World Health Organization

Treat, Train, Retain

The AIDS and health workforce plan

Report on the Consultation on AIDS and Human Resources for Health, WHO, Geneva, 11-12 May, 2006

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EXECUTIVE SUMMARY

A Consultation was held in Geneva in May 2006 to discuss a proposed AIDS and Health Workforce Plan. The Consultation drew together actors from the fields of HIV and AIDS, human resources for health, and development. Participants represented national governments of low-, middle- and high-income countries, professional associations and trade unions, international agencies and financing institutions, academic institutions and civil society organizations (including nongovernmental organizations, faith-based organizations and organizations representing people living with HIV).

The Consultation discussed the proposal for an AIDS and Health Workforce plan . Dubbed “Treat, Train, Retain” (TTR), the plan was seen as both an essential component of the strategy to scale up towards universal access to HIV/AIDS services and an important new opportunity for strengthening human resources for health (HRH) in countries affected by the epidemic.

The plan comprises three sets of elements: a package of HIV treatment, prevention, care and support services for health workers in countries affected by HIV (“Treat”); measures to empower health workers to deliver universal access to HIV/AIDS services (“Train”); and strategies to retain health workers in the public health system, including financial and other incentives and strategies to improve pay and working conditions and manage the migration of health care workers (“Retain”).

It was clear from the contributions of the participants that a large amount of work is already being undertaken in all three areas. However, while some types of programming, (e.g. in-service training) are commonplace, others (e.g. programmes to remove the barriers that prevent health workers from accessing services), require much more attention.

TTR was seen as a “menu of options” which builds on the existing work in the field. Priority actions were identified in the three areas of “Treat, Train, Retain”. Key challenges to the plan were identified as the need for predictable and sustained funding; externally imposed fiscal constraints to expanding HRH; and governance issues. Stigma and discrimination were identified as persistent obstacles especially in relation to Treat and Retain.

Although participants approached TTR from different perspectives and areas of work, there was strong consensus—both on the overall concept and on the need for immediate action in implementing individual elements of the strategy. General principles guiding the establishment of an AIDS Health Workforce emerged, such as:

- The centrality of the health workforce: An understanding of the special needs of the health workforce and their engagement in the plan will be essential to the success of TTR.
- Country ownership and implementation: Ownership, political will and political leadership at the country level will be central to the success of TTR.
- TTR must become part and parcel of plans for the development of national HRH, and HIV, within the framework of the Three Ones.
- “AIDS speed”: It was agreed that TTR, as a response to urgent health needs, must be rapidly advanced. It must combine the coherence of a systems approach with “AIDS speed”.

The main aim of TTR is to catalyse, coordinate and maintain the momentum of the different actors and programmes in the areas of human resources and HIV. It is not a new, vertical plan, but rather represents a new opportunity for HRH and HIV actors to work together, leveraging maximum advantage from the current global mobilization around the AIDS epidemic.

1. INTRODUCTION

In devoting the 2006 World Health Report to human resources for health, the World Health Organization has demonstrated its recognition of the centrality of the health workforce in global strategies to reach health and development goals. The report highlights the growing crisis of human resources for health (HRH), particularly in sub-Saharan Africa where there is an estimated critical shortfall of 0.82 million health workers in 36 African countries. This situation is exacerbated by the weakness of the current training output for Africa which is only 10% of what is needed. The report challenges the global community to find ways to work together through alliances and networks, "across health problems, professions, disciplines, ministries, sectors and countries" to meet health workforce challenges. The World Health Organization has played a key role in the formation of a Global Health Workforce Alliance that aims to bring relevant stakeholders together to accelerate core country programmes.

In addition, the deepening AIDS crisis in many sub-Saharan African countries has catalysed a specific focus on health workforce deficits which pose a challenge to effective delivery of HIV services. The 2005 global commitment to scale up HIV services, with the aim of as close as possible to universal access to treatment for all those who need it by 2010, has created new urgency for intensifying global action to strengthen the health workforce. Both the final report of the "3 by 5" Initiative [1] and the assessment report of the Universal Access Global Steering Committee [2] list the human resource crisis as one of five key challenges to scaling up HIV services.

Against this backdrop, the need for an approach to strengthen the health workforce in the context of HIV and AIDS—and one that is aligned with broader action for health systems strengthening—has become clear.

In May 2006, an international consultation, attended by 134 delegates representing governments, health workers and their organizations, international agencies, development agencies, academic institutions and civil society organizations active in the fields of HIV and HRH, was held in Geneva to discuss a plan which would fulfil this ambitious goal. The consultation gave definition to a proposed AIDS and health workforce plan dubbed "Treat, Train, Retain" (TTR), which comprises three elements:

- Treat (prevent, care and support)—a package of HIV treatment, prevention, care and support services for health workers in countries affected by HIV.
- Train (and planning for HRH)—measures to empower health workers to deliver universal access to HIV services that include pre-service and in-service training for a "public health" approach.
- Retain—strategies to enable health systems to retain health workers, including incentives, measures to improve occupational health and safety and to improve the workplace as well as initiatives to manage the migration of health care workers.

The elements, which are mutually reinforcing, have been grouped for convenience—there is some overlap between them.

TTR should be seen as a "menu of options" which builds upon existing work in the field. Its main function is to catalyse, coordinate and maintain the momentum of the different actors and programmes in this broad field. It recognizes that a coherent approach for scaling up towards Universal Access will need to be broad and multifaceted and will depend on the scaling up of current initiatives both within and outside the "AIDS silo". Country leadership and country ownership, and the embedding of TTR plans into broader planning and processes in the areas of HRH, development and poverty reduction will be central to the success of TTR.

By addressing both the causes and effects of HIV and AIDS in relation to the health workforce, TTR is both an essential component of the strategy to scaling up towards universal access and will make an important contribution to strengthening human resources for health in countries affected by the epidemic.

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1 *Global access to HIV antiretroviral therapy: a report on "3 by 5" and beyond.* Joint United Nations Programme on HIV/AIDS/World Health Organization, Geneva, 2006: Available at www.who.int/hiv/universalaccess.2010

2 *Scaling up HIV prevention, treatment, care and support. Follow-up to the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS.* March 2006. Available at: www.unaids.org

2. THE CONCEPT OF TTR

During the two-day consultation, the overall concept of TTR was discussed and elaborated. TTR was not seen as a new, independent vertical mechanism or structure, but rather as a partnership which takes advantage of the current momentum in both HRH and HIV to build strong health systems that can deliver HIV/AIDS services to all who need them. TTR was also described as a “catalyst, repackaging and rekindling interest in HRH development”.

TTR will work through existing mechanisms, including financing, national planning and development instruments. As discussed below, TTR will be enriched by different perspectives and provide a point of alignment between the AIDS response and broader health and development strategies. In summary TTR is intended as a strategic approach rather than a structure; and systems response rather than a technical intervention.

The consultation did not get as far as confirming the management structure of TTR, however there were suggestions that it should be managed by a coordinating body, such as steering committee comprising key actors in the fields of HIV, HRH, migration and labour.

2.1 A multisectoral plan strategy

While TTR aims to strengthen the health workforce in the context of AIDS, it straddles a number of disciplines, sectors and areas. As such, some elements of TTR may be the domain of AIDS actors, and others may be the domain of actors in other fields such as HRH, education, management of migration, or occupational safety and health.

Some elements of TTR have a specific HIV/AIDS focus whereas others have a broader scope. For example, some elements direct attention to the special needs of HIV-positive health workers or health workers who deliver HIV services while others are geared towards increasing the numbers of health workers, and retaining them in the places where they are most needed.

2.2 A flexible plan

A complete plan or package for TTR can only be designed at country level, according to national priorities. The separate elements of TTR will not be equally important in all countries. For example there is a spectrum of need that is related both to the extent of the epidemic and the scale of the HRH crisis: the needs of countries with high prevalence of HIV and a massive HRH deficit will differ from those of countries with concentrated epidemics, or only a small shortage of health workers. Thus different aspects of TTR will be emphasized in different country contexts. For example the needs in Brazil, which has two HIV-positive people per doctor, are different from the needs in Malawi where there are 4000 HIV-positive people per doctor. Another example is India, which has few health workers who require antiretroviral therapy, but a great need for trained health workers, and would thus emphasize the Train element over Treat.

