Healthcare Workforce: Who Cares and Where?
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NELSON OTWOMA: Since we have more than enough seats in front, please would you be willing to move in front although you'll hear us wherever you are. Okay. We are about to begin our session. Actually, we are supposed to be starting now. Thanks to the panelists and thanks to everybody for giving me the honor to start this off. I want to introduce myself. My name is Nelson Otwoma, the way it's spelt there. I work and live in Nairobi, Kenya. I work with the National Empowerment Network of People Living with HIV and AIDS in Kenya. In short, it is NEPHAK.

In this session, we are talking about healthcare workers and the question is Who Cares and Where? From my perspective, I think, this is really very important, particularly, when we are talking about universal access. This is because it is not just commodities and other resources like money that we are talking about, but where is the personnel, the professionals, the human being to deliver the infrastructure? Do we have adequate; do we have enough, and where they are? Do we have the capacity?

I will be co-Chairing this bridging session together with Sue. Our role is to make you clearly get the panelists and the speakers, and also later on try to help us moderate your questions.

Before I leave it over to Sue, I wanted to say how important, particularly from the perspective of people living with HIV/AIDS, it is important to ensure that we have people in terms of human beings we call healthcare workers starting with community health workers at the community level who are linking with clinics and other facilities to make sure that those who need the services within our facilities access them.

We talk comprehensively about health systems including laboratories. This is important because we are talking about sometimes patients who go to the facilities and wait, not because commodities are lacking or diagnosis is lacking, but because there is no personnel to administer diagnostic or there is no personnel to dispense service for a drug and this is really interesting to us from our perspective.

That is what I wanted to flag off as we are going to discuss. Please, the question remains are we having enough or adequate personnel to take us through what we are talking about?

Then if we have enough, do they have the capacity and are they motivated enough and what path do we think that they are playing towards reaching the targets of universal access whether it is treatment or counseling and care that we are talking about here. I think with that because we don't want to waste a lot of time, I want to leave it to my co-Chair, Sue to

start it off, and then later on I can also say my point. Thank you.

SUZANNE WILLARD: Thank you, Nelson. It's a pleasure to be here. I wanted to thank the organizers of this particular presentation, and also to be able to allow when we start talking about healthcare workers in the workforce. It's really all about, Nelson, and the quality of care that really is important; that the people that he represents need and be able to have.

I truly believe when I watch some of these plenaries and some people saw the cascade and the leaks in the cascade, the community as well as the nurses are really there to be able to plug those leaks. When Mayor Gray talked about no transmissions of HIV from mother to child in the city of Washington D.C., I thought about the one nurse/midwife who sits up in Washington Hospital and it's all because of her and her efforts that he gets that data. I think that that's really important.

We want to have this as much interactive and not just didactic to be able to have a conversation. We hope to be able to have some time for questions and answers at the end, but you know how these sessions go. We may begin to run out of some time.

We will have time for questions, but there also will be these cards that will be handed out by the folks in the yellow

shirts. Please fill them out. Nelson and I will take a look at that and we'll be able to mesh a lot of the current themes and be able to have those questions.

Without further ado, our first presentation—we're going from the global to PEPFAR to a country's response, and then to the community's response to this very important topic about Healthcare Workforce: Who Cares and Where?

Our first presentation is as we see whether this thing really works is The HIV Healthcare Workforce Crisis: An International Perspective on Human Resource Gaps and Needs for HIV Care. This is being presented by Dr. Mubashar Sheikh who is with the Global Health Workforce Alliance in Switzerland.

DR. MUBASHAR SHEIKH: Thanks, co-Chairs. Thanks for the introduction and for setting the scene. Good afternoon, ladies and gentlemen. I hope you guys are enjoying the enriching environment, extremely rich discussions, lot of voices, lot of new ideas, and new thoughts.

I think our session really here is to address one of the critical challenges, one of the bottlenecks which is fundamental to achieve the universal target of access to HIV prevention, treatment, care, and support and the interface between this noble objective and accessibility to trained, motivated, and supported health workforce.

My job will be to share some ideas, some thoughts, some suggestions, and some of the findings for the last few years which have taken place, which has given us better understanding, better

insight, and better, sort of, in terms of framework to address this particular challenge. I'll start to share with you some of the background information. I think it's always important to understand where we stand in terms of the issues which we are going to discuss today.

There is a global crisis in terms of health workforce, a very well known fact. A fact, which is also considered to be a fundamental bottleneck in terms of addressing the health-related Millennium Development Goals three years from now. The time is passing very quickly, but we are fairly behind achieving these particular targets, and one of the challenges really is the health workforce availability and accessibility. Within that, some of the important factors right here in front of you.

Currently, over a billion people do not have access to basic health services through a skilled or trained health worker. We also note that 4 million health workers are missing or we are short of over 4 million health workers in different settings, in different countries globally, regionally, and out of this 1.5 in Africa alone. We also know the WHO has a benchmark in terms of density and availability of health workers: 23 doctors, nurses, and midwives to provide Basic Package of Health Services.

Fifty-seven countries, as we're speaking now do not meet these particular criteria, and out of this, 36 are in Africa. UNAIDS has come out with a statement saying that the scaling up of the services of HIV and support mechanisms, one of the major bottleneck

is lack of widespread non-availability of health workers. A number of studies estimates that the sub-Saharan countries needs to double, and in some cases, has to triple the stock of the existing health workforce to achieve the target of universal coverage.

Why are we always speaking of sub-Saharan Africa? Why is there so much emphasis on this? I think the figures speak for themselves surely. This region accounts for two-thirds of the global burden of HIV, but has only 3-percent of the available health workforce, and out of this, only 1-percent doctors. Just see the magnitude of expectations, the requirements, and the system support and the delivery mechanism, the hands to deliver those services are simply not there.

The crisis is not simply sort of registered in terms of numbers of the shortages, but in terms of complex labor market dynamics, in terms of supply, demand, and deployment of health professionals. A clear understanding in the context of each of these in terms of training, in terms of recruitment, in terms of deployment is essential to ensure that the policymakers and politicians make the right choices in terms of adapting the appropriate policies using the right combination of financial and non-financial incentives, supportive management practices, and adequate regulatory mechanisms. These are critical factors that need to be understood and addressed if we really want to address this particular dynamics and issues.

I think that goes to the heart of the problem. How do we bring multisectoral and different players together in terms of

addressing and overcoming this particular problem? This is not limited also in terms of the factor which I just mentioned earlier.

