

**Human Resources and HIV/AIDS:
Advancing Health Workforce Capacity in Delivering
Care, Treatment and Support
XVI International AIDS Conference
August 16, 2006**

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SHOJI NISHIMOTO: Ladies and gentlemen, good afternoon against and thank you very much for joining us. This afternoon's session is entitled "Human Resources and HIV/AIDS: Advancing Health Workforce Capacity in Delivering Care, Treatment and Support." My name is Shoji Nishimoto. I am in charge of the Bureau for Developing Policy at the UNDP in New York.

Let me first have the privilege of introducing my co-chair, Mr. Leonard Rubenstein. He is the executive director of Physicians for Human Rights. To my right is Mr. Rubenstein who will co-chair this session.

Allow me to briefly introduce our distinguished panelists this afternoon for this session. I have Dr. Teguest Guerma; Dr. Guerma is the associate director of the HIV/AIDS Department in WHO. I believe you are based in Geneva, right? Dr. Guerma, thank you very much for joining us.

Next is Dr. Erik Schouten. He is an HIV/AIDS coordinator at the Ministry of Health in Malawi.

I have Dr. Lieve Franssen. She heads the Human and Social Development for the European Commission's Directorate General for Development.

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Next is Mr. Mark Heywood. He is the head of the HIV/AIDS Law Project in South Africa.

Further down, I have Dr. Abraham Mohammed. He is the program manager of the HIV/AIDS Program in Kenya. He will be speaking on behalf of the Minister of Health, Dr. Kaluki Ngilu later.

Thank you very much, distinguished panelists, for joining us this afternoon.

Let me just do a little, short overview for this session. I may be preaching to the already converted, but we all know that 25 years into the HIV epidemic, the number of HIV infections has yet to decline and more than 40 million people around the world are living with HIV/AIDS today. The epidemic has already cost us 25 million lives and in 2005 alone, I think more than 3 million people died of HIV/AIDS-related causes. In the hardest hit countries, HIV/AIDS is undermining health services in a number of ways from the death of healthcare workers, to the additional number of people needing treatment in understaffed and under-financed hospitals and clinics. In addition, the migration of the skilled labor, the "brain drain" so to speak, of doctors and nurses and under investment in human resources has had a severely detrimental effect on how health systems are coping with and responding to the challenges of HIV/AIDS.

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The implications in the hardest hit countries are obvious, but the challenges are now also applied in the countries with lower prevalence rates. The challenges range from ensuring financing for necessary prevention, care and treatment services to providing adequate remuneration to skilled health professionals, as well as providing the access to healthcare for the poorest citizens.

It is evident that the weakened health system and the scarce human resources for health services are major barriers to scale up un-invested access to HIV/AIDS prevention, treatment and care, as well as support. Action to boost both the health services and systems resources must be taken urgently to implement comprehensive and effective national response to HIV/AIDS and to save countless lives.

The international community and several countries have recognized the urgency of the situation and have taken steps toward addressing the issues related to weak human resource capacity in the health sector. WHO and the UNDP have entered into a partnership to address the chronic health sector capacity challenges in high-prevalence countries and similar initiatives are being undertaken by other organizations. But we all know much more needs to be done.

Today we will discuss the human resource capacity constraints that impact scale-up or that constrains the

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scale-up of HIV response and how we can do it more effectively and more efficiently. In keeping up with the conference theme of "Time to Deliver," the panelists will explore action that can be taken to stem the loss of human capacity and ensure access to HIV-related services.

We will now start the session with the speaker presentations, followed by an interactive or Q&A session with the audience and then close, hopefully, with some concrete recommendations for all of us to move forward. So now I would like to invite my co-chair, Mr. Leonard Rubenstein to give opening remarks. Thank you.

LEONARD RUBENSTEIN, J.D.: Thank you very much. I'd like to welcome you as well today. This session has a rather bland title, "Advancing Workforce Capacity in Delivering Care and Treatment." It might better be entitle "Stopping the Destruction of Capacity," because the principle fact of health worker capacity, especially in Africa, is that people with skills to provide treatment, care and prevention for people with AIDS is that they're leaving. The Joint Learning Initiative now estimates that we're over 1 million workers short. The migration is so great that there are countries like Mozambique and Malawi, which have populations in the many millions, that count their doctors only in the hundreds. For nurses, the situation is, in some sense, even worse.

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Yet, this crisis – and we need to call it a crisis – while very long in emerging, has been very slow to be recognized. Two years ago in Bangkok at the World AIDS Meeting, this very meeting, there was not a single session, not one, on this crisis. Yes, there were some sessions on training and on scale-up, but not a single session recognized what we now see as a key issue, the workforce crisis, especially in Africa.

In the last two years, though, a lot has happened. My own organization, at Bangkok, released a report, an action plan, to stop the "brain drain" and provide for equitable health systems in Africa. The Joint Learning Initiative report came somewhat later. The WHO began to make this a priority. And here this week, we had Bill Clinton and Bill Gates both talking about workforce capacity development and ending the "brain drain." So now it is on the agenda.

We need to understand what is causing this crisis. There are a number of factors, but a few are particularly important. One is that health workers in Africa are underpaid, work in very poor conditions and have very few incentives to stay, especially, for the second reason, because they are at risk themselves for HIV. One study showed that 17-percent of health workers in Africa are HIV-positive. They also work in situations where they don't have protective equipment, they don't have supplies, they don't

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have drugs, and they often don't even have running water in clinics.

Finally, we can't leave out the role of developed countries, for they go and recruit health workers by the thousands, by the tens of thousands, to make up for their own failures to provide training to meet their own population's needs.

This panel will talk about a number of solutions, a lot of innovations and a lot of thought about what can be done. Those solutions go across a range of possibilities. Most of all, it's going to take money. It's going to take a lot of money, mostly from developed countries, but also from developing countries. It will take equipment. It will take supplies. It will take health infrastructure. It will take increased salaries and salary supplements that must be allowed under macroeconomic policy. It will, in some cases, take substitution of one kind of health worker for another and, in particular, the training of a vast cadre of community health workers. All of these are on the table. It is tragic, quite tragic, that 25 years into the epidemic, we're only talking about this now. But we must talk about it now, so I now invite the panel to begin that discussion.

Our first speaker is Dr. Teguest Guerma. She is associate director of the HIV/AIDS Department of WHO. Dr.

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Guerma has vast experience in public health at the national, regional and global levels. Having worked for over 18 years in developing countries, she has made several important contributions in addressing HIV, including working with national governments in developing regional and national strategies on HIV/AIDS in Africa.

TEGUEST GUERMA: Thank you, Mr. Chairman. Health services depend on having the right people with the right skills in the right place, but the world is experiencing a chronic shortage of well-trained health workers. The Three by Five Initiative has once again confirmed this clearly, that one of the major obstructions for scaling up HIV treatment and prevention was the shortage of health workers in the high-burden countries.