2.3 Partnerships and alignments

At the global level. TTR is part of the new Global Health Workforce Alliance. It will be aligned with the ten-year plan proposed by WHO for action on strengthening HRH. It will depend on alliances to ensure a multisectoral focus and synergy between a range of specializations; the International Organization for Migration (IOM) and the International Labour Organization (ILO) have been partners in the development of the plan. It will also be aligned with broader health systems issues which include the recommendations of the High Level Forum on Health, the “Three Ones” principles and the Global Task Team recommendations.

At the country level. The success of TTR will depend on coordination between several ministries such as those of health, education, finance and labour. For example, the participation of the ministry of education will be essential, as the training demands for the scale-up towards Universal Access require a revitalization of tertiary education.

This goes beyond simply expanding pre-service training to deliver HIV services, and includes training for a spectrum of clerical, managerial, supervisory and other skills needed in the health system.

The participation of the ministry of finance will also be essential if TTR plans are to be coherent with financial planning and processes such as sector-wide approaches (SWAps), medium-term economic frameworks (MTEFs) and poverty reduction strategy papers (PRSPs). This will ensure that plans are realistic and will not be thwarted by obstacles such as fiscal ceilings.

As discussed above, TTR plans must be part of overall HRH plans, which in turn must be embedded within national poverty reduction and development plans. It is vital that the AIDS scale-up and strategies to resolve the HRH crisis work together.

At the country level it may be desirable to establish a "TTR partnership" within the Three Ones framework, to enable actors and partners to align and work together. Alternatively, to avoid duplication of effort, existing national AIDS authorities, as multisectoral bodies, may be ideally placed to take on this role.

Action points:

- i. *National governments should receive all the assistance they need to develop TTR plans according to their national priorities.*
- ii. *TTR actors must be advocates for the integration of any TTR plan at the country level into pre-existing country planning and funding instruments, including HRH planning, SWAps and poverty reduction strategies.*
- iii. *The High Level Forum on Health could convene a forum to develop mechanisms for partnerships between TTR (and other priority disease) actors and global health partners.*
- iv *Opportunities to advocate for TTR and all its elements at the global, regional and national levels must be identified and exploited*

3. "TREAT"

The "Treat" component of TTR comprises a comprehensive set of HIV/AIDS prevention, care and support and treatment approaches targeted at health workers infected with and affected by HIV and AIDS.

3.1 Introduction

A common sense approach suggests that health workers, by definition, would have priority access to the HIV services that they need. However, there is evidence to the contrary from many sources. After several years of availability of antiretroviral therapy, many health workers are deterred from seeking treatment and other services for fear of the attitudes and reactions of colleagues and patients. Health workers living with HIV acknowledge the pervasiveness of fear, stigma and discrimination—from patients, colleagues and community members—that prevents them from accessing HIV/AIDS services.

Lack of privacy in consultation and examination situations is also a barrier to accessing services, as is the tendency of health workers to self-medicate.

In the past, prioritizing health workers' access to services has raised ethical issues. However, as death and illness of health workers in the countries worst affected by HIV and AIDS continue to escalate, the problem has been recognized as a major threat to health systems and therefore to access to all health services for the whole population.

Priority access to HIV care and treatment for health workers in Swaziland

Eighty per cent of Swaziland's health workforce are women and it is estimated that they have the same HIV risk as the general population, where rates of HIV prevalence in adults have peaked at 42.6%. In 2005, 6% of the health workforce was lost to death, sickness and migration. One survey has shown that HIV has had a serious impact on health workers, both at work and at home; and when they themselves are infected they find it difficult to access HIV and AIDS services.

The government of Swaziland has therefore embarked on a range of programmes to support health workers in the context of HIV and AIDS. They include expanding tailored services for health workers; integrating HIV workplace programmes in health services; programmes to combat stigma and discrimination among health workers; and integrating infection prevention and control into health care delivery.

In February 2006, the first wellness centre for Swaziland's health workers was opened in Manzini, the capital city of Swaziland. It emerged from a partnership between the Swaziland Nurses Association and the Swaziland National AIDS Programme. It provides a range of services from stress management and psychosocial support to counselling and testing, prevention, antiretroviral treatment, post-exposure prophylaxis, home-based and palliative care, to all health workers in need. It aims to cater for 3000 health workers and their immediate families. Phase 2 of the project will involve expansion to three regional centres.

The programme is constrained by limited funding and the real possibility that stigma will continue to deter health workers from seeking services. There are also concerns about the fact that this is another vertical programme, and is being offered at a site where health workers have access to private providers.

One of the main aims of the project is to de-stigmatize HIV and AIDS so that health workers will feel able to access general services. In the event of this positive outcome of the programme, the Wellness Centres will be used for psychosocial support and other training and support functions.

3.2 Priority elements of "Treat"

Comprehensive workplace policies need to be put in place as a priority, and a basis for more specific Treat programmes. These should be based on the *ILO Code of Practice on HIV/AIDS and the world of work* and the *Joint ILO-WHO guidelines on health services and HIV/AIDS.*

Removing the obstacles to health workers gaining access to treatment, prevention, care and support programmes is one of the priority elements of "Treat". This would include campaigns to combat stigma and discrimination in the workplace, including "self-stigma" or internal stigma. The close involvement of bodies representing the interests of workers helps increase trust and reduces fear of discrimination.

Approaches for ensuring confidentiality for HIV-positive health workers are also essential. These include special sites for care of health workers (see Box: Swaziland Wellness Centre case-study), site swapping and the establishment of special arrangements with the private sector for health workers. Arrangements for the use of the private sector could also facilitate access.

Programmes must be developed through consultation between management and the workforce, and include comprehensive prevention and psychosocial support; care and treatment; empowerment and legal protection for frontline health workers; and "know your HIV status" programmes dedicated to health workers. Access to prevention and testing for medical students at universities, nursing schools and other educational institutions, before they enter the workforce, is also desirable.

Programmes should offer a range of support for health care workers including mentoring, psychosocial support and health insurance schemes where applicable.

Monitoring and evaluation and operational research will be necessary to determine which approaches are the most effective.

3.3 Priority actions in "Treat"

Comprehensive data on the impact of HIV and AIDS on the health workforce will be essential to enable action on Treat at the global and country levels. This includes data on infection rates among health workers, the numbers accessing services and other information. This is essential both for the planning of services and for advocacy at the national level.

At the country level. A top priority is the implementation of special services or programmes in the public sector to meet the needs of health workers as described above. Education for health care workers on the prevention of HIV and AIDS should be provided during pre-service and in-service training.

Education on HIV policy for managers will also facilitate the implementation of good Treat programmes.

Education and training for occupational health and safety are also essential and should include specific strategies to prevent workplace transmission of HIV, tuberculosis and hepatitis B. This will require training, commodities and procedures for universal precautions, as well as post-exposure HIV prophylaxis.

At the regional and global levels. South–south collaboration will be essential for the identification and sharing of best practices in Treat. Technical advice on monitoring and evaluation and operational research is also a priority. International agencies have an important role to play in drawing up guidelines for Treat programmes.

Action points:

- **i.** *Comprehensive workplace policies based on the ILO Code of Practice on HIV/AIDS and the world of work and the Joint ILO-WHO guidelines on health services and HIV/AIDS must be put in place.*
- **ii.** *Countries affected by HIV must compile comprehensive data that show the impact of HIV on the health workforce as well as numbers of health workers accessing services.*
- **iii.** *Country-level: existing HIV and HRH programmes and approaches need to include targeted campaigns for health workers infected with and affected by HIV and AIDS.*
- **iv.** *Regional level: best practices in expanding access to HIV services for health workers must be identified and shared.*
- **v.** *Global level: International agencies and academic institutions must assist in producing guidelines for effective Treat programmes.*
- **vi.** *The "TTR's steering committee" must work with country leaders to identify countries for pilot testing of TTR plans and programmes.*

4. "TRAIN"

The "Train" component of TTR comprises in-service and pre-service training and task-shifting (see explanation below) for a public health model of HIV services delivery.

