# Human Resources The Ultimate Bottleneck
# Kaiser Family Foundation
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**WIM VAN DAMME:** —session on the human resources. For those of you who came from the Plenary I think you will agree that the South African Minister of Health announced a very ambitious plan. They have already the financial resources, but they are now up to the task on how to organize the human resources to decentralize AIDS services to every health facility in South Africa.

And that is really a big challenge, that's a challenge since the beginning of the HIV epidemic and that's why we have a session especially on that. It is really the ultimate bottleneck in scaling up HIV prevention care and treatment, both in low and middle income countries.

So for this session we have five excellent speakers and each of them have fifteen minutes, including question and answers, so there will be time for a few question.

After every speaker and at the end we will have five or ten minutes left for an overall question and answer session, so that is very little, but all the speakers are with us in the coming days also and you can also meet them at other sessions.

I want also to announce there is tomorrow evening there is a special other satellite session on human resources, very much dealing with similar issues and so there will be more time to continue this debate.

The co-chair is not yet there, I don't know so it's quite possible he will join us later but I myself, I am Wim Van Damme from the Institute of Tropical Medicine in Anthrop. I'm a Professor in Public Health and I've been working on human resources as related to the AIDS epidemic over the last eight years. But my background is less important than the background of the speakers and I will introduce them one by one.

So the first speaker is to my right is Fitz Mullan from the George Washington University in the U.S.A. He is a Professor of Medicine and Health Policy at that university, and also Professor of Pediatrics. He graduated from Harvard with a degree in History, surprising, from the University of Chicago Medical School, and he's also a board certified pediatrician. He will give us a general overview of the lasting crisis in the workforce with a special focus on Sub-Saharan Africa. Fitz, please, go ahead.

**FITZHUGH MULLAN:** Thank you, Wim, and good morning. It's a pleasure to be with you and to be able to lead off this session.

My task is to talk about the situation with human resources for health, the workforce, as we go forward. I think it's important that at this particular meeting we acknowledge, I believe, the fact that workforce at HRH is as prominent as it is in the global debate because of the AIDS epidemic and the response to it.

The incredible global mobilization of both people and science that brought antiretrovirals and other modalities to the field over the twenty or so years earlier in the epidemic revealed the fact that once those instruments got to the field that there were very few people there. That workforces in many parts of the world are very weak and AIDS requires, and HIV requires, hands-on workers at all levels.

In 2005 the joint learning initiative on the left publish Human Resources for Health, the first kind of cold arms on this issue, followed in 2006 by the World Health Organization annual report which focused on workforce working together for health. That report concluded that there were 57 nations in the world that were acutely short of health workers and the index that they used was doctors, nurses, and midwives, 36 of those countries are in Africa.

The method used was the premise of 80-percent attendance by skilled birth attendants at deliveries, and this was the particular graphic that represents that, and that required 2. 3 per 1,000 doctors, nurses, or midwives, and that was not met by the 57 countries.

If one looks at workforce as compared to burden of disease, once again we see a very inequitable distribution of where at the lower rate the Americas and Europe have quite appreciable workforces set against a rather low, call it 10 percent each, burden of disease, global disease, whereas when

you look at Southeast Asia or Africa in particular where you have basically a quarter of the burden of disease in the world and a very, very small workforce to deal with that.

If we take doctors for the moment as our index of measurement and look at the vastly different distribution per hundred thousand, most of the OECD countries are in the 200 to 300 range, per 100,000. But as we get the lesser-developed countries and particularly into Africa we see orders of magnitude less physician to population ratio, really almost nonexistent in some countries, and as I say this is a marker, workforces that are similarly depleted across the spectrum of workers.

Now, I'll call southern and northern as short-hand for developed, lesser developed and more developed, but in the south the particular challenges are low education budgets in countries that are strapped economically, and the education budgets reflect that. Modest at best educational capacity, minimal advanced training opportunities, and finally practice opportunities that are limited and very often poorly remunerated creating dissatisfaction and discomfort among the health workers.

And these translate, as we all know, into push factors for immigration, as listed here from the south add to the economic issues security concerns and disease concerns and there's a good deal of push.

The pull factors in the north are essentially the reciprocals with ample training opportunities, particularly for doctors at the post-graduate level. Practice opportunities in nations that are doctor short, better remuneration technology and family opportunities that go along with all of that.

This is the north as I think everyone is aware at this point, all societies, but particularly northern societies are aging rapidly. The demand for healthcare among people over 65 is about double that of people under 65. So as we age as populations, the demand for services will go up quite extraordinarily and that's the demographic that we're looking at in the north, really intensifying the pull factors that already exist.

So how do we approach this? What sort of rebooting about, of the entire system can we contemplate? When I say entire system, I mean both south and north.

Certainly on the southern side of things, educational scale-up is terribly important. Easy to say, it requires finance, it requires education systems, it requires leadership, but it is an imperative. And socially accountable scale-up that is designing systems that will emphasize work in-country and addressing epidemics and ongoing issues of a national and regional significance as opposed to immigration as a goal for the training particularly of higher level health workers.

The realities are tough. We're just completing at George Washington a Gates-funded study entitled A Sub-Saharan African Medical School Study, in which we have done a two-year landscaping study of medical education in Sub-Saharan Africa. These pictures are from that and the numbers of site visits and a continental survey, these will be published shortly.

Classrooms, medical classrooms, are in many cases deficient. Libraries have a 1950s feel, computers are hardly up to date; bandwidth is absent in many, or very low, in many areas. So even with better hardware, you still have difficulty accessing the mainstream of learning and medical information.

In private schools, which have begun to play an important role, this is a sign posted in a library in a school. Feedback from Senate, about 25-percent increment in tuition, so private schools not only demand a payment from students but in some cases those payments are going up.

Now on the other side the desire is there, and extraordinary interest and scale-up in health profession to education throughout Sub-Saharan Africa and elsewhere in the world. This is an amphitheater in Bamako, University of Bamako in Mali, this almost 2000 first year medical students. It is about 40 degrees centigrade in the back of the room where we're standing, and I can assure you that those students in the latter rows can hear very little or see very little, however they're taking notes, they're in there and eager to move on. A

highly competitive system, 350 will survive out of the 2,000 who join.

This is Mozambique; the young woman standing is a graduate of the first class from the Catholic University of Mozambique in Beira. She is doing her national service as a staff physician at the Beira General Hospital. She works exclusively on the pediatric ward, and she is the preceptor for the other three who are medical students from the Catholic University of Mozambique.

This is definitely in the tradition of see one, do one, and then teach one, not perhaps optimal educational philosophy, but functional educational philosophy and this school and these students were very much living that out and this is the future of medicine in Mozambique as it builds itself.

And this is from the Medical Council of Sudan in Khartoum. These are medical graduates sitting for an electronic standardized exam for licensure. This is a country with almost 30 medical schools, more than any other in Sub-Saharan Africa, many factors going into that, but they had moved to regularize their system, make it electronic, transparent, and equitable. And this is, we hope, the view of the future.

And this, taken from a Sub-Saharan African medical school study, is a history of the opening of medical schools in Africa. And if you'll look, clearly in the decade of

liberation there was a bump in schools, 16 opened at that point, but if you look at the last 20 years, 1990 to 2010, 45 schools opened, and this with some external assistance but a lot of this is endogenous, country-driven expansion.

I also call your attention to these three bars representing private education, private nonprofit faith-based, and the green is secular, private not-for-profit, and the yellow is for profit. And today 20-percent of the medical schools in Africa, probably not 20-percent of the medical education because the schools are small, but 20-percent of the schools are private.

So, in some quarters people see this as the way to the future, others consider this, frankly, the devil, and a lot of debate about the role of private education, but it is very much with us.

Now, there are innovations under way, and I say just a few here that are probably known to many of you, but this is what we need to do as we move forward. The Global Health Workforce Alliance, an organization initiated following the 2006 World Health Report, WHO companion organization, funded by the international community that supports policy development, interventions in workforce development all over the world.