To address this problem, the World Health Organization launched yesterday the Treat, Train, Retain plan, which is an important component of WHO's effort to strengthen human resources for health and to scale up HIV prevention, treatment and care towards universal access. It is a short overview of this plan that I will be trying to cover in my presentation. For those who are interested to know more, the document is available in the back of this room.

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Where are the critical shortages of health service providers? There are 57 countries, mostly in Sub-Saharan Africa, but also including Bangladesh, India and Indonesia, with a crippling health workforce shortage. WHO estimates that over 4 million health workers are needed to fill the gap. Within this number, the global deficit of doctors, nurses and midwives, in particular, is at least 2.4 million. Sub-Saharan Africa faces the greatest challenge with 24-percent of the global burden of disease and only 3-percent of the world health workforce.

What does the face of the crisis look like? The flow of this diagram illustrates the cause of the health workforce problem as a work-life cycle of three phases: recruitment, distribution and attrition. Too few people are being trained and enrolled in public health sector. Then there is uneven distribution of the pool of skilled workers, with high concentrations in urban areas and many preferring to work in the private sector. Many resign due to the pressure of poor working conditions and low pay, while others migrate to better jobs abroad or with the private sector and non-governmental organizations and of international organizations. But the leading cause of attrition is HIV itself. In the countries where HIV prevalence is high, huge numbers of skilled health workers simply fall sick and die of

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AIDS. In Botswana, estimates show that 17-percent of the health workforce died of AIDS between 1999 and 2005. If no action is taken, this percentage is projected to reach 40-percent by 2010. In Lesotho and Malawi, death from AIDS is the largest cause of health workforce attrition.

The health worker crisis is part of the vicious circle of weak health systems and weak HIV response. Weak health systems mean low coverage of HIV services. This will make HIV prevalence rise, which, in turn, places an increased burden on the health services. An ailing health workforce further undermines already weak health systems and weak health systems result in inadequate response to HIV epidemic.

What does all this mean? It means that currently the response to HIV/AIDS depends in large part upon a limited number of people who are not fully skilled to deliver services and who are themselves getting sick and dying of AIDS. With this situation, achieving universal access for HIV prevention, treatment and care will remain a dream. We need to find ways to improve the numbers and skills of the health workforce.

One of the solutions that WHO is putting on the table today is Treat, Train, Retain. What exactly is TTR? TTR will address the health workforce crisis in countries most

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affected by HIV. It consists of three elements. First treat; treat includes the testing and counseling of health workers, a targeted prevention campaign including education and training for occupational health safety, stigma and discrimination and providing treatment to health workers in priority and care and support to help them face burnout and stress. What will WHO do in this? WHO will assist countries in developing a package of tools for care and invention for health workers using existing materials.

Secondly, train; train includes increasing the number of skilled health workers entering the workforce by developing pre-service and in-service training. But as you know, it takes time to train. It takes six years to train a doctor. So the other solution is to have task shifting to make better use of available human resources by decentralizing tasks from doctors to nurses and from nurses to community workers, including people living with HIV/AIDS. What will WHO do in train? WHO, in collaboration with the ILO, will support countries to develop a standardized and systematized program for training and certifying profession and non-professional workers. It will help define health legislation to regulate task shifting to allow prescriptions by nurses and also to allow lay workers to do some tests. It will also build on the experience of task shifting already

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implemented through the Integrated Management of Adult
Illness or IMAI in many countries.

Third, retain; retain includes developing strategies
to enable public health system to retain workers including
financial and other incentives and measures to improve the
workplace, as well as initiatives to reduce the migration of
healthcare workers. What will WHO do? WHO will advocate for
financial incentives and measures to improve the workforce,
will support countries to develop and promote sustainable and
equitable pay scale.

As you can already guess, TTR will also need money.
WHO has already undertaken an analysis of the cost that will
be involved in the implementation of TTR. TTR will cost a
minimum of US \$7.2 to be implemented over the next five years
in the 60 highest-burden countries. This is a lot of money
you would say, but if you look at it carefully, \$7.2 billion
represents and increase of the annual per capita of
approximately US \$0.60 of the countries concern. Or it is
between 3 and 5-percent of the levels of health expenditure
typically found in low-income countries. This is, of course,
additional funding, but for an important issue such as human
resource, which currently is a major obstacle for scaling up
most of the disease programs, it could be justified. Funds
need to be mobilized from external and national resources.

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In conclusion, I would like to say that TTR is a broad and multifaceted AIDS health workforce plan which focuses on the special needs to health workforce for the first time. It needs to be owned by countries and be integrated in national plans. It will depend on alternative models of healthcare such as task shifting and the involvement in the communities and people living with HIV/AIDS. TTR will combine the coherence of systems approach with the speed required to respond to the AIDS emergency. Partnership and cooperation will be essential in moving forward to working together with all of you during the implementation of this plan. I thank you.

[Applause]

SHOJI NISHIMOTO: Thank you. Now I would like Dr. Erik Schouten to give his remarks. Dr. Schouten is the HIV/AIDS coordinator at the Ministry of Health in Malawi. A medical doctor by training, Dr. Schouten has been involved in addressing HIV/AIDS both in the Netherlands and Malawi. He has been integral to the development and management of several HIV/AIDS programs, including access to ARV treatment, as well as Malawi's emerging human resource program. Dr. Schouten, please.

ERIK SCHOUTEN: Yes, thank you very much. I will speak on the Malawi government's emerging human resource

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program. I will speak about some of the experiences and also will look into how our experiences can be used in other countries.

Let me start by telling a little bit about Malawi. Malawi is a small, impoverished country in Eastern Africa. There are 12 million inhabitants and 1 million are infected with HIV, or about 14-percent of the adult population. There is an annual death rate of 90,000 people and a severe human resources crisis. This crisis is not new. It is not something that has emerged suddenly, but even though many reports were written about it as early as the early 90s, only recently was it recognized or addressed.

To give you a few examples of the severity of the crisis Malawi, more than 50-percent of the positions in health facility are not filled. There are some districts with less than one nurse per health facility, and there are districts without doctors at all. Although the human resource crisis has hit many countries, the severity differs from country to country. I'll give you an example and compare the number of doctors and nurses per population in several African countries. The situation in Malawi is among the worst. Another example is to compare the number of patients, the number of people, in need of ART. I used the Three by Five numbers as published by WHO that people in need

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of treatment and the number of doctors per country. Also, here we can see that Malawi is among the countries with the fewest number of doctors. I believe the situation in countries like Lesotho is more or less similar.