There is a complex and multifaceted linkage between the HIV response and HRH availability within the broad picture which we are referring to. The availability of health workers is a well known established factor that we need them. They need to be there. They need to be established. They need to be sort of scaled, and they need to be properly distributed; but it always doesn't work in one direction only.

In a number of cases, the HIV epidemic has put increased demand on the health systems and heath workforce by multiplying the demand in terms of workload, indirectly impacting and affecting the health workforce, and increased risk of transmission of infection within the healthcare settings, and the factor around stigma and discrimination.

In a way this leads to a vicious cycle if we don't understand and address this dynamics, a vicious cycle where a weak health workforce within the weak health systems leads to the weak provision of HIV services which further weakens the health systems. With the availability of new technologies, new drugs or combination of new drugs, or the new preventive approaches, this makes it even more important that health systems and health workforce within that system are adequately equipped, trained, and prepared to respond to these expectations.

The Global Health Workforce Alliance recognizing the strong reinforcement between the two dimensions organized a site session last year and a UN high level meeting on HIV/AIDS which was attended by politicians, policymakers, practitioners, civil society representatives, private sector, and others which not only acknowledged this relationship, but fortunately, many of these messages were heard and were reflected in the final declaration of that high level meeting.

To further understand the underpinning facts and the characteristics of these factors, the Global Health Workforce Alliance also convened a task force a few years ago which was co-Chaired by UNAIDS and PEPFAR, which looked at these gaps, analyzed the situation, found out the solutions in how to address some of the challenges to overcome the HRH shortages in terms of not only numbers but the distribution of skill mix accessibility, and then come out with the clear recommendations and findings.

The report of this task force—some of these copies are available in the back of the room. I draw your attention to that. You may like to have a look at it because it looks at the clear question whether MDG-6 can be achieved with the health workforce we can have.

If we look at the literature review, but also complement it by rapid country analyses in five different countries in Asia and Africa, and came out with the findings that there are a number crosscutting constraints which we need to have addressed. Some of

these are very well known. I don't need to go into too many details, but obviously, financial constraints are absolutely critical.

Just to give you an example, a country like Cote d'Ivoire, basically, because of the financial gaps and the structural adjustments, could recruit only 40-percent of the required health workforce between 1996 and 2004.

Similarly, the low salaries, large workloads, and difficult work environments reduces the motivation and the morale of the health workforce. A country like Ethiopia, a country of 80-million population, basically, has only one-third of the required health workforce, and the situation is further compounded by these factors which I just referred to. Fortunately, the national leadership is aware of the fact and is trying to address this issue in a comprehensive manner with other stakeholders.

An important element I want to stress upon is the pre-service training which is very costly, time consuming, but is essential. It does require proper infrastructure, training facilities, and other support mechanisms. Again, many countries are facing extremely difficult situations to address this. A country like Zambia, the task force came to a conclusion they need an additional $60 million and then 360 trainers to recruit students to the required targeted level; and again, a major problem where to get this money and how to train these faculty.

This does require a number of new innovative approaches if we want to really address this particular issue. I think one of the

important approaches which has been talked upon a number of times is task shifting or task sharing or whatever title or acronym you will like to use. Again, the WHO came out with a recommendation in 2008 along with USAID, PEPFAR, and others, basically, saying that there're certain tasks that can be delegated safely to less specialized health workers with an integrated team approach with supportive management and supervision.

Here is a slide which clearly reflects that, in terms of how this can be done. UNAIDS has used two approaches, a current approach where most of the case management is done by the doctors or by a delegated approach where this responsibility is passed on to the nurses.

Again, you will see that although the requirements in terms of the number of health workforce increases annually in both situations, in the second delegated approach, these functions are performed by the nurses. They are easy to recruit and they are less costly in terms of training, and also in terms of per diem so they can be made available to the system pretty quickly.

At the same time, the good news is that a lot of these countries are now taking this as a policy option. Many countries are sort of looking at the skill mix, various combinations of different cadres of health workers, and trying to see how they can use it innovatively and adapting it to the specific requirements.

There's also a large number of studies, peer-reviewed journals, systematic review, including the two conducted by the

Global Health Workforce Alliance on the community health workers and the mid-level providers which also speaks strongly to this particular option and support of this option. This slide illustrates that fact as well.

Also, I would like to draw the attention of the new report which has come out of the All-Party Parliamentary Group in the UK just a couple of weeks which also looked at a number of case studies in countries, again emphasizing the importance of innovative skill mix and recent four meetings community health workers; one, which was conducted here in Washington D.C. and another one in Nairobi, again, coming out with critical message in terms of integrity team approach and the use of midlevel and front level healthcare providers for the population level coverage in terms of integrity, delivery of HIV reproductive, maternal, and newborn health.

What do we need to do in terms of addressing this issue in addition to the task shifting? Task shifting is just one of the options. There are many, many other options, but there are some certain factors. Some certain framework has to be in place to make sure that these options are effective and delivered and provide the right kind of outputs needed of these options.

Here are some of those factors. Again, very well known, but the task force actually emphasized them more critically in terms of starting from the government ownership, political will, preparation of adequate HRH costed evidence-based strategies, integration of HIV within the National Health Service Packages, important management

support systems in place in terms of pre-service training, and very, very clearly in terms of greater emphasis on a combination between treatment as well as the prevention because the evidence again has shown that it works better if they are combined together. They are mutually reinforcing and supportive of each other and this is what is really required.

Obviously, as we move forward towards the HIV response universal access, I think the target really is self-reliance at the country level; but there is also a fact that many countries are receiving significant support from external development partners. There is a real need to align and to get better value for the money for this support.

A recent analysis of the support or the funding coming through GAVI, Global Fund, and the World Bank on the HRH in a number of developing countries, have shown a different picture. Most of the funding was used for in-service short-term training and very little in terms of pre-service training although these countries have huge shortages of health workers.

Also, these are used for salary top-ups without basically looking at the sustainability and the negative consequences with the expiry of the grants. I think these are the critical factors, but are also important opportunities to align the international support with the national priorities.

I'd like to conclude on a positive note which is drawing your attention to these five lines, five countries where the ART

coverage is going up in all five cases, regardless of the setting whether it is middle income, low income, or the fragile countries. Very positive, very encouraging message, but it also underpins the national efforts in terms of strengthening health systems and health workforce within that.

That report clearly speaks of those efforts which were made by these countries to achieve these positive trends. It is very, very important to make sure that we take the right choices and make the right options. The progress is possible. It is happening, regardless of all the challenges. The lives can be saved. They are being saved. The key elements of an effective HIV strategic response are clearly health systems related.