The Sub-Saharan African medical school study which I mentioned to you is a kind of landscaping study, which we think is applicable to many regions, countries, and continents. It

gives a good database not only in medicine but in nursing and other health professions that is a predicate to doing good interventions in education.

The medical and nursing educational partnership initiatives which are PEPFAR money, through the National Institutes of Health and Deborah von Zinkernagel is going to speak to this in a moment, a very exciting set of initiatives.

And finally the transforming of medical and nursing education initiative of the WHO where the WHO is developing guidelines on socially-accountable education that really speaks to how to we build education in medicine and nursing that is regionally focused and looks to retention and long-term sustainability.

The leaky bucket is an issue for all of us, this is emigration if you look at all four of these developed Anglophone countries, roughly a quarter of their workforce comes from international medical graduates, and of those, in the U.S. 60-percent, and you can see the other numbers come from low or lower middle countries, income countries, meaning that many of these physicians come from countries that have very short resources of their own.

The most important perspective is from a country perspective, what percent of your workforce are you losing? And if you look on a continental level or a regional level, the three areas that rate most highly in terms of loss are these

three: Sub-Saharan Africa, the Indian sub-continent, and the Caribbean. Three of the poorest areas in the world are the biggest donors to the north. This is a problem.

In nursing, circumstances are similar, not quite as well developed but moving rapidly towards more emigration, more departure. And this indicates particularly with the U.S. and the UK, if you take the light blue and the black, this represents lower middle and lower income countries, they again provide the bulk of the nurses arriving in the workforces of these developed countries.

So what to do? Task shifting has been articulated as an important concept, moving forward many places, community health workers building a large base of community base workers, non physician clinicians, clinical officers, health officers the like, focus on social accountability as we've talked about and strategic approaches such as sandwich programs, which send people as necessary abroad in the middle of a training program so it's not sending abroad and hoping they'll come back, but their basic training say post graduate training is in a national university or in the country and they go abroad for a period of time. Partnering and twinning is also very important.

In the north, critical is maintaining support for quality and quantity scale-up, as has been indicated in some of these programs, but the other key factor for the north is

training for self sufficiency. So long as the workforces, medical workforces, nursing workforces of countries like the United States, Canada, the UK, so long as we train three doctors or three nurses and plan to import a fourth, they will come. They are ambitious, they are skilled, they're able. And only by closing that window in the north, so that the north trains much closer to meeting its own needs, will we have responsibility and will we develop stability in work forces in southern nations.

The best thing to do is to have planted a tree 20 years ago; the next best thing is to plant a tree today. I hope we're about tree planting. Thank you. [Applause]

**WIM VAN DAMME:** Thank you very much, so we have time for a few very short questions. I see a gentleman behind Mic 3 please.

**MALE SPEAKER:** I see we propose to plant a tree but a tree to grow it will take I think at least three, four, five, ten, twenty years? Meanwhile well, we say okay, we treat 5 million people, 10 million people to be treated. I think many people will die before the tree will be old.

Maybe also have to question from the root what can we do different? Maybe we don't only have to do more of what exists and have more nurses and more doctors and task shift them, but you should maybe also go further and think, can we not question our own health system? And maybe use another

source, another is like the patient themself as maybe to contribute to get further.

**FITXHUGH MULLAN:** The point is well taken, that being that training doctors and nurses has got at least two factors, one is it takes a long time and secondly their numbers will be relatively small. The emphasis that I've put on doctors and nurses and that some international bodies are placing on them is not in the belief that doctors or nurses are the answer to the HIV epidemic or health problems long-term.

The premise is however that for a country to have a stable health system it needs medical and nursing capacity that is relatively stable for some clinical work, for teaching, for policy development and monitoring.

So this emphasis on health workers at the upper end of the training spectrum is not posed as an answer. The use of the informed patient, the use of community health workers and task shifting are critical as we go forward year by year, but if we do that without each country having a core of medical nursing leadership, the system will be less stable, less functional than it might be, I think that's the premise.

**WIM VAN DAMME:** Thank you very much, Fitz, I think this an excellent bridge to the talk of the next speaker, who is Mit from Médecins Sans Frontières. She's a medical doctor and master in public health and has been working for 25 years with Médecins Sans Frontières in very many countries.

Over the last years she in the policy and advocacy unit of the office in Brussels and she has done considerable work on the human resource crisis and on the financing of the workforce.

So she will focus specifically on the how to adapt human resources in very resource constraint settings where Médecins Sans Frontières usually operates. Mit, you have the floor.

**MIT PHILIPS:** So thanks very much for the work and then I'll try to focus indeed in the short time we have. But I see I started eleven minutes already.

So I will speak mainly about how to use and delegate clinical task in HIV care and focus on the lessons that we as organizations learned and with our partners in Southern Africa where we have very shortfall of, very strong shortfall of human resources in absolute terms, it's not only question of that distribution of whole urban areas but really there is a absolute lack. And afterwards I'll speak a bit more about other aspects of HIV care and healthcare in general.

So, just to go back to the rational and certainly not to forget that there are two sides to this. I will focus on the decreasing the needs for health worker time, but there is also a need to increase the health workforce and its output for the patients, for care, for ART care. And so the points of redemption, including treatment for staff production so a piece

of restraining but also importation are extremely important. After people have been trained they have to be recruited into the system and retained and distributed equally.

So, if you look at the approaches that can control and decrease the need for health worker time, first we should always very critically look at what tasks really need a clinical expertise and which not, and what patients need this clinical skills and in which stages of HIV, a disease need it. And I've put here a little schema to symbolize the different steps of ART treatment that the patient goes through.

If you start from the left in the upper bar, after the counseling and testing, according to the stage of the disease, the patient will need some stabilization and making sure that he can before he can start the initiation. And then at initiation itself there is not so much clinical skills needs. It is rather two to eight weeks after the initiation that there is the main risk for post-initiation effects like IRIS for example.

After that the patient is in stable follow up on heart and it's only in the longer term that there is again a need to pick up clinical signs or laboratory signals from complications or from treatment failure. Of course if the patient is in better shape when he starts early and this is the lower bar, you will reduce the need for clinical care. As well at the preparation for the initiation, and but the real challenge

remains in the long-term ART complications would be and it is arguably maybe better even to have lab capacity to detect those instead of clinical skills.

So if I go to the experience on task shifting that we had that I took the example from Malawi where we work in a rural area, a district of 600,000 inhabitants and there the challenge was how can we make sure we initiate patients at a rate that will allow us to keep up with the epidemic and keep up with universal access.

And in order to reach that goal, we went through different steps of task shifting, first at the level of the hospital base clinic where the team was expounded with nurses and lay workers and then afterwards also in the decentralization because in the rural areas often you have only nurses. You have to rely on medical assistance or nurses.

So, decentralization relies critically on the possibility to do task shifting. And without that it would have simply been impossible, we would have reached saturation levels at the ART clinic, we would have not been able to decentralize to the health centers.

The outcomes of that task shifting that has been a question that remained a long time, we need to be careful about that. We were able to compare outcomes in the hospital, clinical officer, medical doctor-based care and in the health

centers, medical assistance and nurses, and as you can see the outcomes for the patients are similarly moot.

But I think most of fears have been really taken away now by recent publication in the Lancet of the CIPRA group where there was a randomized trial of non-inferiority, and it showed clearly that patients have the same safety.

If we go to psychological, psychosocial support and the issue of the lay workers versus the nurses in this kind of platform often it is accepted as something to do, and in many countries in Southern Africa like Lisutu, Malawi and in South Africa also, it has been accepted that lay counselors do an excellent job and there is no need for nurses or other medical staff to do the counseling, also not for starting a retreatment.