4.1 Introduction

There is an urgent need to increase the numbers of health workers, and their capacity to deliver HIV services. Not only are health workers distributed unevenly across regions and within countries (23% of doctors and 38% of nurses are found in rural areas), but many lack the appropriate training.

Key elements in capacitating health workers to deliver HIV services are in-service training, task-shifting and pre-service training.

In-service training has the advantage of building on the existing work force, of strengthening existing services and of providing career development for heath workers. Care must be taken to guard against the negative impacts of in-service training programmes—as, in some cases, off-site courses (hotel training) take health workers away from their patients. Positive models are provided by some country experiences such as that of Uganda where members of the clinical team were trained together in on-site, part-time training programmes, so that participants were able to continue to work.

Task-shifting—or shifting of tasks to less-specialized cadres—enables the rapid expansion of the health workforce and has the advantage of building bridges between the health facility and the community. It also creates job opportunities in the community and new opportunities for people living with HIV. The task-shifting approach should also be applied to the provision of training, and less disruptive and lower cost alternatives should considered, such as people living with HIV coming into the workplace to give sessions on care and support, including psychosocial issues.

Pre-service training involves both integrating AIDS services into the curriculum and increasing graduate numbers and facilities. It has the advantage of expanding the health workforce, which is a global goal. On the other hand pre-service training is expensive and it takes several years to produce skilled health workers.

Training can provide a strong pillar that could link and support Treat and Retain.

An integrated approach to HIV service delivery—The Uganda experience

Uganda has an HIV prevalence of 7%, with 1.1 million people living with HIV and 120 000 having AIDS. The "3 by 5" target was to provide antiretroviral therapy to 60 000 people living with HIV by 2005. Prior to December 2003, treatment and care were available in only five centres and only 8000 people were receiving antiretroviral therapy (out-of-pocket payment).

In late 2003, the authorities adopted WHO's IMAI programme which provides for an integrated system of HIV service delivery, decentralized to the district level. This model incorporates trained members of the community and people living with HIV and AIDS into the clinical team.

After the first clinical teams were trained in the Masaka Region in early 2004, teams were systematically trained across the country in chronic HIV care, antiretroviral therapy, prevention and the management of opportunistic infections. The emphasis was on the strengthening of the district network and on forming close links with the community.

Through this model the number of people on ART increased dramatically in a short time enabling Uganda to reach its "3 by 5" target by the end of the first quarter of 2005. The number of ART sites had increased from 5 to 150 by the end of 2005. Over 1500 health workers were trained—29% of them were nurses and 18% were community workers.

Political will and support were the key factors in this achievement. Links with academic and research institutions also contributed to its success. The adoption of the IMAI approach enabled the integration of multiple HIV service components and was seen as a programme that could strengthen district health systems.

4.2 Priority elements of "Train"

Task-shifting emerged as an important focus for those concerned with training health workers to deliver HIV/AIDS services. Task-shifting includes enabling nurses to dispense ART as well as capacitating community workers to deliver a range of HIV services. This latter aspect has received much attention, and there are many successful country and project experiences to draw on. The challenges for task-shifting include ensuring appropriate quality and standardization of services. Recruitment criteria, certification and remuneration of community health workers are also essential. In some cases new enabling legislation will be required, for example to enable nurses to prescribe ART.

Care must be taken to avoid negative impacts of task-shifting on the wages and working conditions of trained nurses, doctors and technicians, and on their job satisfaction and morale. In some countries professional associations have resisted task-shifting for these reasons.

Other priority elements of Train were considered to be the revitalization of pre-service training and better coordination and management of in-service training programmes.

4.3 Priority actions in "Train"

The key to addressing training needs lies in coherent national HRH planning, policies and programmes. At country level there is a need for good cooperation between the ministries of health and education. Plans and programmes to capacitate health workers to deliver HIV services—pre-service and in-service training, and task-shifting—must be integrated into these overall HRH plans.

At the global level there is a clear role for agencies such as WHO to provide normative guidelines and common technical frameworks for the priority elements of Train such as task-shifting. Regional and south–south cooperation can also play an important role.

Action points:

i. *Training needs for scaling up HIV/AIDS services must be estimated at the national level and integrated into national workforce strategies.(This includes training of management and support workers as well as the clinical workforce.)*

ii. *Task-shifting: Policy issues regarding selection criteria, standardized training, certification and remuneration need immediate attention at the global and national levels.These should be informed by current best practice and lessons from the past three decades of practice in community health worker programmes.*

iii. *Task-shifting: Institutional capacities for accreditation and licensure/certification must be strengthened in the process of instituting systems-wide task-shifting policies.*

iv. *International agencies have a role to play in providing guidelines for task-shifting and other training needs.*

v. *TTR actors must advocate task-shifting at the global, regional and national levels.*

5. “RETAIN”

Retain includes a range of entry-stock-workforce issues related to retaining the health workforce in a context of HIV/AIDS.

5.1 Introduction

The Retain category is more complex than Treat and Train and covers several areas which are not HIV/AIDS-specific. Although there are already many actors focusing on general strategies for retaining health workers in places where they are needed (mainly low-income countries and rural areas), relatively little attention has been paid to the role of HIV either in the problem of retention or in the solution. There is a need for further conceptual work to identify ways in which AIDS issues and actors could and should relate to more general issues of retention.

Although the public–private balance and the rural–urban balance are seen as key aspects of retention, the HIV/AIDS-specific aspects of this issue need further attention. For example, the out-migration of health workers from the public sector to well-funded private and NGO-funded AIDS programmes is a growing problem in some countries, as are the numbers of workers leaving the profession for fear of infection, and because of stress, overload, stigma and dismissal.

HIV and AIDS have been shown to be a major cause of “wastage” of health workers. It is also evident that the AIDS crisis has catalysed positive action on health systems. In the best-case scenario, action on HIV/AIDS has led to new investments and a revitalization of health systems which in themselves are retention factors. A key challenge for TTR is to exploit this advantage to leverage maximum gains for health workers, health systems and people living with HIV.

The Malawi Emergency Human Resources Programme

Malawi has an HIV infection rate of 14% of the adult population and an estimated 90 000 deaths annually from HIV-related causes. Although there has been political will to address this crisis, human resources for health have been a major obstacle. Malawi has 1.1 doctors and 25.5 nurses per 100 000 of the population in comparison with South Africa which has 69.2 and 388, respectively.

The root of Malawi’s HRH crisis lies in long-term underinvestment in the health sector as well as a complex mix of factors fuelling the attrition and migration of health workers, in which HIV plays a large part.

The Malawian HRH crisis was thrown into stark relief when the government endorsed a commitment to ambitious scaling up of free ART by 2010. The 5-year scale-up plan was estimated at requiring 50% of the budget of a health sector that was already on the edge of collapse.

In February 2004, the Government of Malawi embarked on a US$ 273-million 6-year Emergency Human Resources Plan with funding from the UK government and the Global Fund to Fights AIDS, TB and Malaria. The programme is wide-reaching and aims to expand training capacity by 50%. Retention strategies include a 52% (taxed) salary top-up for 11 categories of health worker, rural location incentives and non-financial incentives such as improvements in staff housing. Stop-gap measures for external recruitment were used to fill critical posts.

Although in its early stages, the programme is already having a positive impact on recruitment and retention.

Questions hang over the sustainability of this programme and whether it will be possible to provide universal access to ART without undermining other health services. The need for huge increases in HRH as well as sustainable funding are other challenges that have yet to be overcome.

5.2 Priority elements of "Retain"

Strategies to retain health workers in rural areas and within the public health sector are priorities in Retain. Country-based retention strategies that reduce the push-factor for migration include improving the lives of health workers through financial and non-financial incentives, and improving jobs and the workplace environment. HIV plays a large role in these push factors in the worst-affected countries. In some countries the impact of HIV and AIDS on the health workforce has led to major national emergency plans to treat, train and retain health workers.