The countries can take the right decisions, make the right options, make considerable progress, save more lives by adapting more appropriate health workforce development strategies which are evidence-based, which are context relevant, and which have shown the results over the last few years. Thank you very much for your attention. [Applause]

NELSON OTWOMA: Thank you very much. My task has been made easy because the next speaker probably does not need any elaborate introduction. All of us could know what Ambassador Eric Goosby does, but I want to acknowledge the role of PEPFAR particularly in health, HIV and all services especially in sub-Saharan Africa. The Ambassador is going to talk to us about PEPFAR's efforts to strengthen the global HIV healthcare

workforce and we hope to hear more about PEPFAR. They promised to be part of this in the universal access. Ambassador, please. [Applause]

ERIC GOOSBY: Thank you very much. It's a real burning pressing issue for us. I want to thank the leadership in seeing the importance of focusing on health profession and education as a capacity development issue. I'm going to move through this fairly quickly. Much of it has been covered by my colleague on the burden.

These maps provide a picture of the situations in many low to middle income countries. The countries highlighted on this map are the same countries and regions with the highest burden of disease, particularly, from HIV, TB, malaria, and other communicable disease and non-communicable diseases. In many of these countries, recent investments have led to substantial advances in addressing these problems by governments and international donors, GAVI, Global Fund, PEPFAR, and others.

In order to sustain these successes, it is evident that an expanded and qualified workforce really is critical. Fifty seven countries have critical shortages of doctors, nurses, midwives and 36 of these countries are in sub-Saharan Africa. A 140-percent increase of healthcare providers is required to meet the basic needs of the population.

Initially in PEPFAR, the priority was scaling up HIV/AIDS treatment, care, and prevention. Immediately, it was evident that there were not enough healthcare workers and we started to focus on HIV training.

The immediate focus was on in-service training to teach skills to existing healthcare workers, task shifting dominated, and some integration of HIV content into pre-service degree programs. The real game changer in scaling up HIV treatment, care, and prevention was task shifting, and PEPFAR supported the WHO Task Shifting Guidelines.

In the second phase of PEPFAR, we have transitioned from an emergency response to supporting country ownership moving towards sustainability of programs. In the reauthorization language of PEPFAR, there is a congressional mandate to train and support retention of 140,000 new healthcare workers with an emphasis on doctors, nurses, and midwives.

Recently, President Obama announce targets for World AIDS Day at 2013 of 6 million on antiretroviral therapy, 1.5 million pregnant women on antiretroviral therapy and 4.7 million voluntary male medical circumcisions. We acutely recognized the critical role of nurses and midwives to meet these new targets. [Applause]

In fiscal year 2011, PEPFAR invested over 590 million in human resources for health. Our vision is to have the

appropriate number and distribution of qualified health workers who meet the HIV and other health needs of the population. This can be accomplished by increasing the number and cadres of the health workforce, the balance and distribution of the health workforce, and the performance of the health workforce.

This depiction of the health labor market shows where PEPFAR can intervene, as indicated by the red arrows. For example, the second red arrow can be interventions to getting students to graduate from PSE institutions. The third red arrow addresses delays between graduation and employment, specifically Tanzania and Mozambique.

The red arrow on the bottom addresses interventions to the healthcare workers employed, such as in Kenya. Again here, it's important to highlight that PEPFAR's investment in these interventions are helping the entire health workforce and make a contribution to the Global Health Initiative, the GHI initiative, as well as to the PEPFAR program.

With regard to the production of health workers, HRH TWG is looking at the entire labor cycle not just the graduation of workers from pre-service institutions. Do we have enough people qualified to enter training institutions? Where will they go when they graduate? Will they stay in the health sector? The red arrows represent where PEPFAR can intervene.

The objectives really are to strengthen the pre-service education institutions, to ensure the quality of in-service and

pre-service training and practicing professionals, support the development of new cadres and strengthen the community workforce, improve health worker motivation and productivity, foster positive workplace environments, investigate and apply recruitment and retention strategies in terms of their efficacy, and improve HRIS and utilization of data for improved management and planning.

Creating a new healthcare worker requires multiple supports for students: tuition, accommodations, placement assistance, recruitment from rural areas, in particular, and enrollment into the school. For teachers in leadership: salaries, revised curricula, improved instruction, teacher-student ratios, faculty retention schemes, leadership, planning and management. For infrastructure: classroom, the physical space, the housing, septic and utility utilization, materials, and finding a new location.

The slide here shows one of the constraints in many African medical schools, a shortage of faculty. Here, 14 students share one cadaver due to teacher shortages. In the United States, the number's at most four to six students per cadaver. When I was in medical school, it is one student per cadaver although we shared for the dissection of the head between three students. Things have changed.

Against this backdrop, we have tried to embark on an initiative to begin to work with government institutions and

other partners to strengthen and expand pre-service training and educational programs for doctors, nurses, midwives, and other health professionals.

The goal is to support an expanded healthcare workforce that is well-trained and efficient in meeting the health needs of the population, and mostly sustainable. The task in hand is to support the new political and resource commitments with sound technical and policy guidance, and documented examples of effective implementation strategies in order to achieve this common objective.

Two approaches were taken as part of the initiative. First, a competitive award process to African institutions partnered with US institutions, the Medical Education Partnership Initiative (MEPI). Second, several grants directly to countries to support a country-led process for scaling up of education, training and retention strategies for nurses and midwives; this is the Nursing Educational Partnership Initiative (NEPI).

The general objectives of both initiatives included strengthening an expanded workforce capacity including investments in recruitment and retention of qualified providers and to strengthen the quality and effectiveness of training and educational programs to make medical nursing education and training more relevant to country needs, identifying innovative models to increase the number of qualified healthcare workers,

strengthen research skills and opportunities for African institutions and providers, develop evidence-based policies and technical guidance to help maximize the impact of the investment, and to develop relevant custom models and norms that can be used by government and institutional planners.

Under the current PEPFAR administration, this initiative is considered a high priority and has support among the most senior leadership within the Department of State. In doing so, the Department of State and OGAC has provided substantial levels of funding and direct engagement to the initiatives in order to assure success.

In addition, the projects have been able to engage some of the strongest and most experienced US government agencies, both HRSA (Health Resource Administration) and National Institute of Health in implementing the initiatives. Both agencies have a long history of health provider training in areas of clinical care and research and strong partners in the field in order to provide essential technical support to institutions and information dissemination.

Specifically, George Washington and Columbia University ICAP has been the focus for the NEPI and MEPI programs. Other partners also play in a central role, especially WHO, in areas of policy development and leadership, both essential to the scaling of the workforce capacity.