However in other countries there is some difficulties that we experience, especially when there is a need to create new cadres. In Mozambique for example in comparison with Malawi, there is the difficulty that there is no cadre to which the task could be shifted. So there needs to be a new, a whole process that being set up of staff posted in the establishment who could take on these tasks.

We have the same problems with the lay workers of course as with the general health workers. There is wage bill restrictions at the level of the government and the Minister of Finance. Especially if you want to recruit people as civil

servants, there are clear cappings on that. And so often people, we try to get around that with contracts outside the civil servants area.

And then there are some specific legal obstacles. In most of the countries we are able to have lay workers also performing the testing, including the pricking, but in Mozambique and Zimbabwe this remains an obstacle. And so the patient has to go back and forward between the nurse and the counselors.

But I think it's clear that lay workers are such an added value, not only in offering the package of care to the patients, but also in freeing up time for the nurse to focus on clinical work, and we see the effect here in Mozambique on the arrival of lay counselors on the initiation possibilities of patients.

Of course task shifting cannot happen in a vacuum. And there is enabling factors that are very important. Training is important, but especially onsite and continued mentorship.

So this is something that needs to be much pushed and further explored. And of course you have to monitor. This is an example of a shot that we use in Lisutu where it's quite simple, where the different performances and outcomes are monitored and also their evolution is checked.

Patients that have problems need to have a place to be referred to. It's very important that you don't shift the

tasks and the responsibility for patients to lay workers in the community or into peripheral health units and then leave them with the problems. There is an important need for back-up.

I'll just go a bit quicker, because I seeing that I'm – but one of the things that also was mentioned also before, beyond the task shifting we need really to review the system, and there is certain tasks in the process that a patient has to go through that probably can be cancelled.

One element that helped us a lot in South Africa for example is that there is no longer individual counseling pre-testing. It's a grouped counseling session with an opt-out. It saves a lot of health worker time and it saves a lot of time for the patients also, improves also the adherence. So, simplify, simplify, simplify the process is key.

The other aspect is the frequency of the contacts of patients in the health facility, both for clinical care but also the drug pick-up and I insist that we should look at those in a separate way.

We did a study in Malawi to see what is the human resource needs in that all the districts over the next years and most, the single factor that could use the needs for human resources for help was by reduced frequency of the visits of the patients to the health facilities.

And then there is the other aspect, why should patients come to the health centers if they don't have clinical needs?

We need to find ways for patients to pick up their drugs outside the health center, and because also it will have a positive effect on the adherence and on the burden on the health workers.

The drug supply issue and the dispensing there is also quite some problems still. We see that there is task shifting possibly in the facilities to pharmacy assistants. But in this outer facility community meeting point there is examples from Malawi where we have outreach clinics, from South Africa where there's a system that has been put complimented on a common disease dispensing unit where based on a prescription the drugs are sent directly to a group of patients in a community.

And in Mozambique we have the experience of community heart groups where groups of patients send one of them to the health center to pick up the drugs of the group. They sit together, they have the peer support activities and this reduces strongly the loss to follow up, but also the health worker time.

Okay, I see that I'm have come to my limit, so I just will want to go back to the, sorry, yeah. Too long. I, sorry, yeah, I went too quick there. I just wanted to have you just to look at the last slide because I tried to put, answer your question of the here: Is HRH still the major bottleneck?

In our experience I think we face still a much the same bottlenecks, with a few exceptions, and I mentioned some and we

had also a few days ago the Malawi emergency program for human resources for help, but still there remain fundamental barriers to recruit additional health staff, both as civil servers, both on contracts with outside the civil servant status.

And these barriers of course have an impact also on the possibility to recruit lay workers; motivation, the salaries, no new cadres that can be created, and all the difficulties around the wage bill.

The delivery models, I hinted at it already that we can do much better there, but there is quite some resistance also from bureaucracy and also from administrative ways, especially on the supply and the dispensing.

And so in the current situation where we see back-tracking, especially on recurrent costs, we fear that there might be worsening of the situation even. Because the recurrent costs for these health workers are a major issue and we might come back through. When we started to work on human resources, it was because we had the ARV drugs, we had the supplies but the human resources were lacking, so I hope we are not going to go back to nurses without drugs.

And we need to make sure that the coherence of the different approaches is assured so that if we train additional nurses, that this can be absorbed by the system and also retained.

I want also to point out how it is linked with the stages of the patient. If we cannot start patients early on treatment and avoid secondary effects, then it will be very difficult to task shift, to decentralize, and to make sure that we can offer the patients the best care that they need. Thank you. [Applause]

**WIM VAN DAMME:** Okay, I fear we won't have time for a question, but I think it was very clear.

So our next speaker is Wendy Mphatswe, from the University of KwaZulu-Natal. She is a medical practitioner and also holds her degree in public health, she is a research consultant and an advisor in health systems issues with the University of KwaZulu-Natal. She's also working in partnership with the Institute of Healthcare Improvement.

Your minister has outlined the challenges ahead, so we are very happy to hear how on the ground in the provinces, and especially in KwaZulu-Natal, you will take up these challenges, please.

**WENDY DHLOMO-MPHATSWE:** Thank you very much for the opportunity to speak and to share some of our learning, and hopefully one will do justice to your questions.

What I'm going to share today is really learning by doing and how we can actually maximize the resources that we already have. I think all of us would agree that HIV is here for a very, very long time. It is going to be with us for a

very, very long time and human resource challenges are also going to be here and we are unlikely to solve them immediately.

At the same time we need to improve service delivery of interventions that have been proven, and right now the focus is on service delivery because the ability to roll out those deliveries really hangs on the performance of the health system.

So there are many possible approaches that one can look at. One could be flying in doctors and nurses, that is in areas of need, and think that is being done in certain areas in, and in certain countries. Another one is to be creative about bilateral agreements between countries, to actually look at their receiving countries maybe, for an example training two or three people from the country that is actually supplying the doctors.

We all would agree that it's not possible to infringe on people's right to move and live where they would like to live and work, so if we were to do that, obviously it would deter people to choose a career in medicine or in health, so it's not possible.

Another one is task shifting, definitely that has been alluded to by the previous speaker.

One that I will spend a little bit more time is helping people do things a little bit better, working within the constraints of their environment, within the resources that

they have, and actually achieving those outcomes that have been set out for them. And this is not to say any of these four things that I've outlined are exhaustive, and it's also not to say others better than others; we probably need all of them to actually tackle these issues.

So the question really is how do we leverage existing human resources to achieve the outcomes and the goals that we need to achieve? How do we maximize on the resources that we have? And can quality improvement help us to solve these problems?

Recently there was a report by WHO on the state of the strategies of the health workforce and its impact. One of the recommendations was that we needed to be more efficient in using the existing workforce. And really one would ask, what exactly do we mean by "efficiency"? Are we saying we should extract more work from the existing staff? Should we be maybe waving a big stick to say do more, do better? What really does it mean? Is it possible for us to make people do their work in a different way? To help them do it more frequently and help them to also get a greater sense of purpose of their work so that they are not inclined to leave their countries of origin.

So that brings me to what quality improvement is all about. Quality improvement is really a philosophy, it's an approach, it's a simple method of identifying gaps in the health system and going about closing those gaps in a safe way.

The principles in QI, you need raw ideas and obviously execution. You need the will of the people, multi-disciplinary approach, aligning them to the same aim and the common goal. In South Africa we have a goal to reach less than 5-percent of infections by 2015 so that's a very good rallying point that staff workers and workforce can actually rally around.

It's also looking at ideas, taking advantage of the knowledge that already exists within the system that which you would usually find with the frontline workers and finally executing those ideas, giving people the autonomy to test ideas within their environment to solve their problems.

**WENDY DHLOMO-MPHATSWE:** Is it possible for us to make people do their work in a different way to help them do it more frequently and help them to also get a greater sense of purpose of their work so that they are not inclined to leave their countries of origin?