Improving the quality of the practice environment—including the implementation of comprehensive occupational safety and health programmes together with training, standardized procedures and an uninterrupted supply of commodities—is another priority at the country level. Reducing the risk of transmission of HIV and other blood-borne diseases will also depend on workplace policies being known, resourced and implemented.

Managing international migration is a priority of Retain. A wide range of actors and initiatives are already active in this field, in which AIDS actors have yet to define a specific role.

In recent years, new thinking about the development potential of migration has led to the growth of diaspora programmes. These include programmes for retaining skilled workers as well as strategies to enable skilled diaspora to contribute to their home countries. There are many lessons to be learned from decades of work in this area by organizations such as the IOM.

5.3 Priority actions in "Retain"

Understanding and meeting health workers' needs—both financial and non-financial—lie at the heart of any retention strategy at the country level. Participatory action research and the process of social dialogue can enable these policies. Empowering health worker associations for social dialogue was also seen as a means to tackle AIDS-related stigma. Workplace programmes which protect the health, safety and rights of health workers are an essential basis for action.

Many observers consider that training and other non-financial incentives are central to retention, and may even be of more value than financial incentives, although this should be the subject of further research. Whatever package is employed, incentives should be part of a national strategy and should be uniform, to avoid conflict and distortion.

Policies and Codes of Practice remain high on the global agenda for managing migration, and there are many stakeholders calling for stronger action and enforcement in both sending and receiving countries. There is a need to exploit HIV/AIDS-specific strategies in managing migration, for example in diaspora development programmes. Managing out-migration from the public health system to well-funded NGO and private sector programmes is a priority and its attainment may be assisted by national policies and international agreements.

Action points:

i. *Research into health workers' needs and problems is needed to identify the necessary elements of country-led retention strategies.*

ii. *A process of social dialogue will be necessary to facilitate the implementation of agreed retention strategies.*

iii. *Retention strategies at the country-level must be integrated into HRH planning and financing as well as national health and development plans and strategies.*

iv. *Comprehensive workplace programmes based on the ILO Code of Practice on HIV/AIDS and the world of work and the Joint ILO-WHO guidelines on health services and HIV/AIDS must be put in place.*

v. *Policies and strategies that specifically address HIV issues must be integrated into broader migration strategies.*

vi. *The impact of private and NGO AIDS programmes on HRH in the public health sector requires urgent investigation. Models of best practice for public–non-public partnerships in health and AIDS services must be identified and shared.*

vii. *Increase the numbers of health workers being trained, to compensate for the significant levels of out-migration that are likely to continue into the future.*

6. COST AND FINANCING

TTR has significant implications for global and national health financing approaches as it will require significant amounts of long-term and predictable financing.

6.1 Introduction

Financing for most elements of TTR will be included in the health sector financing policy, and management must be geared towards country-specific priorities.

Different sources of financing for HRH (and TTR) can be grouped into domestic sources, including taxation and improving current spending, and external sources, including borrowing and grant funding.

Major concerns and constraints in health sector financing include competition from other sectors, absorptive capacity, poor governance and constraints linked to sustainability and donor dependency. In many countries there is also a need to strengthen national frameworks for planning and coordination of financing, health spending and management of public funds.

International financial institutions continue to affirm that their goal is to help countries maximize fiscal space for health spending while maintaining macroeconomic stability. One concern expressed was that higher aid flows will create greater demands on national government macroeconomic policy, planning and management.

6.2 Costing TTR

Preliminary costings of a basic TTR package at the global level were presented to the Consultation.

Estimations were made for 60 countries and included a basic minimum package of Treat (cost of treatment for HIV-positive health workers; universal precautions and postexposure prophylaxis); Train (cost of training staff to deliver antiretroviral therapy); and Retain (financial incentives for all categories of health workers).

Different models and assumptions were used to produce estimates. The minimum was US$ 7.2 billion over the next 5 years to implement the plan in the 60 countries with the highest HIV burden, but it could cost substantially more—up to US$ 14 billion—depending on the mode of delivering services and patterns of task sharing among health personnel. This corresponds to an annual per capita cost of approximately US$ 0.60 in the countries concerned, or between two per cent and five per cent of the levels of health expenditure that are typical of low-income countries.

These estimates were intended as a rough indication of costs. Accurate costing will depend on the specific plan chosen, and must therefore be done at the country level. Different assumptions—such as models of care or levels of salary top-ups—and national priorities will result in a range of costings. For example, the Malawi and Zambia Emergency Plans were budgeted at about US$ 45 million and US$ 104 million per annum, respectively. However, the value of these rough costings is to demonstrate that a global TTR plan is affordable, and that costs could be covered within the increases in funding of the health sector that have been recommended in other fora.

6.3 Financing priorities

Fiscal space

The issue of fiscal space for health financing is an important one, and tends to lead to spirited debate.

Many health ministers stress that they are unable to expand HRH due to externally imposed fiscal ceilings. In their countries there may even be large numbers of unemployed health professionals alongside dramatic shortages of health workers and increased donor funding.

On the other hand, the Bretton Woods institutions affirm that they support the position that macroeconomic policy frameworks should not inhibit the use of sustainable additional resources.

There is an urgent need to clarify the misunderstandings about this topic so that challenges to the financing of HRH may be met.

Sustainable, predictable financing

The costing exercise suggests that the absolute cost of TTR will not be excessive, particularly in the context of the recent G8 commitment to scale up development funding, and the recommendation that health funding should account for half of ODA. However, if countries are to implement effective TTR measures, there will be a requirement for additional funding that is both sustainable and predictable.

Domestic funding, from predictable sources, such as taxation, is seen as the most appropriate for sustainable TTR plans. Other potential sources, such as savings from debt relief should also be explored as in the case of Zambia. Sub-Saharan African countries should be encouraged to meet the Abuja target of scaling up health budgets to 15% of GDP.

However many countries will continue to rely on donor funding. There is agreement that direct budget support and SWAps are the best approaches here. There is thus a need for donors to move away from project and pilot funding towards these approaches which have been recommended as good donor practice in a range of international fora.

There is general consensus that a new financing mechanism specifically for TTR actions would not be desirable.

Priority actions

Clear, costed HRH plans, including the full range of appropriate TTR elements are a priority for funding an AIDS Health Workforce plan at country level. These plans must be part of national financing and development instruments such as PRSPs and MTEFs.

At the global level there is an urgent need to resolve the misunderstandings over the issue of fiscal space and for a consensus to be reached.

TTR actors must advocate increased funding for TTR plans at the national and global levels.

Identifying sources of sustained and predictable funding for TTR, for HRH and for scaling up health and HIV services must become a priority on the global agenda.

Action points:

i. *Countries should cost the elements of TTR and include them in their HRH and other plans.*

ii. *A multi-stakeholder taskforce should be constituted with the remit of investigating country experiences of fiscal constraints on HRH expansion. This task force should provide findings on a policy recommendation that the health and education sectors should be exempt from macroeconomic policy constraints.*

iii. *A multi-stakeholder taskforce should be constituted with the remit of examining the options for sustainable and predictable sources of financing for HRH and other recurrent health system costs, including provision of ART.*

iv. *Global funding mechanisms for HIV such as the Global Fund and others should develop clear guidelines on access to their funds for the health workforce in line with the TTR plan and national HRH plans.*

v. *Best practices in expanding domestic sources for HRH, such as through taxation and debt relief must be identified and shared.*

7. DIVERSITY

The May Consultation provided an opportunity to hear from a wide cross-section of actors about the work they are already doing which could be seen to fall under the umbrella of TTR. Not only were they able to share the lessons learnt from their practices, but their different perspectives provided useful insights for TTR.

7.1 Perspectives

AIDS as a driver for strengthening health systems

Actors from the HRH and development fields tend to emphasize the idea that AIDS is a driver for strengthening health systems. AIDS has played a major and revealing role and has brought health issues to the forefront in the global discourse. This has led to unprecedented mobilization and leveraging of new funding. Country case-studies presented at the Consultation provided support for this view. For example, the Malawi Emergency Human Resources Plan was given impetus by the devastating impact of HIV and AIDS on the health system, as well as the extra needs for HRH created by the need to cope with the disease.