People have been asking why; what is the reason for the human resource crisis and why is the crisis in Malawi maybe worse than in other countries? I think a long-time under-investment in training. HIV/AIDS itself is an [inaudible] of the situation. Structural adjustment policies did not really help, to say the least, and human resources for health was not the major theme in health reform movements in the 1980s and 1990s. There are also some in-country issues such as poor retention – the push factor has been said already – low wages, high work loads, not good supervision and inadequate housing for health workers. People have often to work in terrible conditions and it's often been seen as weak and unresponsive human resource management. But also on the other side are other factors; they've often been spoken about international [inaudible] and also domestic dynamics and growth and research. Malawi is a country where many organizations would like to do the work, and also pull towards NGOs and private sector. This also led to us, when we were developing the scaling-up program of ART in Malawi, that there was one thing we should not do. We knew if we

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were going to follow a medical model with doctors delivering ART, where there's a multiple choice of regimens, there's an [inaudible] laboratory monitoring CD4 counts, full blood counts, et cetera, computer followup, we are not going to achieve a massive scaling up. But instead, to address these issues, we had to develop another program. We based the program on realities in Malawi and what we call a public health approach. In the first instance, we knew we had to keep it as simple as possible, a rolling out of first-line regimen only, one regimen type for all patients, no need or necessity for laboratory monitoring of CD4 count, a simple drug supply system, a high level of standardization in case findings and regimen reporting and monitoring, being inclusive and basically using all providers hospitals. Mission hospitals, although often seen in Malawi as part of the public system, profits and the not-for-profit private sector and using lower [inaudible]. Recently WHO called this [inaudible].

The first development of the program has been what we think as successful. We went to 128 sites in the country and at this moment, roughly 45,000 people are alive and on treatment and 60,000 people have started treatment in Malawi. But we have to go further. Our scale-up plans speak about 45,000 patients to put on treatment every year. This is

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about 50-percent of people becoming eligible for treatment every year. One question is how universal is this? But what I want you to look at is that about 1-percent of the adult population is on treatment. In 10 years time, we expect that about 5-percent of our adult population will be on treatment. This is a massive scaling up. We're speaking about probably at least 2 million contacts with the health center every year. The big question is how are we going to do this? We have to be innovative, we have to look at a number of different approaches and we are further developing them. But anyway, apart from innovative approaches on simple ways of scaling up ART, we need to do something about the situation of human resources in Malawi. I wasn't there yet, but when Malawi was developing the proposal for round one, people knew that the human resources crisis was severe. A big component of the round one application was focused on human resources, while that moment was diffused and the funding level was substantially reduced. But basically, what happened in 2004 when we had started looking at the scaling up, at that time our secretary of health really was speaking about how the health system in Malawi has collapsed. We had the visit of [inaudible] and [inaudible] in February of 2004. I remember when we were preparing for this visit, there was basically one thing that we wanted them to understand, that we cannot

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scale up unless something is done about the human resources crisis in Malawi. Very soon this was recognized. They were speaking about the exceptional measures that need to be taken place. Consequently, we developed a six-year human resources relief program. This also is not something new. We basically had this lying in the drawers. This was a \$270 million program funded by a reprogramming from Global Fund. I commend Global Fund for the ease of flexibility and the change in thinking in supporting \$100 million, DFRD supported \$100 million and different donors through the [inaudible] the remaining \$70 million. What we are looking at this program is expanding the training capacity by 50-percent, improvement of retention and engagement, some additional salaries, recruitment of staff, which starts to work, and temporary stop-gap measures by having extra doctors and nurse tutors into a country.

If you're looking at what our experience are in Malawi, it's probably too early to speak about success. Human resources won't be changed overnight; it is a long-term change. For example, the increasing of the capacity for training will take three, four, five years before we see the first people coming into our system.

The question I was also asked to speak about was what are the experiences in Malawi? What could other countries

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with similar situations do? I think because it takes time to do anything about human resources, the first step is to develop a public health scaling up of the ART program or the HIV programs. Keep it simple, standardize it, be inclusive and use the lower [inaudible]. How inclusive and how low depends on which country you're working with and what you are able to do. But also to perform a [inaudible] analysis on the HIV was also part of the essential health package that you have. On that basis, you can develop a bold plan for scaling up. On the basis that you know how many additional human resources are needed. This includes an economic analysis. How many health workers and how many teachers are kept alive with the ART program? We've often been asked, "How many people do you take away from other essential health services?" We haven't finished our study, but we believe that to a large extent, the numbers of staff that are focusing on the ART and working for the ART probably would not have been there if there was no ART in the first place. On the last place is get support. Get good plans and get support for them. We were able to get support for our needs and I believe this visit two years ago of [inaudible] was an essential step in recognizing the problem and also to get support for the program and eventually led to a large program

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of \$270 million that was fully funded by donors. Thank you very much.

[Applause]

LEONARD RUBENSTEIN, J.D.: Our next speaker is Dr. Lieve Fransen. She is the head of Human and Social Development for the European Commission's Director General of Development and vice chair of the Global Fund to Fight HIV/AIDS, TB and Malaria. Dr. Fransen has a long and distinguished career in public health where she has worked with governments, managed research programs and founded task forces with the European Commission. She received the Jonathan Mann Award in 2001 for special merit in addressing HIV/AIDS.

LIEVE FRANSEN: Thank you, chairs and panelists, ladies and gentlemen, colleague and friends. I hope my health will allow me not to cough too much doing this presentation. I wonder if you'll really hear what I'm saying, because I say more of what is being said behind us, so I hope you don't have that disturbance too much in the room.

While the previous speakers have already shown very much how we're facing a critical shortage of health professionals in the poor regions of the world with the highest disease burden and how little attention has been

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given to that in previous years. It is actually keeping me awake. How could we forget that we needed nurses and doctors and health professionals? Unless we expand rapidly the healthcare workforce in poor countries and limit the "brain drain," we will not be able to improve health and confront HIV/AIDS. Doctors and nurses are needed. The Malawi example is quite striking about how creative people can be, but there is a limit, a breaking point I think.

In the few minutes of my presentation, I would like to share with you some critical data and some actions that Europe is engaged in to help address the health provider crisis. I am sure that you will, at the end of my presentation, think that we might have to do even more and any suggestions will be very welcome because I think, in my opinion, this conference should come out with a real, urgent plan for scaling up healthcare resources. The conference here in Toronto should be a breaking point in the right direction I believe.

There are three main causes from our perspective. The loss of health professionals in poor regions is due to migration to wealthier regions for higher-paying jobs and better opportunities, but looking at the figures, 37-percent of South African doctors and 34-percent of Zimbabwe nurses have migrated. In Ghana, three-fourths of all the doctors

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immigrate within a few years of completing medical school. It is incredible. The second cause is the death of health professionals. A colleague from WHO already mentioned this. Actually, the attrition rate through death of health professionals caused by HIV is actually even higher than the migration, but both together are obviously really very high. The third cause, which I think is sometimes not mentioned enough, is burnout and demotivation of health professionals in some countries, especially in the South African region where HIV is highly affecting the whole population. I personally was a district medical doctor in my younger years and I was in charge of 300,000 people. I can tell you that I, too, burned out at that stage and we didn't have HIV. So how do we deal with that now? I'm very respectful for people still doing the job in their countries in those kinds of situations. For the moment, we're missing 1 million health workers in Africa alone and 4 million healthcare workers to provide basic health services alone. I'm not sure that we can grasp the numbers, the extent of the numbers; 1 million only for Africa, 1 million healthcare workers. We don't train them in a few weeks. It took me quite a few years to get trained as a medical doctor and then to really be efficient at a certain stage, I needed even more training, so I'm not sure. In Europe, we have 10 health workers for every

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thousand people and we want more, we attract more. While in Africa, we have fewer than 0.8-percent per thousand people. In some rural and remote areas, as shown in Malawi, there are not even any. But to provide health services and general care for HIV specifically, but also in general, we need nurses and doctors. People with HIV, women delivering babies, because we should not forget that we are here at an AIDS conference, but we also still have women delivering babies, we still have children in need of immunization, and we still have other problems in health that need to be tackled. All of that together, all of these people, women delivering babies cannot wait to get help if they need to, just as people with HIV need to be treated now. They cannot wait for seven years for the medical doctors to be trained. So we need creative ways. Some of the creative ways have been shared with us already in Malawi, but we need much more. This conference has already shown a few of them, but we need to really have a break point here.