So it brings me to what quality improvement is all about. Quality improvement is really a philosophy. It's an approach. It's a simple method of identifying gaps in the health system and going about closing those gaps in a safe way.

The principle is in QI. You need real ideas and, obviously, execution. You need the will of the people, multi-disciplinary approach, aligning them to the same aim and the common goal. In South Africa, we have a goal to reach less than 5-percent of infections by 2015. So that's a very good

rallying point that staff workers and workforce can actually rally around.

It's also looking at ideas. Taking advantage of the knowledge that already exists within the system. That which you would usually find with the frontline workers and finally executing those ideas, giving people the autonomy to test ideas within their environment to solve their problems. So it's really, in a nutshell, applying local knowledge, focusing on the data to see where you are. And not really necessarily working harder, but trying to be smart about the way that you go about your work. And it's all about partnership, multi-disciplinary team.

Ways that this can solve the issues is that, one, if you reduce re-work and waste, you basically save time and you save effort, which is very, very, very important. An example of this, I think there was a presentation yesterday in Kenya where there was a very, very bad filing system. Obviously when clients come back for their medication, it's not possible to retrieve their examples. That is unnecessary. That is time wasted. That is effort wasted.

So, obviously, when you look at the system as a whole and the QI, you can improve some of those things. Simplifying processes, reducing duplications and redundancies, as well as targeting your resources more efficiently as you use your data.

So how have we applied QI? In Kazdin, South Africa, there is a program called 20,000 Plus which was started in 2008 at the request of the Kazdin Department of Health. And what it does really was to look at three districts that have the highest prevalence of HIV, about 40-percent amongst pregnant women, and to use existing staff, use routine health information — in our case it's the DHIS — to improve the performance of the health system. And the scope of work, as you can see, it's about 15 hospitals, more than 200 facilities. At the time that this was started, the HIV transmission rate to babies was 21-percent. Interestingly, this was at a time when we had single dose Nevirapine and, if that was working well, if our health system was delivering Nevirapine, we should have been sitting at 12-percent. So clearly there was a problem. You couldn't have 21-percent when you have a drug that can give you 12-percent. We now have better drugs that should get us to less than 5-percent.

So, generally, what normally happens that obviously a problem is identified in a boardroom, protocols are drawn, and then under QI, you have a team that sits around the table to look at ways and great ideas that you can actually execute or plan towards delivering the services you need.

And then there are cycles of planning, doing, and constantly going back to review whether does this work, does it not work. I'll give you an example if we get our chances at

the end, a chance to share some these examples. And then you obviously then implement, and usually if that succeeds, you sustain it. If that doesn't succeed, you go and try another way of doing things.

Another thing that QI does and this is getting things right. For instance, planning activities where, in a situation that you have routing plats that are being taken, it's possible to actually also put CT4 count. And more often, this is common sense but you'd find that on the ground it doesn't always happen. You find that there are still silos. CT4 count is taken in a different room, in a different building. Yet routine PLADs are still taken on the same day. So planning activities in that way. Same thing with immunizations, getting the babies that are HIV exposed to be tested as well as giving family planning to the pregnant women.

Another one would be to simplify processes. And this is just an example of actually sitting together, understanding the system and seeing where the broken nets are. And this example would be, for instance, if you had a patient who is moving to too many places in one visit and then when the team then designs a better way of doing things, then you actually streamline your processes.

One powerful example would be the completion of the data feedback loop. Most of the time, the people that bear the burden of actually collecting data in the facilities do not

have the opportunity or the ability to actually make sense of that data. It's more like fulfilling a requirement. And under QI, you complete the feedback loop where data is being collected around certain processes of care, then it's analyzed. Not necessarily in a computer. Pen and paper, and they can do it in most facilities, in all facilities, then that is reviewed through a supervisor and then new plans are made.

So what has that translated to? So these would be some of the results where we have seen, in one hospital where CT4 testing improved, and you can see on the annotated graph the different things that they were doing until they reached their target. At the same hospital how, at that time, they read about rolling out single dose Nevirapine which was the standard of care then.

At a district level as well, these changes are being done in the hospitals as well as the facilities, you can see the impact at the district level and this one is in counseling and testing, and there is the target.

Lastly is to look at one recent example which were basically the staff were working on this particular initiative, really they came up the idea and the aim saying that too many women were not being put on HAARTs and they put together a campaign which they won an award for. And you can see the results from the baseline only 72-percent of women were being referred, and by the end of the campaign, which was about five

to six months, about more than 100-percent were being referred, as well as HAART initiation, ARTs initiation also improved.

The byproduct of all of this working together with the frontline workers really is improved staff morale. Obviously, as you remove the pressure from individuals to actually perform and actually make them see that they are part of a system, they have confidence within the system, that it's easier to actually get more out of staff that is happy. They work together towards a goal. And also it's important because as you engage them to be part of the solution, staff is actually delighted to see their health system change.

In conclusion, we really do need to do better with our scarce resources. Definitely, we do need to train more people. A lot of the investments that we are doing today, we are actually going to see the gains in the future, so we need to do better with what we have. Engaging them to be part of the solution and also making better use of natural resources, harvesting ideas from the staff and using QI as an approach.

Thank you very much. [Applause]

**WIM VAN DAMME:** Thank you very much. So we have time for a few questions on this quality improvement project.

Okay, now we spare that time for the overall discussion. Thank you very much Wendy. [Applause]

So our next speaker is Noerine Kaleeba from Uganda. She is a physiotherapist and an educator and worked at Mulago

Hospital. But she is here mainly because she co-founded TASO and made it one of the very famous organizations that, together with many of you, wrote the history of HIV and the successes of the fight in Uganda. She worked as a community mobilization advisor for UN AIDS for ten years, but now she is back home, retired.

**NOERINE KALEEBA:** But not yet tired.

**WIM VAN DAMME:** But not yet tired as they say in Tanzania. And she still works as a mentor for young people who are aspiring to become leaders in the AIDS response and this is formalized in a Fellowship program at the Makerere University School of Public Health. And she will focus on maybe the most important topic of this session, that is how people living with HIV can be a really powerful resource also in clinical medical care. Thank you for bringing that up. So you have the floor.

**NOERINE KALEEBA:** Thank you. I begin with offering my apologies, especially to the translators, that I do not have a written script. I do not have a PowerPoint slide. Not because I can't make PowerPoint slides, but every time I've attempted to make them, I look at them, I can't find the power, and I can't find the point. [Applause]

So I have decided that we will have maybe five minutes of listening to me, and then I'll leave the rest of the time so that we can have a very important and very interactive discussion on the few points that I want to make.

I also want to say that the power is in this room. As I was sitting there, I saw the men and women who walked in here, and because I historically belong to this movement, I could recognize quite a number of you who will be able to nod your head when I say something, or say no, I think she's gone crazy. That's not true. And if you feel like that, please rush to the microphone and stop me and say, don't say that, you shouldn't.

I thought I was asked to make this contribution primarily because I am one of those people, some of you who are in this room will testify, that can bring our history to this room, our history that we bring every two years to this conference. Every time we come to this conference, many of us are looking for something new to learn, some hope, and some inspiration.

And that's also partly why I did not prepare a presentation. Because I thought that from Sunday through Monday, up to today, I would have been able to come to you at this session with some hope and some inspiration upon which we can move forward. I will leave up to you to decide whether, do we have hope? Have you had hope since we've been here? Have we had inspiration? I have had some inspiration, especially interacting with people who have come to this conference.

So I will not attempt to convince you that people living with and affected by HIV are one of the most powerful

forces to make a difference in what we have been doing because you already know that. I will perhaps join you in really just paying tribute to the people that brought us as far as we came here.

And from my own personal reflection, I pay tribute to the gay men in the northern hemisphere who, for me, first taught me the idea of involvement, getting involved, and sold me the notion that nothing for us without us. I have heard that before because, as you've heard, I am a physiotherapist. And here I also want to pay tribute very greatly to men, women, and children living with disability. Because as a physiotherapist, before AIDS came to my house, I had already been inspired by people, men and women and children, living with disability.