This perspective sees in TTR, an important opportunity to maximize AIDS as a driver for strengthening the health system as a whole.

Scale-up of HRH is a precondition for Universal Access

Actors from within the “AIDS silo” tend to focus on the additional human resources required to achieve universal access to HIV services.

This situation is particularly acute in the context of treatment, where coverage of ART has been shown to be directly related to the density of health workers. For example, Lesotho, which has a density of 20.9 health workers per 1000 people in need of ART has achieved only 14% coverage, whereas Uganda, with a density of 145.5 health workers per 1000 people has achieved 51% coverage.

From this perspective, it is clear that health systems must be strengthened to ensure universal access to AIDS services.

From tensions… to creative tension

These two perspectives are not mutually exclusive, nor do they represent divergent paradigms. However they embody some inherent tensions which emerged during the Consultation. These tensions—which can be characterized as the "AIDS–development divide"—can be described in different ways.

- AIDS versus health sector: AIDS is multisector and multistakeholder, but has a major job to do in the health sector. On the other hand the health sector is largely a single sector and is dependent on public sector planning, coordination and financing. The AIDS actors and the health sector must recognize the exceptionality of both—AIDS is not just another health matter, and it cannot be "fixed" in isolation; AIDS actors must consider the critical capacity needs in the health sector.

- Vertical versus horizontal: Verticality may be required to advance AIDS goals, but they should not be met by creating parallel health systems. The two approaches must be complementary, particularly with regard to financing mechanisms.

- Priority programmes versus HRH: Priority disease programmes may be part of the HRH problem, for example because they lead to "poaching" of health workers, or because workers are removed from their posts for "hotel" training. Priority disease programmes may also be part of the HRH solution by expanding the health workforce and empowering and valuing health workers.

TTR provides a new opportunity for resolving these tensions. This is because TTR is based on an understanding of the two-way relationship between AIDS and health systems. Unlike other diseases, AIDS, in the worst-affected countries, is destroying the very health systems needed to cope with it—and other diseases. The AIDS response also provides unique opportunities to strengthen health systems. Unlike other priority diseases, it manifests as many opportunistic diseases, and thus equipping the health system to deal with HIV and AIDS has wider spin-offs.

The exceptionality of AIDS and the urgency of the response that is needed have created an international climate that allows for exceptional action. Global commitments at the highest level, supported by national governments, international organizations, donors and civil society organizations have created the possibility of succeeding with bold new initiatives. Thus, AIDS exceptionality provides both the urgent need and rationale; and the opportunity for a health workforce plan that can build health systems while expanding access to HIV services.

However, HIV and AIDS cannot merely drive the rebuilding of the health systems of the past. In addition to strengthening pubic health systems and primary health care approaches, new strategies must be devised that enable us to place people at the core of the response; to move into the "hidden" territories of customary practices, law and beliefs which shape our health and health-seeking behaviour; and to develop new relationships between public and non-state sectors.

An AIDS health workforce plan provides effective entry points for strengthening health systems at the local, national and global levels. At the facility-level, the public health approach advocated by WHO strengthens health systems by empowering and equipping health workers to deal with a range of diseases. At the national level, TTR provides an effective entry point into health systems in terms of financing, commodities and governance. At the global level, TTR can be seen as a pathfinder for working together: for aligning programmes for tackling priority diseases with broader strengthening of health systems and for advancing global commitments on harmonization and alignment (the "Three Ones", Paris Declaration).

TTR thus emerges as providing a unique opportunity to exploit the synergies between AIDS advocates and the systems/health workforce approach and to turn tension into creative tension. For this to happen, TTR measures must be aligned with broader systems and stakeholders at the national level. At the country level a costed, prioritized and sustainable HRH plan is the key tool for this alignment.

7.2 Practices

What became clear from the contributions of the participants at the Consultation is that much valuable work is already being done which could be classified as TTR action. Many national governments, development agencies, civil society organizations and academic institutions have engaged to some extent with aspects of TTR. For example:

National plans and programmes for HRH: As described above, national governments are making and implementing integrated national emergency plans to strengthen their health workforce, including efforts to address low salaries and poor working and living conditions, as well as occupational risk.

Resource mobilization: Representatives of multilateral and bilateral donor organizations spoke of their investment in HRH, particularly in the training of health workers and lay providers. Others discussed new public–private partnerships which create new resources for HIV and HRH, such as co-investment programmes.

Advocacy: NGOs, organizations and representatives of health workers and people living with HIV described their advocacy and campaigns for taking action to strengthen health systems and the health workforce. International organizations are also involved in advocacy at the global and national levels.

Research: Governments, academic institutions, international trade unions and professional associations, NGOs and other organizations are engaged in research on HRH, monitoring equity in provision of ART and into barriers to access to ART by health workers.

Treating health workers: In addition to the programmes of national governments, organizations representing health workers, faith-based organizations and NGOs are engaged in advocacy and projects designed to expand access to ART for health workers and their families.

Training health workers: In addition to national government plans to boost pre-service and in-service training of health workers, donor agencies, international agencies, faith-based organizations and trade unions are active in the development and implementation of training programmes teaching health workers, community members and people living with HIV to deliver services.

Managing migration: Representatives of international agencies described policy and programming to manage the international migration of health workers including programmes to harness the skills of the health diaspora.

Occupational safety and health: International agencies are involved in advocacy, technical advice and normative guidelines for the implementation of occupational health and safety measures in the health workplace.

This rapid appraisal, although brief and incomplete, suggests that there is much work being done in these areas. However, the majority of practices were implemented on a project basis rather than being part of comprehensive and sustainable national programmes. The reports to the Consultation suggest that some areas are better covered than others. For example there seems to be a wide range of programmes for training health workers to deliver HIV services. On the other hand, programmes that directly address HIV/AIDS-specific impacts on health workers are less well represented.

7.3 TTR—building on diversity

The Consultation made it clear that there is a wide range of perspectives and approaches to HRH and AIDS issues. TTR is intended to find the synergies between these and create maximum synergy and energy to strengthen the health workforce in the context of AIDS.

In some instances TTR may be the catalyst for new actions—for example national emergency HRH plans may be expanded to include elements of Treat which will protect their health workers from HIV and AIDS. In other instances TTR could provide the climate for strengthening existing actions—for example expanding fiscal space for HRH.

By providing a platform for actors with diverse perspectives, TTR aims to generate energy from creative tensions and to assist national governments in rapidly scaling up human resources for AIDS while simultaneously building health systems.

Action points:

i. *A rapid appraisal of TTR activities already being undertaken at country level must be made. This would assist in identifying best practices and practices that are less effective. It will be important to identify all relevant actors, and to differentiate between the functions, coverage and knowledge base of professional associations and trade unions.[3] A rapid assessment could be conducted in two or three priority countries to establish a research protocol. This immediate action could lead to a consensus statement that would build policy and guidelines for TTR.*

ii. *The "TTR steering committee" must find ways of facilitating broad partnerships of "TTR actors"—from HRH and the HIV silo—at the global, regional, national and local levels.*

8. CONSENSUS

During the two-day Consultation there was consensus on the need for urgent and immediate action on the elements of TTR as described above. Consensus also emerged on the broad principles, priorities and challenges for the strategic operation of TTR.

8.1 Principles

General principles guiding the establishment of an AIDS Health Workforce plan emerged as:

The centrality of the health workforce. An understanding of the special needs of the health workforce, and their engagement will be essential to the success of TTR.

Country ownership and implementation. Ownership, political will and political leadership at the country level will be central to the success of TTR, which must become part and parcel of national HRH and development plans.

Alternative models of health care. Scaling up towards universal access will depend on alternative models of health care. Thus TTR actions must support these alternative models which include a public health approach, task-shifting and the involvement of people living with HIV and AIDS.

"AIDS speed". TTR is a response to urgently felt health needs and must be rapidly advanced. It must combine the coherence of a systems approach with "AIDS speed". To do this TTR should be characterized as an emergency programme.