A little bit about migration of health professionals; migration of professionals is a global phenomenon. It is globalization and it has a positive side, as long as it is associated with circular mobility, people come and go and exchange and work together. However, today the promises of better pay, better working and living conditions and career

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opportunities pull health professionals away from regions where investments, working and living conditions and opportunities are lowest. The result is a continuous and often irreversible migration of a large number of health professionals from the South to the North and from rural areas to urban areas. Let's not forget also in the countries themselves and in the regions, we have migration and mobility. In Rwanda, for example, some provinces that we see less than two per capita, per person, to spend on health get depopulated from their health professionals. Other provinces receive \$12 per person, per capita, obviously health workers are migrating in that direction where there is more to do because there is more investment. Health professionals and donors should work with governments to allocate resources in a more equitable way across the different regions in the country and the regions.

This year WHO, as we've just heard, has called for a 10-year global effort to come for health workers and we in the European Union have immediately responded with a positive call for action. The call for action is firstly focusing on what we can do in developing countries and, second, what we should also do in Europe because Europe is also part of the problem and possibly part of the solution. And not only

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Europe, but as being in charge of Europe, I'm talking about what we should do and what we are doing.

First of all, in the developing world, we help secure access to HIV treatment and prevention for health professionals. Health professionals sometimes don't go for treatment and don't go for testing because they are afraid to be discriminated against. We should stop this; we need all of the health workers, even if and also if they are positive and need treatment.

Second, we support innovative ways of providing treatment for people with HIV by community workers, for example, the Malawi example and others. Several good examples have been shown here, and I hope you all have good exchanges about these so that we can multiply the examples in countries as fast as possible.

Third, we support leadership and stewardship of countries to set priorities in their health. Even small resources, human and other, are not always used most efficiently. Governments have to do better, with the help of donors, to set more urgent priorities of investment and training of health providers in providing good livelihoods and salaries.

We, therefore, in the European Commission, provide longer-term, predictable financing to cover recurrent costs

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for training and salaries of health professionals. The European Commission is providing financing for human resources through budget support. For example, in Zambia, a total of 100 million Euro over a period of five years, which means that there is more predictable financing and countries can plan for the health professionals and health professionals can see a little bit more of a predictable salary coming in, although five years is probably still not enough, but very few donors have schemes that they can support longer. In Europe itself, we also take some action. Ministries of Health, first of all, in the member states are working together very recently to assess the needs for training and recruitment of health professionals. Europe's Open Board has increased mobility of health professionals and also patients. Across the continent, European countries need to manage their health resources better and plan for training across Europe. The European Union is also exploring the development of a Code of Conduct for ethical recruitment of health workers to guard against active recruitment of health professionals from the poorest countries. The UK already has such a code and the possibility of extending the acceptance of such a code for Europe is under urgent consideration.

The European Union acknowledges that legal migration and health workers' mobility is an individual right – I want

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to make that statement quite strongly – and can have very positive benefits for individuals, families and their home countries. However, their benefits depend upon a well-managed mobility, which we don't have for the moment.

In conclusion, we in the European Union and worldwide have started responding to a crisis. We start seeing the crisis, but we don't have the time to respond in normal ways, so we really need to have even more creativity and more willingness to work all together to solve step-by-step the crisis of human resources. This is the only way that we will be able to provide universal access to prevention, treatment and care for HIV. Otherwise, we will fail to save lives and ensure healthy populations in general. Healthy populations are critical for poverty reduction, for economic development and for security worldwide. Thank you. K

[Applause]

SHOJI NISHIMOTO: Thank you. I would like to now have the pleasure of inviting Dr. Abraham Mohammed. He is a program manager of the HIV/AIDS program in Kenya. He is speaking on behalf of the Minister of Health Kaluki Ngilu. Dr. Mohammed, please?

ABRAHAM MOHAMMED: First of all, I would like to thank the organizers for inviting Kenya to speak in this forum for advancing health workforce capacity in delivering

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treatment and care. As introduced, I am representing the minister of health who was, for unfortunate reasons, not able to come to this meeting.

The first case of HIV/AIDS was described in Kenya in 1984. In this short 20 years of its existence, this deadly pandemic has caused untold suffering and pain to many people around the world, especially in Sub-Saharan Africa, where the prevalence in some places is as high as 30 to 40-percent. The current prevalence in Kenya is 6.1-percent, having dropped from 13-percent in the 1990s. HIV/AIDS is responsible for at least 1.5 million deaths in Kenya, and it is estimated that there are about 1.6 million AIDS orphans in Kenya. The single most important limiting factor for HIV/AIDS treatment and care scale up in Kenya is a lack of sufficient staff for the management and care for people living with HIV/AIDS.

According to the minister of health [inaudible], the health workforce has declined in size from 50,504 workers in 1996 to 42,910 in the year 2001. This is still reducing. At the same time, the health system is training to cope with new and increased pressures due to challenges posed in the era of HIV/AIDS, staff attrition, increased HIV/AIDS-related workload, absenteeism, training needs and staff recruitment [inaudible]. The rapid scale up of treatment has

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necessitated the training and redeployment of healthcare workers in HIV care services. As these services continue to expand rapidly, the number of healthcare workers providing comprehensive healthcare services has been outstripped by the demand. The need to employ and deploy staff according to need cannot be overemphasized. As services are decentralized, care is going to move to the level of healthcare centers where staffing is normally even more precarious. This will require that district health management teams guarantee to support healthcare workers at a more peripheral level to ensure that services are not disrupted. Provisional quality health services, particularly in delivering services to HIV/AIDS is a labor-intensive business that requires qualified health workers. Owing to the number of those infected country-wide and other complications that arise from HIV/AIDS, there has been a gap in human resource in our institutions.

An investment of US dollars, \$50 million per year for five years, is required to have in place a reasonable number of healthcare workforce able to deliver quality healthcare. Human resources, in terms of numbers and skills required, is a major constraint, hindering progress towards to achievement of universal access to HIV/AIDS prevention, treatment and care by 2010.

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Also, attracting and retaining skilled staff is a challenge for various implementing agencies, structures and institutions. This is attributed to the government pay structure, which is often lower than the private sector, which controls a large pool of skilled staff. Availability of adequate numbers of well-qualified human resource is a challenge for the government, the various ministries and institutions established for coordination and [inaudible] service delivery at the central and provisional level.