And the point of the inspiration, for me, was the involvement and active participation in whatever is going on to resolve the issues that are around us. So I think that point was made, not in this room, but long before we decided to make a difference in HIV and AIDS.

I wanted to highlight some of the — despite the fact that we know that involvement and the active participation of people living with and affected by HIV is critical — we have made such a miserable attempt in making any, creating this involvement. Attempts have been there, and I'm sure each one of you individually, particularly the TASO family, will testify

here that we have made a great attempt, right from the beginning of our efforts in TASO.

Because we were founded by people infected and affected, we recognized, and we continue to recognize, and I have very high respect for the TASO leadership — Robert Ochai, I saw you coming in here. I have great respect for you, that you have continued to maintain that as a key value, at every level, right from governance. Not involvement in home-based care. Not involvement in activism. But the involvement throughout the entire response and the work that TASO does. I think we should clap for TASO. [Applause]

I would have liked to clap for the United Nations because I worked for them for ten years. And during that ten years, I was part of a process that attempted to develop a process and models in different countries through which this involvement would be made a reality. And this was following the Paris Declaration in which the GIPA principle was outlined and agreed. Everybody agreed that GIPA is wonderful. We all clapped and applauded when the declaration was passed.

But after that, we struggled, how do we make GIPA a reality? And I remember being part of that process, working with UN AIDS, where we attempted to outline a model through which people with HIV could be actively involved. We wanted to make it greater in number so that we have a greater number of people with HIV actively involved in the response, but also

greater in levels. We wanted to raise the activity beyond the activism at community level in order to ensure that this involvement works throughout.

We made a very feeble attempt, and I am very ashamed to say that after the pilot projects in Zambia, Malawi, South Africa, and the Burundi, the program was scrapped after three years. And this is why I wanted to highlight this issue because we will continue struggling until we resolve these issues.

The reason why the program was scrapped was because the United Nations chickened out and instead of hiring these men and women who had offered to use their part of experience, to be part of the rest, instead of hiring them substantively as staff members, we hired them as national United Nations volunteers for a period of two years. After two years, we dropped them. We had no system or we failed to organize a system of accompanying and organizing that which would make it really work.

And the other reason why the program was scrapped, is because we activists began to discuss among ourselves and disagree as to who is living with HIV. We argued that in order for you to qualify for this program, you have to have tested HIV positive. We said we didn't want to involve those so-called affected.

I remember being at meetings where Noerine Kaleeba was called to task to say and declare whether I was HIV positive. I said to myself, well, the last time I checked I wasn't, but I know that my husband died of AIDS and I know that I was one of the first voices to speak about involvement and lead this crusade. But I remember even being thrown out of a meeting because that meeting was discussing and was exclusively for people who have HIV positive.

In this conference today, this week we've been discussing about serodifferent couples and we have met many couples that are identifying themselves as serodifferent, but not so discordant, I think we use the word discordant may mean that you are discordant and therefore you don't agree. But the men and women that I met in this conference who are serodifferent are very concordant. They are together. And they are confirmed regardless of whether they are HIV positive or not. That is a big problem. When we go out there in our programs, who are we involving?

The other problem, that's my last point I want to make, is the continuing prejudice and stigma. Until we hit the nut on stigma and prejudice and particularly the prejudice of healthcare workers who believe that because they are healthcare workers they are therefore much more superior and therefore the person living with HIV, the person affected with HIV, who aspires to be part of the team is less important. And we use

language like “task shifting.” For me, in my language in Uganda, task shifting means from here to there. And yet what we are talking about is increasing the breadth of the team and the diversity of the team and being able to intervene at different times, so the language we use and the plans that we are making are not helping us.

Finally, I want to emphasize that it works involving persons living with HIV, involving persons with disability, we know today that HIV treatments are also causing disability. We are seeing people with HIV who are on treatment who are getting complications and are becoming disabled.

So when we talk about involvement of people with HIV, we should also talk about involving persons with disability, persons with disability HIV, and involving persons with disability to ensure that they can protect themselves from HIV. So all of this involvement is what we must discuss, and I want to leave some time so that you can ask me questions, but ask yourselves the questions, because I do not necessarily have the answers, but I know you have. Thank you. [Applause]

Do I have time?

**WIM VAN DAMME:** Thank you very much. I think you got the point and you felt the power. Any questions directly addressed to Noerine? Mic 4. Gentlemen.

**MATTHEW:** Thanks. Hi, my name is Matthew from Oxford University and I’ve been doing research with TASO in Northern

Uganda. At first I wanted to say that it's a great privilege today to hear you speak today, and that you have been a hero for many of us, so thank you.

My question is about the relationship between people with HIV and the governments and I know TASO and Uganda has had a very good working relationship with the government. In what ways can you promote civil society and on the ground movements to engage with government but still have enough freedom to be able to speak out against government and criticize government when they go awry, and maybe you can speak about Uganda and the problems there.

**NOERINE KALEEBA:** I think our experience in Uganda has proven to us what we know as civil society is that it is important to work with a government with it's also important not to be in the same bed. You don't share a bed with government and even when there are condoms that you can protect yourself. [Applause]

So I think one of the strategies that we adopted in the early movement of civil society in Uganda, and that was actually spearheaded by TASO, was to ensure that what we do first of all, that we get involved in developing the national strategic framework. We get involved. We are there when the framework is being developed. And because we are there, a lot of what is in the framework we subscribe to.

But at the same time you have mentioned government as a bedfellow had a habit of turning around and wanting to have intercourse without wearing a condom. So we have to ensure that we are not in bed with them, but in the sense that you identify very, very clearly areas of agreement but also able to raise the voice when the process of doing of those that have agreed completely diverges.

I can give the example of the difficulties we have in Uganda at the moment. There are two obnoxious bills before Parliament, two obnoxious bills. The first bill is the so-called HIV Prevention Bill. It is obnoxious in the sense that it is largely punitive. It's raising the debate on this discussion that without, that Uganda would never be able to raise in this day and age over international transmission of HIV. And it's focusing mostly on the person who knows first their sero status is therefore responsible for ensuring that others don't catch HIV. That responsibility is being put on the person who knows.

The other obnoxious bill is the so-called Anti-Homosexuality Bill. It is again a bill first of all which tells Ugandans lies, it says that homosexuality is not African. And then the bill says that the response to homosexuality should be catch them, lock them up, including their parents, if you are a parent or a counselor and someone comes to you in counseling and shares with you that they are gay, you are

supposed to go to the police immediately, and if you don't go, you are also punishable.

So on those issues, we have had to support a small group of activist groups to ensure that we first of all inform the legislators, because they are very ignorant on some of these issues, and we help them to be able to legislate on the basis of facts as opposed to emotions. So that's what we have done.

**WIM VAN DAMME:** Thank you very much. So I will take three brief questions one after the other and then give opportunity for a brief answer. So gentleman on Mic 3. Mic in the back and the lady on Mic 4. And then I will have to close.

**MALE SPEAKER:** Thank you for your comment to use the patient as a resource. I would have two questions.

In which functions do you think that the patient could participate in his care, according to your belief, and should the patient be salaried, should he get a salary for that, could the participation of search and easy access be an incentive for the patient to participate in his care? Thank you.

**WIM VAN DAMME:** In the back.

**MASON JIN:** Thank you very much. I'm Mason Jin from the University of Tokyo, Japan. I think as you mentioned the role of people living with HIV is very important, and I'd like to ask you if there's any systematic defaults to encourage people living with HIV to become professional nurses,

professional medical doctors, we were installs [misspelled?]. I think people living with HIV should not remain just as volunteers. They should be professionals, and what have you done for this?