Cooperation. TTR is not a stand-alone vertical initiative, but must find its place alongside and inside other initiatives such as the Global Health Workforce Alliance. This principle of cooperation also applies to TTR actions that are part of the core business of technical agencies, development partners and financing agencies.

Evidence and advocacy. TTR actions-plans must be evidence-based and informed by ongoing research, monitoring and evaluation. Advocacy for TTR will be based on economic and other evidence for its efficacy.

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3 Trade unions represent greater numbers of health workers, drawn from a wider range of occupations including doctors, nurses, laboratory technicians, administrators, cleaners and porters.

8.2 Priorities

The priorities identified by participants were:

TTR included in national plans. TTR plans must be drawn up at the country level and be part of costed national HRH plans which in turn are embedded in national development and financing instruments.

Rapid assessment. A rapid assessment at the country level is needed to examine current activities and to identify gaps and best practices. This would include an assessment of the state of HRH planning.

Financing. The problem of macroeconomic constraints on expansion of HRH must be resolved.

Priority elements of TTR. AIDS-specific elements of TTR that were seen as priorities were identified as:

- removal of barriers to access for health workers (Treat);
- task-shifting (Train); and
- "AIDS migration", or out-migration of health workers from the public sector to the private or NGO sector (Retain).

8.3 Challenges

There are several underlying challenges which must be met for TTR to be successful.

Political commitment. Political commitment, will and good leadership are essential if TTR plans are to become a reality at country level.

Government capacity. TTR will place an additional burden on government capacity which is already under pressure in many countries. As a multisectoral strategy, TTR places new demands on ministries of finance, health and education at the national level as well as on health governance at the district and local levels.

Sustainable financing. Sources of predictable and sustainable financing need to be available to enable countries to make ambitious TTR plans.

Technical support. The planning and implementation of TTR may create the requirement for additional technical support. Technical agencies may need to clarify the division of labour and ensure that they have adequate capacity to offer the necessary support.

9. THE WAY FORWARD

The AIDS and Health workforce plan must move from discussion to implementation. For this to happen there are some immediate steps to be taken.

9.1 Institutional and organizational arrangements

A "TTR steering committee" must be constituted to look at the next steps for the plan. Technical taskforces to look at the elements of Treat, Train, Retain—or at specific priority actions within the categories of Treat, Train, Retain, could also be constituted. The division of labour at global, national and local levels needs to be decided.

9.2 Priorities for immediate action

Priorities for immediate action must be decided. These could be priority TTR measures or priority countries.

9.3 Advocacy and advancement

The global agenda offers several opportunities in the near term to advance TTR. Some of these are:

- May 2006: World Health Assembly, Geneva
- May/June 2006: High-level meeting on AIDS at the UN General Assembly, New York.
- June 2006: Post High Level Forum on Health Millennium Development Goals, Tunis
- July 2006: G8 Summit in St Petersburg
- August 2006: International AIDS Conference, Toronto

10. SUMMARY OF ACTION POINTS

1. National governments should receive all the assistance they need to develop TTR plans according to their national priorities.
2. TTR actors must advocate for any TTR plan at the country level to be integrated into pre-existing country planning and funding instruments, including HRH planning, SWAps and poverty reduction strategies.
3. The High Level Forum on Health should convene a forum to develop mechanisms for partnerships between TTR (and other priority disease) actors and global health partners.
4. Opportunities to advocate for TTR and all its elements at the global, regional and national levels must be identified and exploited.
5. Comprehensive workplace policies based on the *ILO Code of Practice on HIV/AIDS and the world of work* and the *Joint ILO-WHO guidelines on health services and HIV/AIDS* must be put in place.
6. Countries affected by HIV must compile comprehensive data that shows the impact of HIV on the health workforce as well as the numbers of health workers accessing services.
7. Country level: existing AIDS and HRH programming and strategies need to include targeted campaigns for health workers infected with and affected by HIV.
8. Regional level: Best practices in expanding access to HIV services for health workers must be identified and shared.
9. Global level: International agencies and academic institutions must assist in drawing up guidelines for effective Treat programmes.
10. The "TTR steering committee" or coordinating body must work with country leaders to identify countries for pilot implementation of TTR plans and programmes.
11. Training needs for scaling up HIV/AIDS services must be estimated at the national level and integrated into national workforce strategies.
12. Task-shifting: Policy related to selection criteria, standardized training, certification and remuneration needs immediate attention at the global and national levels. Policies should be informed by current best practice and lessons learnt from the past three decades of practice in community health worker programmes.
13. Task-shifting: Institutional capacities for accreditation and licensure or certification must be strengthened in the process of instituting systems-wide policies on task-shifting.
14. International agencies have a role to play in providing guidelines on task-shifting and other training needs.
15. TTR actors must advocate for task-shifting at the global, regional and national levels.
16. Research into health workers' needs and problems is needed to identify the necessary elements for country-led retention strategies.

17. A process of social dialogue will be necessary to facilitate the implementation of agreed retention strategies.
18. Retention strategies at the country level must be integrated into planning and financing for HRH as well as into national health and development plans and strategies.
19. Comprehensive workplace programmes based on the *ILO Code of Practice on HIV/AIDS and the world of work* and the *Joint ILO-WHO guidelines on health services and HIV/AIDS* must be put in place.
20. Policies and strategies that specifically address HIV issues must be integrated into broader migration strategies.
21. The impact of private and NGO programmes on AIDS on HRH in the public health sector requires urgent investigation. Models of best practice for public–non-public partnerships in health and AIDS services must be identified and shared.
22. Increase the numbers of health workers trained, to compensate for the significant levels of out-migration that are likely to continue into the future.
23. Countries should cost the elements of TTR and include them in their HRH and other plans.
24. A multi-stakeholder taskforce should be constituted with the remit of investigating country experiences of fiscal constraints on HRH expansion. This task force should provide findings on a policy recommendation that health and education sectors should be exempt from macroeconomic policy constraints.
25. A multi-stakeholder taskforce should be constituted with the remit of examining the options for sustainable and predictable sources of financing for HRH and other recurrent health system costs, including provision of ART.
26. Global funding mechanisms for HIV, such as the Global Fund and others should develop clear guidelines on accessing their funds for the health workforce in line with the TTR and national HRH plans.
27. Best practices in expanding domestic sources for HRH, such as through taxation and debt relief must be identified and shared.
28. A rapid appraisal of TTR activities already being undertaken at the country level must be made. This would assist in identifying best practices and those that are less effective. A rapid assessment could be conducted in two or three priority countries to establish a research protocol. This immediate action could lead to a consensus statement that would build policy and guidelines for TTR.
29. The “TTR steering committee” must find ways of facilitating broad partnerships of “TTR actors”—from HRH and HIV silos—at the global, regional, national and local levels.

Annex A: DISCUSSION PAPER

1. INTRODUCTION

"Despite increased discussion about the incapacity of health workers … to cope with the epidemic … few, if any, bold measures have been undertaken by the international community or by national partners to address the major factors underlying this constraint."

Global Steering Committee on Scaling Up Towards Universal Access, January 2006 [1]

"Treat, Train, Retain" is a proposed global plan to address the health workforce crisis in countries severely affected by HIV and AIDS. It will initially focus on selected high-burden countries. In addressing both the causes and effects of HIV and AIDS, an important component of the strategy will be to scale up services for HIV and AIDS towards universal access.

Although the plan emerges from the challenge of global commitments to universal access, it will not be a vertical, stand-alone programme but rather will be aligned with current work in all areas it encompasses. In particular, it will be lined up with the initiatives to strengthen health systems, and to embed health-system-strengthening in national poverty reduction and development strategies.

It comprises three main elements:

Treat (prevention, care & support) – a full package of HIV and AIDS prevention, care & support and treatment for health workers;

Train – strategies to scale up human resources for health needed to reach the goal of universal access as close as possible, and to empower the current health workforce to deal with HIV and AIDS. These strategies include planning as well as approaches to expanding the health workforce through recruitment and task-shifting, and encompass pre-service and in-service training;

Retain – a package of measures that will enable health systems to retain health workers in a time of AIDS; including incentives to retain workers, occupational safety and other workplace issues as well as initiatives to manage the migration of health-care workers.