As you can see from the list of implementing agencies and partners, PEPFAR has undertaken really an ambitious approach to address the issue of scaling up the workforce capacity across the key areas of technical support and policy development.

We believe that this investment will have long term and sustainable impact in the advancement of medical nursing professional in Africa, as well as overall improved outcomes for communities and families. We also believe that this will be a foundation for the movement of what has been predominantly a syndromic approach to diagnosis and treatment to one where there is a specific diagnosis made with the appropriate laboratory support, and that that diagnosis then has a specific treatment.

Let me spend a few minutes providing an update on the current status of the two initiatives, NEPI and MEPI. Both NEPI and MEPI were awarded in 2010 and awardees represented a large range of countries, institutions, healthcare providers, medical physicians, nurses, midwives, public health, and other provider types and partners.

MEPI included three types of awards, 11 basic programmatic awards to establish training and educational interventions, and eight non-HIV linked and pilot awards to address other health priority areas such as MCH, cardiovascular disease and cancer. MEPI intends to provide up to USD 130

million over five years to African institutions forming a network of 30 regional partners, country health and education ministries, and more than 20 US collaborators.

The NEPI was awarded to three countries: Lesotho, Malawi and Zambia and will include new countries in the future. These awards were provided through grants to the countries to support the direct scale up of nursing, midwifery, training and retention activities on country priorities. NEPI intends to provide up to USD 35 billion for five years to support the specific country efforts and to support the efforts of a coordinating center for curriculum models, development, and evaluation, and an information dissemination function.

This slide includes the location of the MEPI and NEPI awards as shown. Thirteen countries have received MEPI and/or NEPI awards. MEPI awards are direct awards to the African institutions as the principal investigator. NEPI awards are to the country: Lesotho, Malawi and Zambia.

In addition to awarding the MEPI and NEPI grants, PEPFAR and WHO are collaborating to support the new political and resource commitments around healthcare workforce development by providing sound policy and technical guidance in areas of medical nursing and midwifery education. This collaboration will result in the development of a transformative medical nursing and midwifery education guideline.

Objective three is to support the development of new cadres and strengthen the community workforce. For example, in Mozambique, where only a thousand doctors serve a population of 21 million, one doctor per 20,000 people, PEPFAR supported the development of a new cadre of health workers, medicos, tecnicos to fill in gaps; and in South Africa, a new cadre clinical offices for underserved areas.

Unfortunately, pre-service reform and task shifting have not been institutionalized in professional regulatory frameworks. To address the issue of changing professional standards, we are supporting the African Profession Regulatory Collaborative or ARC.

This is four-year initiative to strengthen the nursing and midwifery leadership and regulation in 17 sub-Saharan African countries. The approach is to foster south to south collaboration and support regulation improvement grants, targeted technical assistance, and rigorous program evaluation.

Objective four, improving health worker motivation and productivity can foster positive workplace environments. Here we see the difference in patient waiting times when health workers are supported.

PEPFAR supported programs including the establishment of wellness centers separate from the clinic in which they work for HIV positive providers in Swazi and in Uganda. Just to bring your attention now to one of the WHO recommendations.

This physician was recruited from Botswana in Tanzania is attending medical school in the same area and will stay there when he is finished. Other recommendations include combination of physically sustainable financial incentives such as hardship allowances, grants for housing, free transportation, and paid vacations.

I think the elephant in the room remains the unavailability of a living wage. Individuals who move out of these country settings are usually doing it not to go get rich, but to move to get into a position where they are able to address their school fees, uniforms, books, and housing requirements and not anything extravagant. That lack of that living wage has resulted in major movement of health professionals all over the continent. Until that is addressed by each of the countries, we are going to continue to see the huge shifts in trained personnel. [Applause]

HRH bottlenecks are often due to lack of reliable and cohesive information. This objective is about the improvement and utilization of human resource information systems for better HRH planning.

Chart from zeroing in doctors, AIDS donors and Africa's health workforce, the Center for Global Development in August 2010 shows the differences between the Ministry of Health's recommended positions, those approved by the Minister of Finance, and those actually filled. Essential to the part of

PEPFAR's agenda is supporting the implementation science to provide the evidence base for future programming. Here's an example of some of the research projects that have been supported to determine an evidence-based approach to strengthening nursing and midwifery programming.

I'd like to conclude with several issues for consideration when moving forward and identifying and gaining consensus around key policy and technical areas. These issues are not meant to be comprehensive, but reflect some of the core principles and values embedded within our program.

Recognizing the critical need for rapidly increasing the number of healthcare providers and better preparing those already practicing, we should strike an appropriate balance between approaches to assure both quantity and quality in order to support the development of qualified and skilled health workers.

Multi-sector approaches particularly between health and education sectors in areas of policy reform and programming are needed as are long-term sustainable changes in the areas of recruitment, education, training, and retention.

The use of evidence-based information would demonstrate the effectiveness in low and middle income countries is essential if we are to create effective and efficient programs and we really must plan now for the long term to assure

sustainability and affordability within low-income countries. Thank you. [Applause]

SUZANNE WILLARD: Thank you, Dr. Goosby. Again, we have question cards and we'll have time afterwards to have a discussion. Our next speaker is Dr. Anne Phoya who is a nurse from the Ministry of Health in Malawi. I had worked there about 10 years ago so I'm excited to be able to hear all the progress that has happened. Dr. Phoya. [Applause]

ANNE PHOYA: Thank you, Chair, for that introduction. I would also like to thank the conference organizers for inviting Malawi to share its experiences in dealing with this problem of human resource crisis. Usually, when you're making a presentation you don’t start with your conclusion, but the Chair reminded us that this is very strict on time so I would want to start with my last slide just to concur with what Ambassador Goosby has said and also just to refocus on the title of the session Who Cares for the Health Workforce.

I would like to share with you this afternoon that the government of Malawi cares for the health workforce and the honest business we advocate for inclusion of HRH issues in the Health Development Program. Government realizes that skilled health workforce is necessary because if we don’t have those people, then we would not be able to meet our economic agenda.

We are all aware that a sick person cannot do any business. Lastly, if it there is any take home message from my

presentation is that a reform is necessary if we have to meet the challenges that the two last speakers have mentioned, but not only to invest in reforms, but also substantial investments are required if we to make sure that the agenda for universal coverage is achieved.

Now, I would like to make my presentation within the context of what is going on in Malawi. Before I go into the exact strategies which we have implemented at country level, firstly just a little bit of history.