Actions being taken by the government to respond to the challenges of scaling up HIV prevention, treatment and care include ongoing trainings and increased enrollment in medical training colleges and universities aimed at building a national core of health workers. Another action being taken is human resource needs implementation for the national response being incorporated into the overall human resource planning. There is also a need to train and retain more health workers. To reduce the turnover in the health sector, it will be important to introduce retention strategies. For instance, health workers trained with government resources have to be bonded to limit migration to other countries. The other is hiring of skilled staff for the ministers of health and remunerating them adequately to avoid high staff turnover. The other is to provide adequate resources to

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develop civil society care givers to be able to provide home-based care services.

In conclusion, at the international level, we would like developed countries to limit the hiring of health workers from developing countries. Developed countries should support trading of healthcare workers in developing countries. And developed countries should provide debt relief to create additional resources to support human resource development.

Finally, international financial institutions should remove barriers of hiring healthcare workers based on macroeconomic stability concerns. Thank you.

[Applause]

LEONARD RUBENSTEIN, J.D.: Our final speaker today is Mark Heywood who is senior researcher and head of the AIDS Law Project at the Center for Applied Legal Studies at the University of Witwaterstrand in South Africa. He is treasurer of the Treatment Action Campaign and has a very, very long history of advocacy in HIV and human rights. He has consistently worked for equitable access to HIV/AIDS treatment. He has been involved in successful public impact litigation on the rights of people living with HIV in South Africa.

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MARK HEYWOOD: Thank you, thank you very much. I think as the last speaker, I have disadvantages and one advantages. The disadvantage is that much has been said already; the advantage is that perhaps I can comment on some of it and try to draw some of the strands together.

The first thing that I want to say is that I believe that the human resource crisis is not just a global crisis, but is a globalized crisis. What I mean by that, as the earlier speakers have demonstrated, is that if you pull the string in one part of the world, it unravels often in another part of the world. So Canada steals healthcare workers from South Africa. South Africa steals healthcare workers from other African countries. The South African private sector steals healthcare workers from the South African public sector. The urban areas steal from the rural areas. I make that point because if it is a globalized problem, there has to be a global framework to the resolution of the problem.

[Applause]

Not just a series of ad hoc patches that may give remedies of a temporary nature in some countries, but will store up problems further down the line. I will come back to this point in a few minute's time.

The second issue that I want to make is that I think, in having this discussion, we're struggling from the rhetoric

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of recognition of the problem to practical steps to address the problem. We've got to take that gap sooner than later. Although HIV gives us an immediate cause to square up to the healthcare worker crisis, as Lieve Fransen said, it would be a mistake to justify sorting out the human resources solely on the basis of scale up of HIV services. We need to replace health at the center of the development agenda in the way that was recommended by a report that we all seem to have forgotten about, which was the report of the WHO Commission on Macroeconomics and Health from 2002, which contained many important recommendations.

I would suggest that we need to identify a number of short, medium and long-term steps that need to be taken. Not just the emergency measures, which are necessary, but the measures that we need to embark on now, which we will only be able to deliver or will see the results of in four or five year's time, or even in decade's time. I want to make some suggestions in each of these areas.

The first is that I think countries have to recognize that even in the face of resource constraints, sometimes we have a greater resource base than we imagine. In South Africa, for example, nurses complain that there is a need to change scopes of practice to make it possible for nurses to

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provide treatment and care to people that is currently prohibited by existing legal requirements.

[Applause]

We need to look into that and make recommendations.

The second is that the World Health Organization should recommend that the large, informal health workforce that exists in many of our developing countries is brought formally into the health sector.

[Applause]

In South Africa, it is estimated that 60,000 people are informal healthcare workers. That is that they work on a daily basis providing counseling, providing care, providing a variety of different types of support, but receiving very little or no remuneration or training or recognition as a consequence. That is a precious resource, but if it is to be sustained, it needs to be costed for and treated with respect and dignity.

[Applause]

The third thing that I would suggest – and the list could be much longer – is that we need to identify the critical areas of shortage and make plans for those critical shortages. It hasn't been mentioned yet, but pharmacists, for example, there is a terrible, desperate shortage of pharmacists in developing countries, not just doctors and

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nurses. When we talk about roll outs of antiretroviral treatment, for example, you'll go to many areas and find that there may be a doctor and there may be handful of nurses, but there is no pharmacist. Without a pharmacist, you can't dispense the medicines. So we would say to developed countries and to developing countries, find a way to help us deal with those critical bottlenecks, which if we don't deal with in the short term, will paralyze our ability in the medium and long term.

Finally, or almost finally, I would take what Lieve Fransen and what the WHO has said and say that we need to go further than what you have proposed. We need an international agreement on the human resource issue that binds in the same way that the WTO agreement on trips binds countries, binds countries in conduct in relation to the distribution of human resources in our health systems. Voluntary agreement will not work. Already, the British agreement on poaching healthcare workers in being circumvented; I can tell you that it hasn't stopped healthcare workers from South Africa from being recruited by private recruitment agencies in Britain. We have to look at something more binding and I want to suggest three components to that. The first is that there should be minimum conditions for healthcare workers. There absolutely has to

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be a set of minimum conditions. Minimum conditions in terms of remuneration and minimum conditions on a range of other things, because if there aren't minimum conditions, than the circulation will continue.

The second is that there needs to be a legally binding agreement to stop the poaching of healthcare workers from one country to another country.

[Applause]

A legally binding agreement.

The third is that there needs to be some sort of concrete plan for the production of healthcare workers, not just a vague statement that we need more doctors and nurses and pharmacists and so on, but a targeted, quantified plan to start that production. Then there has to be a recognition that in developing countries, our ability to produce healthcare workers has been gravely limited by the loss of skills and the hemorrhage of skilled teachers out of developing countries, often to the developed countries, and therefore the onus and the training of a new generation of healthcare workers has to be placed on the developed world, not exclusively, but there is a direct responsibility in that regard.

So I want to conclude with, I think, four points and they're all very brief.

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Point one: We have to involve healthcare workers in this discussion. In the same way when we talk about HIV, we talk about the principle of GPA, we cannot have these discussions if the voices of doctors and nurses who are on the front line and if their trade unions and staff associations are excluded, which, very often they seem to be.

[Applause]

Point two: We have to approach the human resource question as a human rights issue, and I say that as a human rights activist. Various international covenants talk about peoples' rights to the highest attainable standard of health. The highest attainable standard of health needs to be qualified and it needs to be both a moral and legal driver for addressing the types of problems that we are discussing. That would help us with an international agreement because many of our governments have signed international covenants that create specific duties around public health and population health in the countries we come from.

Finally, I want to suggest that AIDS and our response to HIV give us a model for what we have to do now in relation to human resources. It gives us a model because we're starting to look at AIDS in terms of targets and the monitoring of whether we meet the targets that we set. That has to happen with human resources. It gives us a model

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because we start to look at AIDS globally and we coordinate our response to HIV, rather than solely looking at it at a national level. It gives us a response because we raised funds for the response to HIV, and we should take a similar approach to raising funds for the production and sustenance and development of a healthcare workforce, not just for AIDS, but for public health into the 21st century. Thank you.