Box 1. Definitions

Health systems strengthening *includes initiatives to strengthen the key components of health systems, which range from policy and financing to human resources, service management, supply systems, information and monitoring. Improvements must be shared across the services and sustained over time.*

Human resources for health *(HRH) are the people who make health care happen. They include dentists, nurses, midwives, pharmacists, physicians, auxiliary health-care workers, community health workers, traditional medicine practitioners, technicians and other lower-level cadres.*

The health workforce *includes all workers in the health system from health professionals (like those above) to a wide range of administrative, semi-skilled and unskilled workers.*

The health sector *includes organized public and private health services (including those for health promotion, disease prevention, diagnosis, treatment and care); health ministries; nongovernmental organizations (NGOs); community groups; and professional associations; as well as institutions that directly contribute to the health-care system (e.g. the pharmaceutical industry and teaching institutions).*

A coherent strategy to equip the health workforce to scale up towards Universal Access (UA) will have to be broad and multifaceted and will depend on the scaling up of current initiatives both within and outside of the AIDS sector. It will therefore include the coordination of many partners at different levels who are already engaged in related activities. In addition, new elements and actions specific to HIV/AIDS will be integrated into current initiatives.

1 *Global Steering Committee on Scaling Up towards Universal Access.* Issues Paper for Meeting of 9-10 January, 2006

2. BACKGROUND AND CONTEXT

In the past few years parallel initiatives to strengthen health systems in poor countries, and to scale up the AIDS response have intensified. These two approaches—which can be loosely characterized as a "systems approach" and a "vertical approach"—have developed separately, to the detriment of both.

This section aims to show that an AIDS-related strategy to strengthen the health workforce is an essential element of health systems strengthening in high-prevalence countries.

2.1 "The HRH "systems approach"

The Millennium Development Goals (MDGs) have provided the vision and impetus for a growing global movement around the issue of health systems strengthening in low-income countries. Three high-level forums on progress towards the Health MDGs (Geneva, January 2004; Abuja, December 2004; Paris, November 2005) focussed increasingly on the issue of human resources for health (HRH), and in particular on the HRH crisis in Africa—*inter alia* an estimated shortfall of 1 million health workers—which was seen as requiring exceptional action. A series of African consultations and meetings have taken place alongside these forums, with the African Union playing a key facilitating role.

These discussions have focused on the central role of country-led policy, planning and implementation of strategies to strengthen health systems and human resources for health. The meetings have discussed a wide range of issues, including:

- The importance of embedding HRH plans in national poverty-reduction plans, particularly poverty reduction strategy papers (PRSPs);
- Funding – many donors reported that they were reforming their financing policies to allow the funding of recurrent costs to meet the human resources (HR) crisis; the Global Fund clarified that it would welcome proposals that include the training of health staff;
- Measures to improve the performance of health systems that include increasing salaries; improving working and living conditions of health workers; and expanding training;
- Migration of health workers: improving database, policy options for managing migration, etc.[2]

The outcome has been a new global architecture and action plan for strengthening human resources for health. For example:

Global Health Workforce Alliance

This global platform for human resources for health was launched in May 2006. It is not a new independent global entity but a consolidation of actors already working together in support of country and regional activities. It is a mission-driven (10-year time-driven) partnership of key stakeholders aimed at strengthening health systems and priority programmes. Its main functions will be to promote learning and support to countries through small grants linked to technical support. It will include fact-finding, sharing of information and knowledge, advocacy, coordination, monitoring and evaluation and support to country work. These activities will be aimed at strengthening systems development, harmonization and aid effectiveness.

African Observatory on HRH

This is a technical facility servicing countries and regional networks and monitoring good and bad practice;

African Platform for HRH for Health Development

This will be a network of key institutions that will articulate a common position and voice and engage countries and international partners.

2 The IOM, ILO, International Monetary Fund and World Bank are also contributing to significant new initiatives around this issue.

The Transitional HRH Working Group, formed in April 2005 to take these plans forward has proposed[3] specific deliverables for a two-year period. These are:

- A dozen countries with sound HRH plans under implementation and harmonized with stakeholders and allied activities;
- The establishment of a global focal point for information-sharing and exchange;
- Global forums for all stakeholders to report in progress, share lessons and create a community of HRH practice;
- Promotion and advocacy of HRH issues;
- Networking and promotion among Southern and Northern leaders in key domains such as migration and fiscal space.

A recurrent theme in the above meetings has been the sometimes challenging relationship between Global Health Initiatives (GHIs)and broader health systems strengthening (the "systems" versus the "vertical" approach). WHO has described many ways that GHIs can contribute to health systems strengthening.[4] Some examples are:

- Development of comprehensive HRH strategies to combat priority health problems within the context of the overall health strategy;
- Creation of new, intermediate cadres of health with the necessary skills;
- Clear salary, workplace safety and other incentive policies, as well as more coordinated in-service training;
- Harmonization of salary and other incentives offered by all service providers;
- Efforts by the public sector to work more effectively with private health workers;
- Alignment of priority health HRH strategies with overall health strategy.

On the other hand, GHIs should avoid investing in projects that focus on single solutions without indicating how other HRH needs are being addressed.

An AIDS health workforce initiative that conforms to these principles presents a unique opportunity to use the AIDS response to strengthen health systems. By safeguarding the health workforce, and maximizing its efficiency, it performs the dual role of health systems strengthening and scaling up access to AIDS services.

2.2 Universal access to HIV and AIDS services

As the AIDS epidemic has continued to spiral in sub-Saharan Africa, the epidemic of impacts has unfolded. A large body of literature has pointed to the fact that reversing the spread and impact of AIDS is not only a Millennium Development Goal in itself, but the route to reaching five other MDGs. This means that not only must health systems be strengthened to reach the MDGs, but they must be provided with capacity to deliver quality HIV and AIDS services when and where they are needed.

Out of the energy generated by WHO's "3 by 5" Initiative, a strong global movement towards universal access to antiretroviral therapy and other services has emerged. This was embraced by the G8 at Gleneagles in 2005, and subsequent meetings led to the formation of a Global Steering Committee on Scaling up towards Universal Access (GSC – facilitated by the UNAIDS Secretariat) to oversee this commitment. Central to all these discussions was the acknowledgement that country leadership and ownership would be the key to scaling up towards universal access, and that the strategy could only be successful if integrated into broad development and poverty-reduction planning and processes.

By December 2005, the commitment towards UA had been endorsed by all United Nations Member States and embedded in a United Nations General Assembly Resolution (A/60/L.43). The General Assembly:

3 *Working together to tackle the crisis in human resources for health.* A report of the transitional HRH Working Group to the High Level Forum. Paris, 14-15, November 2005.

4 *Opportunities for Global Health Initiatives in the health system action agenda.* Working paper 4. Making Health Systems Work (Draft). Geneva, World Health Organization, 2005.

"…Request[ed] that the secretariat of the Joint Programme and its co-sponsors assist in facilitating inclusive, country-driven processes … for scaling up HIV prevention, treatment care and support with the aim of coming as close as possible to the goal of universal access to treatment by 2010, for all who need it … also request[ed]… an assessment of these processes, based on inputs received from Member States, including an analysis of common obstacles to scaling up and recommendations for addressing such obstacles, as well as accelerated and expanded action".

2.3 AIDS and health systems—a vicious circle

It is widely acknowledged that weak health systems, in particular scarce human resources for health, are a major barrier to scaling up the AIDS response, and indeed the UNAIDS Global Steering Committee has ranked this as one of five major obstacles to scaling up.

While the additional health personnel requirements to scale up towards universal access have not been accurately estimated, they are likely to place an enormous stress on health systems. WHO estimated that there was a need to train an extra 100 000 health workers, just to reach the 3 million treatment target.