**WIM VAN DAMME:** Thank you for this interesting question.

**SUE WILLARD:** And really just a comment, I want to thank you for being a very wise woman in this group, the issue of language is very important.

My name is Sue Willard. I'm from the Elizabeth Glaser Pediatric AIDS Foundation. I am not a mid-level provider. I am a nurse practitioner. I provide services to patients and I think sometimes when we utilize these words of putting to task and this person can't do that, is that we take it out, that the patient is really at the center of our role. So I thank you for your wisdom. Thank you.

**WIM VAN DAMME:** Thank you. [Applause]

**NOERINE KALEEBA:** Can I quickly answer a question about whether there is a systematic effort. To my knowledge, maybe other panelists know, to my knowledge the answer is no, that there is a systematic process that plans to help people living with HIV, because some of them are outpatients. Some are patients, some are outpatients. When a person lives with HIV, they are not patients. Not all the time. But I am not aware of any global effort to actually help them acquire the

professional aptitude that they need. I'm not aware of any of that. Now, which functions, our experience in TASO has shown that we can perform any function depending on their aptitude and depending on their voluntarism.

And very, very importantly a point I say to make is that a person living with HIV, a person affected by HIV, who volunteers to use their experience to make a difference. They are volunteers already. That is volunteer beyond any of us can ever describe. But they must have incentive. They must be incentified. And I think all of you in the audience have tried different mechanisms. TASO has patient support, the people that accompany others in treatment, adherence supportive staff. TASO has quite a number throughout the country that are come and support others. They do get a bit of an incentive. They are given a bit of incentive. It is not enough but at least it recognizes that support that they give.

But for you to just say that because we are patients, because they are people living with HIV, they are volunteers, they will not be incentified, it doesn't work. So we have to organize a package of incentive to support that input.

**WIM VAN DAMME:** Thank you very much and a big round of applause for Noerine who has really been a source of inspiration for many people over the last twenty years. And now let me introduce you to the last speaker, Deborah Von Zinkernagel. She will present on the new approach of the U.S.

government for medical education partnership. So she serves as the Principal Deputy Global AIDS Coordinator in Uganda office of the U.S. Global AIDS coordinator, which leads the implementation of PEPFAR. And previously she served as the vice president of the Pangaea Global AIDS Foundation. I think many people are really interested to know what is the new policy of the U.S. related to human resources. Please go ahead.

**DEBORAH VON ZINKERNAGEL:** Thank you. It is indeed an honor and a privilege to follow Noerine Kaleeba, and for both her work and the passion that she brings to it, which is the reason that we're all here today. And I appreciate the chance to be able to talk to you a little bit about the new initiative, the medical and nursing education initiative that PEPFAR has recently begun.

And I want to acknowledge upfront this is one piece of the barter health system was referred to earlier today in Dr. Philips presentation as well as the role of patients and communities in that system, and in the delivery of care. So this is looking at one slice of the pipeline, one slice of the issue and trying to bring some additional focus to it.

So, the broad background I think you're all familiar, the PEPFAR program started years ago, has now put about $32 billion into the AIDS Relief effort, and PEPFAR is the cornerstone of what we're now referring to as the presence

global health initiative. And the central concept of that is that is basically working to integrate a cross where often vertically-organized programs for HIV, TB, Maternal Child health, food, and nutrition, and trying to look at the synergies amongst them and also address the needs of patients as they present to you. You don't just treat one thing. The woman who comes in and is positive, also needs family planning and the family planning center can also be a site to access and increase counseling and testing. So, it's a more philosophical approach of integration.

Working in the goals of what we call PEPFAR 2, which is our second phase of PEPFAR is that treatment will be extended to more than 4 million patients, prevention of 12 million new infections, care for 12 million people, including 5 million orphans and vulnerable children. And to meet these goals, PEPFAR will need to support the training of large numbers of new healthcare workers, in order to deliver the services.

So, we have a legislative mandate in the second phase of PEPFAR to increase the number of healthcare workers in the workforce by 140,000. And what is meant with that, there was an emphasis placed on the training and deployment of doctors and nurses as well as other professionals and paraprofessionals. And to look at that within the context as well of recruitment and retention issues and the larger dynamics which are impacting the workforce.

Issues have been raised today that you can train and train and train, and if people are leaving and leaving, or they train and there's no job to go to, you haven't really looked at the policy environment in which you're providing educational services.

In our legislation the training was defined primarily as pre-service education for new healthcare workers graduating with an institution, with the capacity to fill any particular niche of the workforce. I would note that PEPFAR has been involved for many years in diverse ways around training, workforce training, clinical training, a lot of it on site for people who are already out. And this particular initiative is stepping back and saying we need to step back and look at the needs of the institutions that are in place and are being asked to create these workers and look at what their needs are as well.

Also, it recognizes that you can't look at these institutions in isolation. You have to look at also their civil service, civil wage issues as well as the nature of the places where these trainings are taking place and their diversity.

So the medical and nursing education partnership initiative is $20 million was set aside this year to expand the clinical capacity and clinical quality of African medical and nursing schools, and to strengthen these institutions in their

mission. The purpose is, the broadway is to increase the pipeline of available professionals who are available within countries. The third linked activity was to strengthen the capacity of local scientists and healthcare workers to conduct research.

This was an interesting angle which has come in as we've recognized that some of the key issues in retaining faculty in medical schools and also the nursing schools are the opportunities for faculty and to be able to offer them some kind of career advancement opportunity for medical research has been important in medical institutions as well. This is an added component which is coming in now, and I'll talk more to that a little bit later.

So the goals of the initiative are strengthening training institutions, seeing this is essential to building a long-term, sustainable supply. Looking at supporting innovative strategies and practices that do end up with retaining the workforce of what you're goal is. There are many components of this that I think we've been learning as we've been talking increasingly to people; there are strategies such as community-based learning, problem-based learning, where the nature of the education that you're providing is much more tuned to what the real life situation is that a professional will be confronting.

We're putting emphasis on utilizing existing partnerships, between African and U.S. medical educational institutions. I would note that in the medical initiative component of this, these grants go to African institutions that would partner, that are partnered or have a history of working with a U.S. medical school or university and want to continue that relationship with their faculty and in their research component as they wish or instructional methods.

Their goal is to inform basically curricular development, faculty preparations and strategies for their retention. This is also I think very important as we've looked at a lot of the nursing education processes. There's a lack of mentors, there's a lack of clinical trainers. If you go out into the clinic or the hospital, you have a student that is basically out there unattended or is dependent on the nurse on the ward to provide their education. So I think we need to look at all areas of faculty, making sure they're comfortable, supported in their scope of work and also extending that work out into the clinical setting.

And to promote innovative models for education, I think to prepare individuals. There's some wonderful examples we've learned from South Africa and Eastern Cape, whereby how it is they recruit students, where they seek their students from, and how they're offered training. And field work incorporated into

that has very high retention rates of graduating physicians who remain and are practicing in South Africa.

So it's looking at some of these strategies I think is additional tools that aren't immediately apparent when we're trying to look at the broader picture.

The objectives of this first phase of the initiative is to find five to nine African medical schools working in partnership with the U.S. medical schools and universities. And I would hasten to add here we want to increase also South-South partnerships and the grants process we've just been in the process of completing. We have had some South-South partnerships of strong institutions in the South, matching up with others.

To also gather information on countrywide assessments of nurse training capacity, we focused this first on three countries, and this is really digging down deep. It's looking at going and visiting every school, it's looking at the facilities of the school, the capacity to faculty, the students, the arrangements for the students, really understanding if you wanted to support the school, what would be the issues that would be important to be addressing. And to work the Ministries of Health to select out of each country to select several schools that they would want to start with. Where do they want to start? Where do they prioritize, where

do they think would be the most helpful to the additional capacity.

We also are looking at supporting two coordinating centers. One for the medical education component, one for the nursing education component that will help to bring together a network across the countries, bring folks together, look at what's going on, and really try to draw the lessons from this.