[Applause]

LEONARD RUBENSTEIN, J.D.: We'll take a number of questions at a time. We've three microphones. Why don't we take three, one from each? We'll start with microphone one, then two and three and then we'll answer them.

LAURIE GARRETT: Thank you, this is great. And I was worried that this discussion would never take place at this meeting. Thank God. I'm Laurie Garrett from the Council on Foreign Relations. We've been putting a lot of energy into this, and I want to take Lieve's challenge; why don't we come up with some solutions? Jumping off of Mark saying that we're looking at a globalized problem, we've been trying to say, "How can we go to an economy of scale that makes sense?" Why should it be that Malawi and Kenya are ordering drugs at ridiculous prices when there could be a global, high-volume ordering mechanism with a global, high-volume procurement and distribution system? The same goes with the front-line

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infectious disease care. We strongly believe that we need to create a vast army of community healthcare workers, not just to address HIV, but integrating the major infectious disease killers into a single frontal assault package. If we don't, what's going to happen – and all our data shows this – is that we're going to have a net increase in death due to draining healthcare workers away from the less glamorous diarrheal disease programs in children, vaccine-preventable diseases in children and then we will look back at this time and say that AIDS killed the health programs of a vast majority of the population. It is essential that we be talking about this now as an integrated problem, that this human resources crisis is not just an AIDS and ARV rollout crisis and that we seek solutions that raise all the boats at once.

[Applause]

ANDI DEVEREUX: Thank you. My name is Andi Devereux [misspelled?] from Mindset Health in South Africa. My question is directed at Mark. Mark, in terms of what you're saying about task shifting and letting the informal health workers do a lot of the work, letting nurses dispense and so on, a concern that has been raised in South Africa very often is that there is no standardization of training of the informal health sector. You can do a one-day course or a

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one-year course and you're still called a lay counselor. So in light of that, I wonder if you could please comment on the amount of damage that could be done by ill-trained and ill-prepared people. Also, having done a lot of research with nurses, we do a lot of training of nurses, I was just wondering if we had to sort of pitch your response to the healthcare workers crisis to them, how would you respond to them saying that taking healthcare workers and forcing them to work in the country where they were trained is a human rights violation on them? I disagree with that, but I'd just like to hear your opinion. Thank you very much.

LEONARD RUBENSTEIN, J.D.: Can we keep the questions short? We have a lot of people with question. Microphone three?

EMILY FREEBURG: Okay. Emily Freeburg from the Toronto YouthForce. There are a lot of young people here discussing prevention issues, but one of the Millenium Development Goal targets is also decent employment for youth. I wonder how youth are involved in the strategies as part of the strategies and the recommendations of these scaling-up plans and how many young people are part of the trainings that are taking place.

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SHOJI NISHIMOTO: Thank you. Let's go around one more time and then ask the panelists to respond. Number one microphone, please?

LEE GREENE: I'm Lee Greene [misspelled?] from the AIDS Treatment News. My question is to Mark Heywood. I have a brief question about how the recent South African legislation limiting the contract of foreign health workers; has limiting the percentage of foreign health workers in South Africa had an effect on the public health sector, positive or negative?

SHOJI NISHIMOTO: Thank you. Number two, please?

BROOK BAKER: Yes, my name is Brook Baker; I'm from an organization called Health GAP. My question is about the risk that we confront that the donors will impose employment conditions on the new category of community health workers that will be highly contingent, highly low paid and stipend-based and continue an ethic which has really called these workers volunteers. A slight improvement in status, a slight improvement in training, a slight improvement in connection to the formal health sector, but fundamentally not addressing the need to professionalize, as Mark was suggesting, and also to put into the public sector this group of employees, to formalize their employment, to pay them a living wage, to

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train them and support them and help them in their career development.

SHOJI NISHIMOTO: Thank you. Microphone three, please.

INGRID LUTHU: Thank you. My name is Ingrid Luthu [misspelled?] from South Africa. I have a question to Mark. Mark, your colleague and friend Zaki Ahmed [misspelled?] has challenged the west and the north to institute international community health service, like we have for doctors in South Africa. Is this an option; could this fit into the human resource needs of the south to institute a type of Peace Corps with health workers from the north and the west to the south?

SHOJI NISHIMOTO: Thank you. Let's pause here and let the panelist take up these points. I'm sure, Mark, you have a lot to say on this one.

MARK HEYWOOD: Yeah. In relation to the question – I didn't get the person's name – from Mind Set, what I'm saying is that we have to recognize that there is a significant, informal health sector workforce and that the health sector has become dependent on that workforce, particularly in relation to HIV. When I'm saying we must formalize that workforce as part of a package of interventions, I'm not saying so in suggesting that we should reduce the quality of

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the care; I'm saying formalize and train in order to improve the quality of care. Formalize and standardize training, formalize and improve remuneration, so as to also improve the morale of the people who provide those services because I can tell you that when people get a salary one month, then they don't get one the next month, it's not particularly good for the quality of counseling that they do in relation to HIV testing.

I don't think that you can force a healthcare worker in a developing country, by law, to stop them from migrating to a developed country. That is not possible. But what you can do is you can reach an agreement by law to stop developed countries and agencies in those countries from creating the basis for drawing people out in the first place, together with improving the conditions of healthcare workers in developing countries, so that there is less of a need to go. Because as you know and I know, a lot of healthcare workers, say, from South Africa, who go to Dubai and all sorts of places don't feel happy when they go to other countries; they go for material reasons and also, there are a lot of healthcare workers who exit the health system all together. We often don't talk about them; we think they all just get poached, but a lot of people just stop being nurses or stop being doctors and go and do something else.

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The impact on the public health sector on South African legislation – Well, South African legislation has started to change, but I think it is a difficult and a delicate balance. South Africa would also have responsibilities not to steal healthcare workers from Burkina Faso and from Congo and from a whole range of other countries. So we need foreign healthcare workers in South Africa and we need to take away disincentives of people coming from developed countries, but it is a balance; it is a complex question to try and answer in 30 seconds.

The last question for me on the international community health service year, I think it is a very good idea that developed countries should encourage students, medical students, to some sort of community service. I think Laurie Garrett would agree that in the context on increasing infectious disease crises across the globe, for people in England and Canada to actually have to deal with these types of diseases would be beneficial, but it should be a [inaudible]. It has to be something that is looked into alongside more profound and long-term solutions to this crisis.

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SHOJI NISHIMOTO: Thank you, Mark. I would like to now ask Dr. Guerma from WHO to comment on this globalized issue, globalized solution.