In Malawi, we adapted the sector-wide approach in 2004 as a framework for planning, financing, implementation, and monitoring of resources delivery. The rationale for adapting this approach was to improve performance of the health system. At that time, there were so many challenges in the health system and I just want to mention one or two of these challenges.

One of them was, of course, the crisis in the availability of human resources. You might have noted the two slides presented by my colleagues. We noted that one of those countries listed by WHO as facing a crisis for human resources for health, but we also noticed that we didn't have enough finances to do all the things that were necessary to make sure that there are enough health workers in the nation. As if that was not enough, we also noticed that the work environment was not conducive.

Some of the things that we noted that the work environment was poor, and frequent stock outs. You know that you may be a skilled health worker, but if you don't have the resources to work with, then all your skills would go to waste. Issues of frequent stock outs was a problem. Issue of poor equipment was also a problem, not to mention the infrastructure itself.

Also, just to share with you the impact of the health system challenges on the health indicators which I'm sure most of you would know. If we looked at the indicators at 2004 when we started our health sector swap, we noticed that our indicators were not the best in the continent. For example, life expectancy was very low at 59.

I'm sure Malawi is not the only country that is loved by God that our people should be called back to heaven at 59 years of age. If you also look at the issues of infant mortality, it was quite bad. I don't have to go through all the indicators.

I'm sure you can see, but I would want to bring your attention to the last two. If we looked at facilities that were providing testing and counseling for HIV and AIDS including initiating treatment were less than 10-percent. The same thing applies to people that were accessing ARVs, they were less than 4,000. This is in a population of more than 10 million people.

Also to look at the available health workers to deal with the health challenges that I have mentioned to you, you may wish to note on the pie chart that probably it is just a quota of the health workforce that was available to do the actual hands-on care. Most of the health workers in the nation were either administrative support staff who don't do the hands-on care for patients, and of course, a big chink of community health workers have to do that to work at community level.

If we looked at the people that do the actual patient care for example, nurses and midwives, medical doctors, lab technologists, they were just a quota of the people that are required. Those are the challenges that we thought we should address as a nation.

Now, what are the reforms that we agreed as government to put in place to address the challenges? Firstly, we needed to decide as a country what would be the Package of the Essential Health Services that would be delivered to the nation to improve the poor health indicators.

We defined an Essential Health Package comprising of 10 disease conditions, one of them being HIV and AIDS. We agreed with everybody in the country that this would be the core business of the health sector, but we also developed a stand-alone health plan for human resources which was nested within

the National Health Sector Strategic Plan so that we need to follow exactly on what needs to be done to improve the numbers.

The last strategy under the reform was to create a policy environment that would allow all partners to take part in the presentation because we knew as government that this is not one man's show. Everybody needed to have a share on what they should do.

Just to highlight a few of the interventions that we had put in place, which are more or less like a mirror image of what Ambassador Goosby had mentioned, we challenged the training institutions that we needed to train as many health workers as possible.

We went to each health training institution and asked them what it is that they needed for them to increase their numbers, and obviously, the common things came up. They needed more classrooms, labs, name what have you and government, we said yes. We will provide those things. We assisted each training institution to improve its capacity to increase their numbers.

We also wanted to invite so many school events to come and train as health workers, and because of that government agreed that we will pay school fees for everybody who went in to train as a health worker. We paid school fees for everybody, either through the Ministry of Health budget or through the Ministry of Education budget.

We also put in a very extensive recruitment campaign to recruit people at school upon graduation or to recruit from the open labor market. We also put in interventions for retention because we noticed one of the issues that contributed to shortage was migration from the public sector to, either within the country to research institutions or private health facilities, and obviously some people were going overseas.

The incentives we put in was to improve the salary structure. We gave every health worker 52-percent increase in salary, but since we also have a contingent of community health workers, we also gave them some of the increases.

We also put in a policy to recruit every health worker that retired if they wanted to work. Basically, if you are working for the public sector, you retire like today, next morning you are back at work. Hopefully, the people are not too tired to do their work.

We also felt that issues of promotion an issue so we created our own Health Service Commission so that promotions can be accelerated because in most of our countries we have the Civil Service Commission that promotes everybody in the entire government system and usually there's a backlog for them to do this promotion. Through an act of parliament, we created our own commission so that our people can be promoted in a timely manner. We also felt that the other incentives are housing. We noticed that we need people in the rural areas and we don’t

have real estate agency in the rural areas that can have houses out there to rent. We went in and built houses for our people.

Fast track of post basic education is also one of the things that health workers value for them to progress professionally and we thought we needed to do that. Issues of task sharing, you can't do that without regulation so we also supported the board, for example, the medical board, the nursing board so that they can look at their regulations to increase the scope of practice, but also to make sure that people can take up other responsibilities.

The Chair is saying I don't have much time so I will skip one more slide, but just to mention that we also put in a policy to care for the carer. The health workers are not exempt from HIV so we thought that if we have an HIV-infected [applause] health worker, they needed to be given opportunity within the work setting so that they are taken care of.

We also felt that there was need where we are training our people; we could use people from areas where they can come and work so we had a policy for recruiting international volunteers, either through the UN, Peace Corp or VSO, and then we recruited additional community health workers.

I would not say more because my colleague will be talking about community health workers, but just to note that our community health workers are fully paid because you cannot depend on health workers on voluntarism. [Applause] Then to

ensure a quality of work, we provided technical supervision. We created offices near and where the workers are going so that people can be given supervision.

Financing, I cannot leave without saying where is the money coming from. Through the swap arrangement, we created a common basket fund or a pool fund where both government and the partners put in their money together to finance the health sector's strategic plan which included the plan for human resources.

Within a period of six years between 2004 to 2010, we spent not less than USD 95 million and this money came from government and the partners that I have listed which I will not go through. Like I said, the government commitment we always say put your money where your mouth is.

Government put in its money so that the partners can follow suit. Even as I'm talking today, we're putting more money into the health sector especially for human resources. The current budget which was passed by parliament at the beginning of this month 40-percent of it if not more has gone to human resources program.

What has been the impact quickly, migration has decreased drastically. When we started this program, I was working as Chief Nursing Officer for Malawi and that one time I nearly took my office to the airport because that's were the

nurses were, leaving the country. Now, we have managed to reduce that.

The graduating numbers have increased from the schools and the facilities now that have the capable bodies to provide care have improved. For example, 95-percent of our facilities are able to do PMTCT. We have adequate community health workers that are also supporting counseling and testing for HIV. Currently, we have more than 1.7 million Malawians that have been tested and more clinics are providing ART, and just to mention that in Malawi nurses start ARTs that is why more patients are accessing services. [Applause]

Just to go though a few slides, you can see there is a decline in the vacancy rates. Of course, the impact you cannot feel it because we started on a low note, but those of us that look at the old figures we can see that the program is making some progress.