The goal would be eventually to definitely expand this. I think we're in the learning phase of trying this first group, but this should move into all of each country's plan as an ongoing part of the HRH component that would be funded more generously and more continuously, as part of the PEPFARs program.

We're also engaged in a partnership with the WHO around an evidence-based, building a practice base for what has been effective, what seems to work, what are recommended things so that this can begin to be more generalized. And also another component is doing some costing studied, as we're doing this concurrently, the first thing a ministry wants to know is what does it cost. What does it cost to produce this, what does it cost to do it? So we want to pay attention to that up front.

This is the broad goals of the WHO collaboration I think we've spoken to that briefly. So again, looking at innovative educational approaches focusing on how would we actually develop the excellence, retain it? How do we look at

the research component that also supports it? The Fogarty Center of the NIH has really taken this on as an interesting component for them. Obviously they are looking at the next generation research and building those capacities. And 19 out of the 27 NIH centers and institutes are contributing and supporting this initiative as well. So we're very gratified to have them engaged up front, particularly in the medical school piece where they have a great deal to offer. So, thank you. I'll leave it open for questions. [Applause]

**WIM VAN DAMME:** Thank you very much. Are there any questions particularly addressing this talk by the speaker from PEPFAR. Mic 4 and then Mic 5. We take three or four questions and then Deborah can answer.

**LAURA VAN VUUREN:** I'm Laura Van Vuuren from Medical Teams, nationally in the U.S., and does the plan advocate or promote a continuing medical education component, which is a common practice in the U.S.?

**DEBORAH VON ZINKERNAGEL:** That, I think, is definitely a part of what we need to look at in terms of if you're looking at a sustainable component, this really has focused on the initial education, the initial provider coming into the workforce. But I agree with you. That's often a very important piece of keeping people in the field and also supported and engaged and quality of work. So this initial

piece focused on strengthening the institutions, but it is an important component.

**WIM VAN DAMME:** Mic 5 in the back, then Mic 3.

**PATTY WEBSTER:** Hi, thank you very much. My name is Patty Webster. I'm with the Institute for Family Healthcare Improvement, and I want to thank all the speakers. I think there's critical links that could be made for each of you, and I appreciate that the training and the workforce development can take an inter-disciplinary approach. It's a comment and a question. I'm wondering with the PEPFAR activities, if right now it's a critical point to involve people living with HIV. It's a point to involve patients and families in developing a curriculum that focuses on involving them in actual training, and mentoring and shadowing. So, I would like to commend Noerine on involving the issue of patients and families. So that's kind of a question for you. The second part is: Do you have plans to involve training and systems improvement? I think Wendy pointed out some real critical links, and as did Mit, in terms of really focusing on systems improvement activities, and training these nurses and practitioners in systems improvement at the very level where you're discussing where you're putting funds. Thank you.

**WIM VAN DAMME:** Okay. Question here in front.

**ANN LYON:** I'm Ann Lyon, I work with Health Systems 20/20, a health systems strengthening project. I have a couple

of questions for you. The first is 20 million congratulations on setting aside 20 million. It still seems a little bit low, considering the overall 35 billion I think you mentioned at the beginning of your talk. So I'm wondering how that amount was decided upon. My second question is, there have been efforts for the last 20 years working with medical schools and nursing schools in Africa and we're wondering what effort you are planning to engage so that the lessons learned from that can be incorporated. Thank you.

**WIM VAN DAMME:** Thank you, so in the back to Mic 2. Brief questions please.

**MALE SPEAKER:** Okay. My question is specifically about funding for salaries it seems the bottleneck for human resources really like long-term, sustained funding for salaries as opposed to commodities, you know, ARV tests—sorry, HIV test, ARVs, training, research. What kind of movement has there been in getting sustained funding, locked-in funding for living wages, real salaries for health care workers in Africa?

**KAY EHRHART:** Kay Ehrhart, New York, Columbia University. With the new effort on education of healthcare workers, are you including mental health, since mental health is increasingly becoming an issue in AIDS and for treatment adherence, et cetera?

**WIM VAN DAMME:** I'll take the last question on Mic 4 and we will have to close. Yes.

**SILKE SECO:** Thank you very much, I'm Silke Seco. I'm a health and AIDS advisor for DFID. I know a lot of my colleagues in Africa work very closely with PEPFAR and human resources for health. I was wondering if you could possibly be more how do you address the stigma of discrimination in your training program because we know this is significant bias and is prevalent in healthcare settings. Thank you.

**WIM VAN DAMME:** Okay. Now in two minutes I hope you can solve all this issues.

**DEBORAH VON ZINKERNAGEL:** I'm happy to take anymore questions after this session as well, because I'm not going to get through this all.

I'll take the last two both mental health issues and the stigma concerns, which are huge issues out in the work setting. And both of those I think we need to work with our faculties within the schools around bring what we know from our experiences in terms of curricular needs, things to be covered. Competencies that are important to have. But also work respectfully with the institutions themselves and the faculties around how those issues are integrated.

I think you're looking at the end for a really quality practitioner clinician, and so from our perspective those would both be important pieces to include and focus and work with partners on. In terms of benefitting and taking advantage of the many years of work that have been done by many partners and

of other organizations around medical and nursing education, yes, there's a lot to be learned. There's a lot to build on. We started to have consultations and would continue to do that, and also hopefully the work of the coordinating centers in each of the two disciplines will help us to bring those lesson together, to the field, as we're sitting down and talking about these projects and programs.

The question on the salaries issue, I wish I had a good answer for that. I just know this initiative takes place within a much larger policy environment and upfront it has been important to acknowledge what happens to the individual when they leave. You don't talk about retention, you don't talk about recruitment, in the absence of sort of a sense of this as a professional opportunity that's will give you a living wage. So here this is an arena we have to be in a larger dialogue with the Ministries of Health and our partners around this, it is a key point. That's what I can recall.

**WIM VAN DAMME:** Okay, thank you very much. So I'll invite a few questions, but really cross-cutting questions, questions that link different talks together, if anybody feels like asking such a really cross-cutting question. Somebody waving in the back. I cannot see very well who you are, but please go ahead.

**CHRIS MATHEWS:** Chris Mathews, from the University of California, San Diego. I think the panelists addressed the

issue of rapid scale-up to meet the demand for delivery of HIV care by task shifting and other mechanisms. I was very glad that the issue of quality improvement was included in that and I believe Dr. Philips made reference to the CIPRA study that showed equivalence between doctor and nurse management of antiretroviral therapy in South Africa. But what wasn't mentioned was the very high protocol-defined failure rate in that study in both arms exceeding 40-percent. And I think it makes the point that task shifting of itself will not achieve the quality results that are necessary there are in place sensitive indicators of quality and a quality improvement process to respond to those data.

**WIM VAN DAMME:** Segrin [misspelled?].

**SEGRIN MARGAREL:** Thank you, I'm Segrin Margarel [misspelled?] from Norway and I at the moment share the board of the Workforce Alliance. And just to say the panel has put together a spectre of the challenges we face that we very much would affirm, but also demonstrating the complexity of those issues, and yet a number of things we can do. The link between what we can do in implementation and research on the one side and what we can do with much more inclusive engagement, and local problem-solving is also to me, a very critical message from here. My cross-cutting question was: We still have very little information about the actual gap in service delivery at the periphery of the system. We've struggled a lot with that

in our discussions, too, because we keep on working with aggregate data, we know that it's very hard to know when it actually is a health worker present, skilled, motivated, supported, at the bravery of the system and particularly in remote areas. So now when we want to manage for results, scale-up for results, we may be working in a system where it looks like we have numbers but the people are not where it really matters. So the gap in the periphery and any of you working at actually getting out knowledge, and so that we know when we do it better, what is this gap in functional presence in the periphery of the service as the intermediate result we need to have before we actually can get result of outcomes service delivery?