TEGUEST GUERMA: Yes, I would like to comment first of all on health workers for HIV versus the health sector. I think it is very important that we realize that the health workforce problems were there for years and years and years. It was a chronic disease of the health system. But it is only with HIV and particularly with the Three by Five initiative that this has been highlighted once again. And for the first time – and you said it here – all the people in the conference, Clinton and Bill Gates, everybody is talking about human resources for health, but this was different. So what we have to do is really use HIV/AIDS as an entry point to strengthen human resources for health and in general health system, because that is where the funding is and that is where the attention is. If we don't take this opportunity, we will be again left over for years because this has happened for years and years. So it is important that the human resources that we will be strengthening will work for the whole health system, for the whole health sector, but we have to use this opportunity.

On the globalization, of course it is a global problem. It can't be really patched, as Mark said, but we

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have to start by doing the first step. As Lieve said, we need to have short-term, medium-term and long-term solutions. The short-term is to use this entry point of disease program to strengthen human resource forces, but we need to have a global solution to strengthen human resource for health. Thank you.

SHOJI NISHIMOTO: Dr. Fransen, I think there was some comment on the preparedness, so to speak, from the north, from the European side, for instance. How would you be so prepared to come to discussion with the issue of the conditions of the so-called compensation, that if the northern countries are to take on the health workers from the south, what sort of scheme that you can think about how to help both the short-term and the long-term shortage of health workers in the south?

LIEVE FRANSEN: Again, I'm not sure I totally understand. We hear very badly here. But I would not talk about compensation. I think we need to look at the global problem and find a global solution and each of us take our responsibility. What I was trying to express also is that Europe has a responsibility, has recognized it and is trying to respond to this now. For the moment, we are looking at a code of conduct that is voluntary, I take the point, and that could be a discussion further as to how far voluntary will

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get to it. We also are very committed to increasing the training needs because the training needs and the capacities in Europe and in the developing world. We're working there because the problem is also across Africa. The EU work quite closely with the African Union on this and I think there is an important aspect there. I hope WHO can also help further in proving the know-how in standardization and formalization of health workers. That is not a decision that the EU or the EC takes for countries actually.

I would like to make – while I have the floor – a comment to the suggestion about the infectious disease response, rather than HIV. I would really plead to look even further than infectious disease, because I'm not sure that – for the moment, I have striking examples where pregnant women have less and less care when they need it because there is more and more pulling away from non-infectious diseases. Pregnant is not a disease, but if you are in front of a difficult delivery and you need attendance, it is really critical and I find it really sad that the world has given so little attention to maternal health and women's health in that context. So I think we're coming back a little bit to the essential package of what is essential to be dealt with. I would very much strongly say, again, what my final words were in my presentation, to also put health in the center of

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the attention. We have neglected health. For years, the world has not invested enough in health and that is true across the world, and now we have a crisis where unless we have a large-scale response to it, we are not going to solve it. Europe is still attracting more people because there is an increasing perception at least of a need for more health workers; whereas, we stopped for years the training of healthcare workers in Europe because there was the perception that we had enough. Thanks.

LEONARD RUBENSTEIN, J.D.: Why don't we take some more questions. Microphone one?

REBECCA HURTIS: Thank you. Rebecca Hurtis [misspelled?] from the University of Oxford. I welcome the adoption of a treat, train and retain program and I think the rhetoric is very seductive. But my concern, like Mark's, is that it saddles the poor world with responsibility. Now regarding the rich world, Dr. Fransen has spoken about the EU's responsibility regarding treatment, but I think that, in terms of the fact that 3 million people died of AIDS last year, you'll have to forgive us if we're a little bit dubious about the EU's sincere commitment to treating people dying with AIDS in the poor world. Also, Dr. Fransen, you also spoke about mobility as a solution. I'm a bit concerned and well, confused, about how increasing mobility is going to

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address the "brain drain" of health professionals to the rich world. To Dr. Guerma and Dr. Fransen, how can poor world countries hope to attain the medical staff when they are actively poached by rich world health systems to patch up their own flagging health systems? I would like some concrete solutions in this regard.

LEONARD RUBENSTEIN, J.D.: Thank you. Microphone two?

SALLY SIMPSON: My name is Sally Simpson. I'm a registered nurse and I'm based in Toronto, Canada here. I've worked for 17 years in the field of HIV/AIDS. I've had brief experiences in a South African country. I practiced in a rural clinic for a about a month, in an HIV clinic, and I had some experience as well in an Eastern European country having to do with nurses, physicians and social workers in HIV. So I speak from a place where I'm Canadian, however, I do have some perspective. Many of the things I've heard here today are wonderful and very, very welcome news. There were some things, however, that I had some concerns about and I'd like to make a suggestion from my opinion as an RN. And that is that as you are beginning to examine this plan and to roll it out, however that might be, that you examine the hierarchy of the medical system. I heard today - Dr. Schouten, please forgive me - that we talked about lower cadres. In my

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experience, all people who are interested in working in HIV/AIDS care – not matter where they are – should be welcomed and they should be treated with the same dignity and respect, as Mark had said. Community healthcare workers have much to give; volunteers have much to give. I agree that volunteers should be considered professional people. As registered nurses, we are the folks that tend to know most about our patients; yet we are often silenced within the traditional medical system. I strongly recommend that if this could be rectified, that this would be attraction for nurses to stay within the nursing profession. Thanks.

[Applause]

LEONARD RUBENSTEIN, J.D.: Okay, number three?

ALAN HARRIS: My name is Alan Harris and I'm from Zambia. I've been teaching in the medical school there since it opened, so that a lot of my children in medicine are probably at this meeting; in fact, I've run into a lot. I want to talk about the resource that we seem to be forgetting. Those who are being retired, retired when they should still be giving something of their knowledge, their wisdom, their skills. Very often governments say that the retiring age is 65 or even 60 for many nurses. They don't want to retire and they could still go on. I'm not too far

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off my 80th birthday and I'm still working full time. I'm working nine hours a day.

[Applause]

And let anyone dare tell me that I don't know how to learn new tricks.

[Laughter]

I know quite a lot of old ones as well. I can put this knowledge to your service. How many of you at this meeting were about 40 or 45 when the AIDS epidemic began and are now approaching retirement age and going to get out of it, saying "We've done our bit." Why don't you stay in and do a bit more? Thank you.

[Applause]

LEONARD RUBENSTEIN, J.D.: We'll take three more and, unfortunately, we're already over time so everyone else will have to come up afterwards. I'm sorry. Let's take the last three and then we'll have answers.

SUSAN STROUSER: I'm Susan Strouser [misspelled?]; I'm based in Lusaka, Zambia. I, too, want to reiterate the sentiments of the nurse from Toronto; thank you for reducing my blood pressure a few degrees. I am very saddened that there is not a nurse on the panel today. We are not a lower cadre of health worker.

[Applause]

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We are the cadre of health worker in rural Southern Africa. I've worked as a nurse in Southern Africa since 1988. I went there in 1988 and by 1990 our hospital was chaka-block [misspelled?], full of people on the floor with HIV and AIDS. We had lots of HIV and AIDS patients, but we did not have a doctor. That's the reality for us. We do not have doctors in most of the places where we work. We need the support; we need the training. A month ago I was in Zimbabwe and I went back to that hospital where I worked. The nurse that is running that hospital told me something. I said, "Sister Maggie, how's the hospital?" She said, "We're doing okay. We have no pain medicine. We have no IV fluids. We have no doctor." That is today.