If we look at the actual outcomes from the schools, the graduation rates has also improved. More graduates are coming out. In terms of health outcomes, of course, HIV prevalence is going down; of course, not at a higher rate, but we know that we are making a difference. Other health indicators, antenatal coverage is on the increase. Skilled attendants at best are going high.

One-year-olds that are immunized are also improving, not to mention, mothers that are accessing prevention of mother

to child. [Applause] That is what I have to present. Thank you [Applause]

NELSON OTWOMA: Thank you very much, Madam. As we invite the last panelist for this bridging session, I wanted to remind participants that before we started we asked people if they have questions to give cards, and cards are available and you can use that. Our speaker now is going to be Florence Enyogu who is based in Uganda and she is going to talk about Transforming and Expanding Careers at The Grassroots: A Model for Enhancing the Numbers and Roles of Community-Level Caregivers. Let's welcome and listen to her.

FLORENCE ENYOGU: Thank you very much, Chair. There are some unnoticed universities which are community-based which can produce graduates which can be very helpful to this nation. I'm Florence Enyogu. I'm a grassroots woman leader.

I'm a home-based care trainer and a home-based caregiver, a widow and a grandmother representing over 30,000 grassroots women caregiver leaders in the alliance [applause] from an organization known as UCOBAC. UCOBAC is Uganda Community-Based Association for Child Welfare. It's a non-government organization and a member organization of GROOTS international and Huairou Commission. As I told you, I'm from Uganda.

The Ministry of Health in Uganda announced that HIV incidences have risen from 6.7-percent to 7.3-percent. This is an AIDS indicator survey which was currently done in 2012. Approximately

2 million people in Uganda are HIV positive while the infection rate was at 1.1 million in 2005, thus creating 7.7-percent of the women and 5.6-percent of the men that are HIV positive. This is a clear indicator that the pandemic is on the rise.

Why do you think that there is a rise in the HIV/AIDS transmission? There is low awareness of the safe sex practices especially among the adolescents. There's lack of availability of contraceptives. Even the condoms at times, they are not there.

There's increase in unsafe traditional delivery practices that result in high cases of child HIV/AIDS transmission. This one is mostly common in the single mothers, the widows, the married couples and even the adolescents. What is home based care? It remains a question to many people, but home based care is the care and support provided to persons infected and affected with HIV/AIDS at home.

What is involved: Home based care involves home visits. That means home based develops her home and she goes to visit the person who is HIV/AIDS infected or affected. Cycle shows support which includes counseling. It can either be spiritual counseling, video counseling or group counseling.

Necessity of care. Many of our patients are clients or friends. They develop opportunistic infections. We always help them to overcome some of the opportunistic infections or to manage them with the provision of drugs like pain killers and antibiotics. Practically, once we are given some small

funding, we give our friends tab Panadol and Septrin to continue living.

Provision of health education, especially in hygiene, nutrition, family planning, prevention of mother-child transmission and counseling: At times we cut out mediation and support in the courses of conflict. That means at times at home we go on domestic cases as well as the involved in domestic violence [inaudible] and the like.

We even help with widows. Many widows suffer the fate of property grabbing, so we go and help such widows attempt – they don't know where to start from and they don't know how to go about it. Formation of home, of community based posts, clubs. After counseling we make sure that we engage our friends in the post-statistic labs so that they continue living with hope.

Coming to mobilization and sensitization: Like I have already told you, we mobilize many of these friends of ours to go for visits. That is voluntary counseling and testing. They go for family planning, and at times we even extend taking them condoms and referrals to specialized health care systems for specialized treatment.

Many of them, at times, lie at home waiting to die. They even don't know where to go next, but once we carry out our home visitations and find such cases, we always refer them to relevant medical assistance.

What is the Home Based Care Alliance: This is a grass roots strategy in a transforming the health care workforce. In our communities we have what we call formal that involves the individuals, the individual care givers, and then we have what we call – that is the informal. Then we have what we call the formal. This is when we collect all home based care givers to come together, sit together and we formulate an alliance.

Why do we have to formulate these alliances: The mission of the Home Based Care Alliance is to bring cognition to the contradiction of caregivers and to serve as a platform for advocacy and negotiation with the governments, donors and other decision makers in the field of AIDS?

Why should we form alliances: To bring together home based caregivers for collective visibility, advocacy and action; to gain formal recognition as partners in the health care workforce; to seek resources to support; to support, strengthen and motivate each other; to contradict the growing myth that caregivers are volunteers we require formal support. [Applause].

I call it little in a way because I don't want people to say that we are demanding so much, but at least we need some support; and the sort of support, we really need it. Thank you. [Applause].

Where is the Home Based Care Alliance: We have formulated home based care alliances back in our countries. We

have a home based care alliance in Uganda, Kenya, Cameroon, Ethiopia, Ghana, Nigeria, Rwanda, Zimbabwe, Zambia to mention but a few; these home based caregivers came together and formulated alliances.

What are the structures of national home based care alliances: Home based care alliance organizing means that you get together home based caregivers in a particular community and then you bring them together, you sit together, you share all the challenges, the achievement and you feel your way forward.

Back in Uganda, I talk about districts. We have home based care alliances right from the community to parish level to sub-county level, district level and then national. That is what it is to all nations depending on what they call their small locations and their small parishes. In Uganda we have nine alliances. We have one in Jinja, Bugiri, Busia, Mbale, Kramoja, Masaka, Nakowa and Irovaga [misspelled?]. We come together and sit in one meeting and we forge our way forward for home based caregivers.

Who supports the Home Based Care Alliance organization: At this time allow me to thank the group's international [applause]. The Wayou Commission [misspelled?] selected donors, like the Newfield Foundation, Steven Lewis Foundation, Cordaid, UNDP and their team. These people have done a lot [applause]. Sincerely, you clap for them. They have really

done a lot in the home based care organizing. They have helped us to come together and they are – actually, they have helped us even to attend such a big occasion as like this one.

Challenges in home based care organizing: We have problems in logistical constants. That means we always have problems in transporting our home based caregivers from their various places to come and attend the meetings. We have problems of stationary.

You could miss computers and the internet. We have the ban out. Many of our home based caregivers, they carry a work load so they end up being psychologically stressed. When I talked about the 30,000 home caregivers, that is not all. Many of them have dropped out because of the stress.

Another challenge that we face is that there is no documentation. We have really done a lot. We have cared for many of our friends, but the contradiction to the health care or the cognition and supporters keep patronizing the health care. It's not seen.