**WIM VAN DAMME:** Thank you. So this gives me also the opportunity to announce that Segrin will be sharing a satellite session tomorrow afternoon in session room 4, from the Global Health Workforce Alliance, very much dealing with similar issues. So if you cannot ask all the questions or want to go further, you are invited to her session.

So any of the speakers who would like to address some of these questions? Yes, Mit, please.

**MIT PHILIPS:** Yes, on the issue of the quality I think it's clearly key, but indeed there is not so much data about quality. And I think you can have also discussion on what is quality to different people. The adherence and loss to follow-

up will be an important element of the outcomes of the patients on treatment still. So this kind of studies showing differences between different cadres in doing certain clinical tasks is only part of the image, part of the issue. And as you pointed out, if the results overall are not good, it doesn't matter so much if you have similar results. And this is—I think the reality is also that, although some of the health workers, in name for example, might be nurses, the quality care that is provided is not always so much better than a lay person who is trained short term. And I think that's where the challenge is really that we can make sure that the health worker is of added value to specific clinical task or to specific tasks that the health system should provide real support for real problems and not a barrier because between the patient and the drugs, for example. And the information gaps we are seeking, I think it is a major problem, but there are some examples that's being done of simplified tools not so much to evaluate the numbers but mainly also to give tools to the health worker district, people to have a management tool, because they don't have information really to act upon.

**WIM VAN DAMME:** Wendy?

**WENDY DHLOMO:** I'll attempt to answer the second question, looking at the functional gap. I think one of the important things really is to look at the system as a whole and actually getting more people involved, from your provincial

district as well as facility coherence system mechanisms to understand the system. There have been instances in our own work where we could improve the efficiency of the system to a certain level and it cannot go anymore beyond that without injectional resources. In that instance, obviously when you have good linkages with your province and your districts, including national, it was possible to actually advocate for new resources in the form of nurses or roving teams to actually have us breach that gap of delivery.

But it's important to be very efficient with what you have, rather than to pull without being able to create systems that actually are functional.

**WIM VAN DAMME:** I can take two more questions; Mic 4 and the mic in the back.

**DAVID ALTSCHULER:** David Altschuler from One to One Children's Fund. We've heard a lot about the incredible potential of people living with HIV and those affected by HIV to break this bottleneck. We're funding more than 200 what we call expert patients in 50 clinics that are affiliated to the organization PATTA [misspelled?], in Africa.

What we're struggling with is how to train the patients and in some sort of universal training that could be accredited in some way. Each clinic currently trains the patients in their own particular way and uses the patients to perform tasks that are relevant to their situation. We've given scholarships

to each clinic to get involved with medical training programs. But what we're looking for universal program and I wondered whether the panel could comment on that.

**WIM VAN DAMME:** Okay, now the last question in the back.

**DOUGLAS HAMILTON:** Douglas Hamilton, Irish Aid, to thank all the panelists for excellent presentations and giving great insight into the different possibilities and also the capacities of human beings who actually deal with various very challenging situations. In terms of bringing all these aspects together I don't think we've addressed enough the huge problem of brain drain both intra country and internationally. We'll be so at the plenary session and Session 1 this morning, this huge brain drain to countries like the U.S. and the UK from the middle and low income countries. Clearly efforts at retaining staff, retaining all levels and cadres of medical staff including patients was mentioned in the presentation.

From Uganda in relation to the failure to actually retain those patients even there, but without particularly unique initiative. I think one example of hundreds where we failed to attain. I don't think the problem maybe is to train so much; it is to retain. It is the lack of pull in countries in Africa to keep staff. And it's the excess pull from us, and since this is an international AIDS conference I would like to see what sort of ideas the panel might have on reducing our

pull as Europe and the U.S. and increasing the retention, the pull, in Africa. Thank you.

**WIM VAN DAMME:** Thank you very much. So, Fitz, I think you have some answers to that.

**FITZHUGH MULLAN:** On the last question I think there's a major agenda in front of us of consciousness raising, and I would hope that activists in the AIDS community would do all that they can to raise consciousness in the north about the affect of continued brain drain. And raise just quickly as a case in point the U.S. Congress is considering legislation, has considered and is still considering legislation, to fund more medical residencies with public money.

The immediate effect of funding more residencies would be to allow or require more foreign medical graduates to come to the United States, since the system in the United States everybody who graduates from medical school gets a residency. But if they fund more, it will mean more doctors from abroad, and that is raised in a value-free environment. Nobody in Congress to standing up and saying this is immoral. We do need that kind of leadership. Some of us in the north are trying to promote that, but certainly having the international community be very clear in raising this as an issue will help to develop a response in the north that we need badly, so I agree entirely stabilizing the situation by diminishing the brain drain is

key. And I do think the HIV community can be articulate on the topic, and that would help a great deal.

**WIM VAN DAMME:** Thank you very much. I think for the sake of time, I'm supposed to also make some smart, concluding remarks. And now we face the funny situation that we have a big in-flow of participants. I don't know very much how to interpret that, so I will to try to say a few smart things in the last five minutes.

So I think many of the presenters have shown that human resources is a very complex issue. Each of them have brought different perspectives on a particular point so there are still many obstacles for good human resource policy. Some of the countries have led the way and I think that is very paradoxical. To note that the countries like Malawi and Ethiopia who objectively by far have the biggest challenge, have been really reacting strongly and have already addressed courageously some of the real problems, while other countries like South Africa have been much, much more hesitant. So this morning the Minister of Health has announced that finally they will really embrace task shifting and simplification and decentralization as part of their ambitious policy.

In fact we should recommend to the government of South Africa to go to some of these very poor neighbors and learn from their experience. I think we have heard a very welcome focus on the power of people living with HIV. As provided the

expectations, as peer educators, but there is really a big concern as has been highlighted here, the good intentions of cheaper have really not materialized, and my impression also with observing what is happening in human resources in Africa is not a positive experiences with people living with HIV as providers are very small, are mainly indolet [misspelled?] and are not scaled up.

So there is really an enormous challenge. I think you have to understand better the challenges and the obstacles for governments to really embrace that principle, otherwise there would be very little progress.

Another point I've noted is that there has been, in fact, very little attention for the non-physician clinicians and Fitz has written this landmark paper a few years ago while many of the best experiences in Sub-Saharan Africa are building around health offices and clinical offices and medical assistants, and sometimes you have the impression that this is being marginalized and that everything is focusing on medical doctors who have not such a brilliant track record of serving the needs of the community, and that I think is really a danger in what we have heard here also, that really a lot of attention will go to medical schools, with partnering with medical schools to the north, from the north, who absolutely have a dismal track record of training doctors that really are sensitive to the needs of the community. So I hope this scale-

up of training will really embrace what the broader set, innovative, community-oriented models and not just scale-up training for specialist doctors who will call for bigger, central hospitals and more technology, and which is absolutely part of the brain drain.

So I think we have indeed, as some people said at the end, focused on what is happening with the brain drain, but if we train people in Africa, with the curricula of the north we will really be fueling the brain drain rather than training a workforce for the rural areas in Africa.

So the attention for retention is very welcome and very needed, and this, of course, is very related to how the work force will be remunerated, paid, and so this brings us to the entire financing issues of the medical systems, the health systems, in the south.

So, as some of you have said, you cannot disassociate the workforce from any other element in the health system. It is really a complexity of issues, and for those who want to continue this discussion, right now at 1 o'clock, there is the next session in Room 4 that focuses on the relation between HIV and health systems.

There was a pre-conference on that topic on Friday and Saturday, and it is obvious that human resources is very, very central in this articulation between AIDS programs and the wider health systems. So for those of you who want to continue

this discussion, in 15 minutes the next session starts in Room 4 about this. But let me conclude by inviting all of you to thank the speakers and also the audience for this very nice session that surprisingly ends with many more people at the end than when we started. Thank you very much. [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.