear that there has been tremendous progress. Of course we could do better but as Peter said, there has been tremendous progress. Let me think of what the situation is like in Vancouver, when we come to now, there has been tremendous progress. Let us recognize that and that progress would not have been possible unless there had been health

systems functioning. They have not functioned ideally but they have functioned. This is not to say that we must be complacent, hubristic [misspelled?], and not do anything but let us recognize it is unfair that the millions of health care workers out there that give the impression that nothing has happened. There has been progress [applause].

If you agree, there seems to be general agreement as Jim was saying that this debate is a sterile one and we ask why does a sterile debate continue? I used to work for [inaudible] who used to say that we, in health, have the tendency to be arrested at the level of binary thought. It is either/or. We can never see that the light that was not like that, things have to exist together.

Another is an old English tune that says the devil always has the sweetest tunes. I am not [inaudible] the devil so do not say that. The devil always has the sweetest tunes. If you look at what has allowed this debate to continue is that good thing that there has been increased funding available for this funding, not enough, agreed but there has been increased funding available for this and not that the money is the root of evil but the problem is that we face how to use this money more effectively? That is the root of the issue. how do we use the increased resources available, make it, to use it more effectively? How we use the exceptionality, exceptionism, I am not sure which word is correct, of AIDS more appropriately.

I think and after the [misspelled?], it would be irresponsible of us not to take advantage of the exceptionality of AIDS for the purposes that Jim has set out initially.

The global health workforce [inaudible] my colleagues here from the Alliance has sought to address this problem. I think in a very logical way and if I may sum up [misspelled?], what they have said is that there is a clear need for all 190 countries for more resources.

All countries should be self-sufficient. The old idea that there were source and destination countries is passé. Many of the big countries are source countries, at the same time, they are recipient countries and what I would like to see are acceptance of that as a global problem and we are not going to reach the day yet, not in my lifetime, the utopia when there are enough human workforces, human resources, but let us accept the thesis that the Alliance puts forward that the basic approach is one of numbers, distribution, and disposition. Until the day the utopia comes where we have enough, let us agree with the workforce that we have to deal with things like ethical recruitment for a convention to ethical recruitment of workforces.

I would like to pose two questions or two theses for this part of discussion. One, that all of us go from this place singing we will never allow anyone to sing that tune in our presence again. We will never allow people [applause] to

try to put it in the sense of a dichotomy resource of [misspelled?] AIDS. We must never do that.

The second thing I would ask, that we approve and applaud the activism around AIDS and we should have that activism around AIDS, have it embrace what the human, what the Global Workforce Alliance is trying to do. It is possible. I am convinced with the kind of activism we have seen and result of activism to have movement in terms of the workforce that is necessary for the appropriate treatment of all the world's diseases including AIDS.

Now HIV has, I believe, unleashed a level of activism that I have never seen in my lifetime before and I think that it would be irresponsible of us not to engage that community in issues like these. I think that many of us and many people have a false impression of unique self-interest in terms of the AIDS activism. I believe that is not true. I would like to see this activism embracing these sort of issues I mentioned before.

The second issue that was addressed is your stigma and discrimination. I would like to address this in the context of what was said in terms of the progress. We have made progression. We have seen advances in terms of treatment. We know there is an angst about prevention, tremendous angst about prevention, tremendous angst about universal access prevention,

and the extent to which stigma and discrimination impedes that universal access to prevention.

If we agree that the universal access to prevention is going to involve workers that are not traditionally counted as health workers and I agree with Gregg that those persons, when they become involved with HIV, they are going to be stigmatized, the point he makes. So we are going to see an expanding pool of stigmatized persons because in one sense, because of our attention to universal access to prevention. There are reams written about stigma and we cannot get into it here but as Julio says, it is both stigma and fair. The aspect of fair is a sense, correctable, as for the stigma is more basic and more difficult to correct but I believe that it is possible to address the epidemic of stigma.

I believe that it is possible to address it and has been said by many in the panel by addressing the individual who stigmatizes others and address the enabling environment, which facilitates that those individuals exercising stigma and discrimination.

My heart warmed to the idea of not making AIDS into a special case that making AIDS another one of the problems of the infectious disease and why I say this, in my lifetime, I have lived to see mental health, psychiatric illness incorporated in general practice and leave a lot of the stigma behind because it was incorporated in general practice. So I

laud the idea of incorporating AIDS into the kind of general treatment that you mentioned.

I am concerned and it was expressed here that not only this expanded pool of health workers may stigmatize but they themselves may be stigmatized. We have to look at if these represent the frontline workers in addressing the AIDS population, can we afford them to be disengaged and not optimally effective because they are stigmatized because those persons who are stigmatized are not optimally effective. Can we allow that and the answer categorically is no.

We have heard some concrete suggestions how we might do that and I like the idea of education within the health professions themselves. The evidence is the education, the young school children can reduce their possibility of stigmatizing others and I would like to urge my colleagues in their professions to be active, be actively engaged in promoting the idea that education within these professions can encourage them not to stigmatize others and to value themselves to the extent that they do not stigmatize one another but it is not only internally. I think we should address this and this is not going [inaudible] discussion but I would introduce it legislation. Do not, let us make legislation as a possibility of reducing stigma and discrimination among communities of workers.

I know that the places where the labor laws still allow for discrimination against health workers. This is changeable. This is modifiable. I like the idea that positive practice environment. I would not like to give the idea that I leave here because I am an optimist that I believe everything is rosy and not that more has to be done. There is a tremendous task that needs to be done and one of my favorite and [inaudible] spiritual says dear Lord, do not move away the mountain. Just give me the strength to climb. Thank you [applause].

DR. JIM YONG KIM: Thank you very much everybody.

[END RECORDING]