If many people are really presenting in different governments, they don't talk about home based care provisions as if it is not a service. [Applause]. Lack of funding and [inaudible] this is one of our challenges, and then we have weakness in the collective voice. That means we have a weakness in advocacy and action.

Still, this one makes us have few alliances. We should have many alliances, but because we lack advocacy and we lack some resources we can't bring many people in the alliances. We still lack strategic links and networks. Many people don't even know that we are there, so we can't link up with them. We can't even link up with donors and partners apart from the few you heard me talking of.

Achievements of home based care alliances in transforming the HIV healthcare: Composition for contribution research was done. Grass Root Women led the research, documentation and evidence based advocacy in the contributions made by caregivers in the health care and compensation deserved.

This was actually carried out by many countries, I'll mention a few: Kenya, Uganda, Zimbabwe, Malawi, Zanzibar and some others. Caregivers recruited as – have already helped the teams. In Uganda, some of the home based caregivers were recruited as ready health teams and they have been planted in various health systems. This has helped many of them to be visible, but it's still very few.

With partners and linkages with local governments, through local to local dialog sessions, we have managed to influence local decision making and it is also a location to remain [inaudible] healthy. I will stress on this. May of our women are kept behind because of the cultural norms. She

cannot go to the hospital minus the authority of the man. She cannot seek any services minus the authority of the man. So, the local to local dialog tool has actually helped a lot.

Grass Root Women participation in decision making processes on health at local, national and international levels: There's promotion and protection of women and children's rights in the context of HIV and AIDS. This is done through community [inaudible] and property rights.

Capacity building of caregivers through holding help the trainings and [inaudible] exchanges. This is done through the Grass Root Women academies at a global level. Grass Root Women empowerment has created a greater gender equality and contributes to the medium development cause.

Recommendations: Utilize and strengthen existing structures at a grass root level to transform health care worker force. That is, caregivers should be recruited as team members in Uganda. There is no need for new structures to duplicate services.

If we are there, why should you look for other structures when we can perform? Recognize and support Grass Root Women and initiate in transforming the health care workforce. [Applause].

Direct funding to the community at a grass root level; where we exist as caregivers and have been providing health care for a very long time without being noticed. [Applause].

Stakeholders should involve us and treat us as partners in a transforming health care workforce, and not as Beneficial's of the process. [Applause].

Conclusion: On behalf of the Grass Root Women groups organized in the home based care alliance movement, we appreciate the opportunity to be recognized on such an important panel. We will work and trust our inclusion will continue in the fight against AIDS as Grass Root Women caregivers and a national force. [Applause]. Together we shall change the nation. Together we shall end HIV and AIDS. Thank you. [Applause].

SUZANNE WILLARD: Thank you. As I said earlier, we would have the cards which is always a great idea, but I think we have a volume up here that we could probably publish a book. We will try to answer some of them. One of the things I wanted to say, gleaning from the cards, to be able to pull it all together, I am an advance practice nurse.

I've been practicing for well over 20 years in this epidemic. My area of expertise was in prevention of mother-child transmission. If I could get a woman under my wings with my community health care workers that I was working with then, I was the one person who they initiated with. So I was their primary care provider. I didn't have any transmissions. [Applause]. So that's one of the things that we can keep in mind, and it takes a long time.

When people begin to change the way we provide care, and HIV has been a fabulous opportunity for all of us to look at what is it that a patient needs and then how are we going to address the needs. It's no longer just based on the science, it's no longer based on any one provider, it's really based on what is the team – it's a team approach to be able to provide care. [Applause].

You cannot do that overnight; it takes a while. Patience is there, but the important thing I want to mention is that just be empowered. Know what you can do and it's not in one cotter of workers idea. It is a team that is needed to be able to handle this complex illness.

Whether it's the mental health workers, whether it's the community based workers, the physicians, the surgeons, the dentists, everyone is important to be able to take care of our folks. I'm going to turn it over to Ambassador Goosby who's able to take a couple of moments to look at the multitude of questions that he had. Then I also have some questions for Dr. Phoya as well.

ERIC GOOSBY: Well, I seem to have been targeted for a lot of the questions around the living wage issue and I'll address that; the importance of that. I also want to just briefly speak to – and just getting a gestalt of the types of questions.

The task shifting strategy is an essential component to providing enough health care workers to respond to the unmet needs that really are in every country we're in. Many of the countries that have moved to this effort have positioned the trained health care worker in a situation where they do not have appropriate referral and back up to support the decision making that that provider is now in front of.

When there is not the appropriate back up, so you have a person who is a health care worker in front of a disease that they are not trained to diagnose or treat, you run the risk – and we have seen this in developed settings in the United States, in our own system of health care and I've seen it over and over and over again in virtually every country we've worked in, where a health care worker – a trained nurse now being a provider dispensing medication, but also responsible for monitoring and follow up – are put in a position where when there is a bad outcome – somebody gets hurt or dies – the provider does not know if it's the disease that did it or if it was a deficiency in their training that resulted in the bad outcome.

That usually results in that health care provider pulling themselves out of the delivery system because they don't want to stay in it. They get demoralized, and we have lost someone who had interest and was trained and was in the position that we're trying to fill.

Our thinking has been we really – in order to support and take appropriate advantage of health care worker trained and nurse provider trained individuals, that there needs to be a referral back up explicitly laid in place; not just on paper. To our thinking, the overall expansion of the health care delivery system with trained nurses and physicians are still the critical foundation on which a health care worker and a task shifting strategy will be most successful. We have tried to focus on all of those different components of the whole cascade down to the delivery of care at the primary care setting.

I think the living wage really is the elephant in the room. We have seen terrific efforts in support and training of individuals. They get trained and then move on to another more – a job where they're paid more and also are supported better, and the incentive strategies that people have tried – cell phones, internet, computers, having the minutes paid for the cell phone, transportation, etc. – are all temporizers, but they don't deal with the underlying problem that you have a civil society – a civil system in terms of the pay scales that the country has defined.

The government is almost always hesitant to identify jobs that should be paid more and they don't want to get into a discussion, well what do you do with teachers and other

individuals in society that are part of the civil service system. It throws a domino kind of effect into the mix.

We have taken that particular part of the discussion into a discussion with presidents and ministers of finance. It's usually a legislative fix that's also required, so I have been frustrated with our ability to move that agenda. Countries are constrained by their economies, but we have been in early discussion with World Bank around developing a rapid assessment capability and strategy that can come in to a country and help garnish some of the new resources.