[Applause]

MAJOR GENERAL MATIUR: Thank you very much. On denying the fact that we want the number of nurses – first of all, I should introduce myself. I am Major General Matiur [misspelled?]. I'm from Bangladesh; I'm the chief HIV advisor. The question remains that we should not take it in a [inaudible]. Every country has its own sort of peculiarity; we should don't divide developing country and developed country. The developing country, when we talk of them, we talk of the disease burden. It is a question of the disease burden. Some of the countries [inaudible] the

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diseases are much more. They need more doctors, they need more nurses and they need more support. So the other part is the question of the country where the disease burden is less, there we ought to put more money so that we train more doctors and more nurses, so that whenever they're in difficulty, they can fall back with their increased numbers. Now, by telling that, what I really mean – if you say "brain drain," what is "brain drain?" You say "brain drain" in a free world. We are in a free world. [Inaudible] without having any restrictions. It is the government, it is the sovereign nation to decide whether they need to send their doctors to other countries and having that need be fulfilled. That is out of the questions, so we cannot impose – say, in my country, say Bangladesh, we are having only 658 HIV/AIDS [inaudible] cases in our country. We have very many doctors, we have very many nurses, we have so many things, so our doctors, I personally feel that they should go to the other country where there is a need to learn and bring their expertise to be utilized in our country. I very, very strongly feel that it should not be a generalized terminology; it should be country-specific and burden-specific and leader-specific. The other question has already been mentioned about increasing the [inaudible]. So I hope that is the approach, not penalizing a country by telling

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big, developing nations – as we are a developing nation. So thank you very much.

LEONARD RUBENSTEIN, J.D.: Number three?

FEMALE SPEAKER: Hi, [inaudible] from UNDP Angola. Just an issue that I haven't really heard brought up is the south-to-south transfer, specifically in Angola in rural areas there is a great dependence on North Korean and Cuban doctors. I haven't heard this mentioned. I know also in rural parts South Africa there is a lot of dependence on Philippina and Cuban and doctors from other parts of Africa. What are some solutions, in terms of thinking about incorporating these doctors? Many times there are linguistic problems with incorporating these doctors into the hospitals that they're working in and also into the HIV care. One of the issues we have is in terms of inviting these doctors to trainings; they are many times left out of trainings by the government and not seen necessarily as focal people, even though they're the ones who are there and sometimes the only ones available. Thank you.

SHOJI NISHIMOTO: Thank you. I'm afraid that we have to do an impolite sort of cut-off of the discussion. I'd like to invite the panelists to make very short, final intervention, please.

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TEQUEST GUERMA: Let me start, because I started the presentations. Let me say, first of all, that I have the highest respect for nurses.

I have worked in many African countries as a practitioner and I know the load of work that nurses had and how they managed by themselves without doctors. So what we are proposing through TTR is teamwork, a clinical teamwork. We want to decentralize and we want to give more power to the nurses, to the community workers and to the people living with HIV to work as one team to provide services to HIV patients. I think that is very important. The other thing on which I wanted to comment is that we are proposing a concrete solution. The concrete solution that we are proposing is that health workers are dying. We can't train in a very short time a number of health workers. We want to expand the existing health forces. To expand the existing health workers, we first have to save them from HIV/AIDS. We have to treat them. We have to prevent them from HIV/AIDS. That's why we want to give priority to the health workers, for them and their families, to get treatment, prevention and for them to be alive to provide services to healthcare seekers. I would stop there and ask the others.

SHOJI NISHIMOTO: Thank you. Dr. Schouten?

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ERIK SCHOUTEN: Thank you very much. On three issues, one was mentioned on if ART and scaling up of ART or the HIV services would deplete health workers from other essential services. We have been looking into it, but we haven't finalized it. But what we see is that quite a few health workers' lives are saved because of the ART treatment. So I think WHO did a new study that up to 30-percent of health workers in countries with a prevalence of 15-percent could be lost in 10 year's time if there is not treatment available. So the affect of having less health workers for other services, I'm not so sure is this is really as severe as we thought, including me, a couple of years ago.

The second point is on retirement. A part of the emergency scaling-up plan is to ask people who are already retired to come back and to work for several years in civil service.

The point on lower cadres – As we see in Malawi, there is an absolute shortage of doctors and nurses. There is an absolute shortage of clinical offices and all health workers. Whatever cadre, there is an absolute shortage. It was very clear from the beginning that we could not scale up compared to other countries where you could scale up and doctors are prescribing ARVs and the followup of patients. This is simple, not possible. It wouldn't be anywhere and I

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probably wouldn't be here to present anything on what is happening in Malawi if we had chosen that route. At this moment, we are scaling up for clinical offices. It is a cadre where there has a shorter training than a doctor and people [inaudible]. ARVs and ART is being followed up at this moment mainly by nurses and they're doing an excellent job. But we're looking more and [inaudible] that medical assistants with less training and I'm sorry if a lower cadre gives some people high blood pressure here, but I believe and we see that medical assistants do excellent work and are absolutely able to scale up. We have to go further; if we really want to make a change, we have to go to other cadres that are traditionally seen that should prescribe these very complicated types of drugs. There is also a part in recognition of the good work that is being done. If the lower cadre is here only means people with a lesser or a shorter training than some other cadres. Thank you.

SHOJI NISHIMOTO: Dr. Fransen?

LIEVE FRANSEN: A few quick responses to some of the comments or questions. First of all, the EC and the EU are providing support for year's treatment, care and prevention in general and for health. I would not like to leave the impression – the EU together is providing 60-percent of the overseas development aid worldwide. Obviously, this is not

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enough. It is going to increase now quite rapidly towards 0.7-percent of GDP that was promised years ago. Again, too late, but we are still the largest donor of overseas development aid worldwide. The issue is there that the package in general should be increasing and the focus on health should be increasing worldwide. That is true for domestic resources, as well as for overseas development aid, I believe.

Let me also correct that the EU is providing 60-percent of the budget for the Global Fund. Again, the Global Fund doesn't have enough funds yet and as the vice chair, I'm working very hard to make sure that the Global Fund gets enough funds so that we can continue seriously with the work. That being said, I think I've heard quite a few interesting suggestions. I have very high respect for nurses and loved working with a lot of nurses when I was a district doctor. With 300,000 people as the only doctor, surely the only way that I could work was with volunteers, community workers and nurses. I'm sorry that we have not worked further since the 30 years that experience, for me, happened upgraded the recognition of nurses, the standardization of training and the legislation around what nurses and other workers in the health sector can do. I think that might be the right moment to do so.

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LEONARD RUBENSTEIN, J.D.: Excuse me, Dr. Fransen.

We have, unfortunately, been told that we have to vacate the room, so the other panelists won't even get a chance. We could have had two hours more to discuss. We're sorry that we didn't get to continue, but thank you all to the panelists and I'm sorry for the last two.

[Applause]

[END RECORDING]