Not redirecting existing budgets, but with extractive industries that are in many of the countries we're in, where there's new income coming in to the national treasury, that those new resources that have not been allocated actually be earmarked for health and education type services for the population.

I think it's going to require that type of a fix, and in an ever expanding economy, in most of the countries we're in six, seven, eight percent, that those be corralled into being the motor to support those living wage gestures.

A couple of other questions and then I'll turn to my colleagues on the panel to answer some of the others. Focused on whether or not the NEPI program could have a research component to it would be very interesting to indeed have that. Something beyond a monitoring and evaluation does make sense

for us to look at and document best practices for things like I showed you in the slide set; changes in waiting times or loss to follow up strategies.

It's our belief that a properly configured clinic with health care workers, outreach workers, nurses and doctors can actually create a solid ability to know when people fall off of the out of care of loss to follow up and to have, especially in many of the clinics we're in we have put patient information systems that are electronic, computer based, that easily can show you who was supposed to come in and who didn't.

The transformation that we have now seen in the use of patient information systems, ten years ago it was the sister's book on the desk as people would come in. It's still that in many rural areas we're in where it's handwritten in, three or four sentences on a patient or no real documentation of the visit.

Vital signs are not part of the picture routinely. The numbers are overwhelming and often preempt that. Issues around triage and referral are also not part of the institutional memory or capability. So all of those types of things that have been introduced in our HIV care packages really lend themselves to a much tighter control and use, I think, of health care worker and nurse provider trained providers when you have that enabling infrastructure in a medical delivery site. We're very keen to document that.

I think a nurse and health care worker research agenda is something that we could define, but we haven't to date really put resources towards that, but I'd be very interested in thinking through that more.

SUZANNE WILLARD: Thank you. One question for Dr. Mubashar and also for Dr. Phoya; change in power. So when a new elected leader comes in place and all these efforts are being done, what happens? I understand in Malawi there's a new president, and if you could talk about specifically in Malawi with a new elected president, is there any change in, Dr. Mabashar, from your world view? Have you seen any changes and how's it affected?

DR. ANNE PHOYA: Thank you for the few questions that are specifically for Malawi. One of the issues raised was that somebody had heard that the money provided from the development partners had dried up and how was government going to cope. You may recall in my presentation I mentioned that we had a six year health and development plan from 2004 to 2010. That plan expired and we developed a new plan. What we have to do now is to go back to the mobilization table and mobilize new resources.

You may wish to know that the PEPFAR money hasn't dried up in Malawi. We are implementing HRH programs that are within the PEPFAR. Our traditional government partners, the British, are still in Malawi. We have just signed a new financing

agreement, and the other partners like the Germans, the Norwegians are still in Malawi; they haven't left.

The important thing is that the Minister of Health has to put his act together by making sure that all HRH issues are within the National Health Sector Plan. This is the document that the Minister of Health will take to his colleagues in the Cabinet to ask for money.

If HRH issues are missing in that particular document, then the Minister of Health and the technicians like ourselves, we don't have something important to show the partners that this is where you should put your money. So, we have a plan and we are mobilizing the resources and we are hoping that the partners will not run away because we have shown value for the money. Thank you.

DR. MUBASHAR SHEIKH: Just to add on to that, I think we have come a long way over the last few years in a sense that there is much greater recognition. We have gone beyond advocacy to a certain extent, that human resources or health workers are important, and within that role and the competencies and the contribution of various cadres and approaches like task shifting.

But more in terms of showing the value for that particular investment in terms of the health outcomes. I think the leadership has recognized that the health workers are

important. The various programs like PEPFAR and others have contributed.

A number of countries have also taken initiative – the leadership. Ethiopia, Malawi we just heard, Ghana, many other examples where I've seen the leadership coming forward; coming forward in terms of taking the right policy options, but also investing more.

I have just come from a meeting in Tunisia - which was conducted two weeks ago by the various partners – where the Ministers of Health and Ministers of Finance came together from Africa. The entire African continent was represented with a two part becoming this important base to coming together. This is where we need to build those bridges.

The Ministries of Health and the health community has to have the right arguments, the right capacities, the right competence to build a case. The Ministry of Finance is much more willing to listen to them, to ensure fiscal space. Within that, we also need to recognize that, I think, six of seven of the rapidly growing economies are in Africa now. These are real opportunities.

This is where we need to take advantage, just as we heard from Ambassador Goosby. New money is coming forward. It might be available, but we need to make sure that we develop the right arguments, but also make sure that we have a comprehensive holistic approach. We are here to discuss HIV,

but we are also facing a global epidemic of non-communicable diseases. That's another issue, but we also have shortages of health workers.

How do we bring all these elements together so that the health workers are – one health worker has the right competencies, the right skill mix and the right support systems in place to deliver these services in a manner where they are required in terms of the needs. Not necessarily looking at one element or the other. So there are opportunities, and I think these are exciting times. We really need to take benefit of that.

SUZANNE WILLARD: Thank you and I have one final question because I know there's another meeting after this. This question is for both Florence as well as Nelson. Why is it important for caregivers to speak on these forums about their priorities? In other words, for Florence, why was it important that you were here?

FLORENCE ENYOGU: Thank you so much. Why was I put on this panel? Why did they create space for me? In effect, after realizing that home based caregivers are doing a lot of work back at home. We live in the communities. We share the challenges with these communities. We are the committee members. If it means sickness, they are transporters. If it means giving support, at times we touch our pockets.

I think they are beginning to realize that we are a very important sector in our communities, and they are beginning to realize that without us, even the trained health care staff cannot do much after prescribing the treatments. For example, for the TB patient; or, for example, for the HIV/AIDS infected person, no one is there to take care that these patients that are taking those drugs.

Some patients are given drugs and they just leave them there. They don't take them because they lack food. It is the work of the home based caregiver to go and encourage this patient to take the medication. It is the work of the home based caregiver to go and see that this client or the ones we call friends are involved in the post [inaudible] clubs so that they cope up. Our major role is to improve the lifespan of the people infected and affected. Thank you. [Applause].

NELSON OTWOMA: I think my colleague from Uganda has given a comprehensive overview of the reason as to why they need to part of this global arena and to present themselves in terms of giving their visibility and voice. Also, getting the science that is discussed here and applying it at home in the work at the grass root level, so I don't wish to add.

We seem to have come to the end of this because we've run out of time and my role is to thank everybody who came here, starting with the panelists who came here. So join me in giving them applause [applause]. Also, thank you to the

organizers for doing this and for the next time we are together in the Health Care Workers Alliance. Thank you. [Applause].

[END RECORDING]

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.