However, the ability to respond to this need for health workers is being undermined by the epidemic itself. Recent research has identified HIV/AIDS as a major emerging source of "wastage" in human resources for health.[5]

- Mortality: Various studies have documented rising mortality statistics among health-care workers in an era of HIV, and the World Bank has estimated that a country with 15% adult seroprevalence rate can expect to lose up to 3.3% of its health-care providers from AIDS annually. A 2002 South African study showed that 16.3% of the health-sector workforce was HIV-positive—13.7% of professionals and 20.3% of non-professional staff.[6] Even though prevalence may be higher among unskilled staff, the loss of just a few highly skilled professionals has a serious impact on weak health systems. A recent study[7] of a cohort of Ugandan doctors graduating from one medical school showed that 16 out of 77 died of AIDS-related causes over a 30-year period.
- Loss of productivity: Absenteeism and low productivity of ailing workers, as well as those who are caring for sick relatives, has been noted in many studies.[7] Reports indicate that the average person living with HIV can be absent for up to 50% of their final year of life. One study in Botswana estimated that the public health sector could lose 57 000 work days in 2005 to AIDS-related absenteeism.
- Demoralization: In addition to loss of personnel and productivity, fear of HIV infection, stress and burnout have been shown to cause out-migration from public health services in AIDS-affected communities. In the South African study, 33.8% of health-care workers complained of low morale, with 16.2% being treated for stress-related illnesses in the past year, and 63.9% having taken sick leave; and this was attributed directly to the added burden of AIDS.
- New research also suggests that the negative impacts of HIV/AIDS have changed the way young people see health work, and it may no longer be a desirable career choice in some countries.[8]
- Skills deficit: Not only does the burden of disease place impossible stress on the health-care system and its workers, but new competencies are required to deal with HIV/AIDS. The complex nature of HIV/AIDS means that health personnel require a wide range of new competencies to deal with all associated diseases of AIDS.

Thus, on the one hand, scaling up towards UA to AIDS services is a prerequisite to reaching the MDGs; and on the other hand, the health systems required to do this are weakened by the very disease they must contain, and are in need of strengthening.

Health-care workers are at the centre of this vicious circle. A strategy to protect and strengthen the health workforce in the context of AIDS represents one way of breaking it.

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5 Summarized in Dovlo D. Wastage in the health workforce: some perspectives from African countries. *Human Resources for Health. 2005, 3:6 and Evidence base for the impact of HIV upon health systems.* John Snow, Inc. (UK) and HSRC, commissioned by DfID, February 2003.

6 Letlape L, Shisana O. *Impact of HIV/AIDS on the South African Health Work Sector.* Presented at the Commonwealth Secretariat Meeting, Cape Town, April 2005.

7 Reviewed in Tawfik L, Kinoti S. *The impact on health systems and the health workforce in sub-Saharan Africa.* Prepared for USAID, June 2003.

8 Unpublished research on attitudes to health care in Zambia, Norbert Dreesch, personal communication.

2.4 An AIDS health workforce plan can strengthen health systems

The verticality of the AIDS response is often seen as dissonant with the HRH systems approach. However, from the above it is clear that an AIDS health workforce plan may be a viable entry point to strengthening health systems in the worst-affected countries. In particular, when the health system benefits of reducing "wastage" of health workers, and decongesting hospital wards and clinics are considered, the dichotomy between universal access to AIDS services and health systems strengthening may prove to be a false one.

Not only are there benefits "by default", as described in the paragraph above, the AIDS response may also have positive outcomes for health systems. The experience of "3 by 5"[9] suggests that scaling up access to care and treatment in itself has provided significant new opportunities for health systems strengthening in many countries. For example:

- Drug procurement and supply systems: A key objective of AIDS Medicines and Diagnostic Services (AMDS) has been to ensure that investments made in systems to procure and distribute antiretroviral drugs also build local capacity for other medicines. AMDS partners have trained over 500 supply chain managers from 74 countries.

- Human resource capacity: Strategies to maximize human resources include a range of approaches to expanding the scope of people who can deliver HIV/AIDS services. Task-shifting has upgraded skills of nurses and other health professionals, and at least 25 000 health and community workers have received training. In particular, 29 countries have adopted the WHO Integrated Management of Adult and Adolescent Illness approach (IMAI – see below), which teaches health-care workers essential skills, not only to deliver ART but for chronic care in general.

- Integration of HIV and AIDS with other programme services: "3 by 5" has highlighted the importance of using existing opportunities and health infrastructure to deliver ART and scale up HIV prevention. In particular, tuberculosis (TB) programmes have emerged as important partners. ART services have also been integrated into reproductive health and maternal and child health services to the benefit of all.

Thus, there are clear synergies between the two approaches, and these need to be further explored. The AIDS Health Workforce plan provides one opportunity to do this.

3. TREAT, TRAIN, RETAIN

The proposed AIDS Health Workforce plan comprises a menu of options for strengthening human resources in the context of AIDS. For convenience they may be grouped into three categories under the headings "Treat, Train and Retain". (There is some overlap between these categories.)

Aspects of these three components are already part of the ongoing work of international and country partners, while some are recent and therefore require strengthening. Very few are completely new elements. The challenge of this plan is not so much to design a new package, but one of catalyzing, coordinating and maintaining momentum of diverse players.

3.1 "Treat" (prevention, care & support)

The health workforce must have the skills and opportunities to protect themselves from HIV and AIDS. The proposal is for a complete package of prevention, care & support and treatment interventions for the entire health workforce, including non-professional categories. This includes:

- Prevention awareness campaigns. Especially designed HIV prevention campaigns may be needed for professional staff.
- Counselling and testing. Current campaigns need to find ways of specifically reaching out to the health workforce.

9 *Progress on Global Access to HIV antiretroviral therapy.* Geneva, World Health Organization (draft report, December 2005)

- Universal access to prevention, treatment and care. Priority access for health care workers has long been debated and should not be seen as an ethical issue, but a precondition for safeguarding the health workforce. The possibility of extending treatment to the families of health-care workers may also be explored.
- Post-exposure prophylaxis (PEP)
- Protection from HIV transmission in the health-care environment.

Demand-side barriers to accessing treatment are of major importance and must be given priority in any strategy.

Confidentiality—a barrier to access

Situated as they are in the heart of the health services, it could be assumed that health workers have unlimited access to the HIV services they need. However, stigma and fear of disclosure present major barriers for health-care workers to make full use of prevention, treatment and care services in their own workplace.

Though it has not been well-documented, there is anecdotal evidence that points to it being a widespread problem. The International Council of Nurses agrees that fear of disclosure is a major obstacle for health workers because they must "stand in the same queue, at the same health-care facilities as their patients, which undermines the relationship of trust and authority fundamental to their effectiveness in health care." [10]

Because of this, special strategies must be employed to encourage health-care workers to access services. "Know your status" and "Disclosure and acceptance" campaigns may be geared specifically towards health-care workers. Good leadership at health facilities may facilitate these and other campaigns to reduce stigma. Such strategies will only be effective when job security is guaranteed by adequate workplace policy (see below).

One practical approach to protect the confidentiality of health-care workers is for agreements to be made between neighbouring sites to swap health workers in need of treatment and care. Special arrangements for time off and transport may need to be made to facilitate this. However, the benefits of this low-cost, integrated approach will have to be assessed against its efficacy. The International Council of Nurses advocates the establishment of separate sites for health-care workers, and is working with the Government of Swaziland and the Zambian Council of Nurses in establishing the first dedicated centres in their countries.

There is an urgent need for more research on what health-care workers need, and how effective campaigns may be designed and implemented. Professional associations may be best placed to undertake this.

Occupational health and safety

There is an urgent need to implement occupational health and safety measures across the health service in high-burden countries to protect health workers from work-related infections. The International Labour Organization (ILO)/WHO guidelines include policy and training for safe work practices such as:

- Safe handling of disposable sharps and injection equipment;
- Cleaning, disinfection and sterilization;
- Cleaning blood spills;
- Body handling and disposal;
- Laundry;
- Waste management;
- Access to commodities such as personal protective equipment such as gloves, gowns and masks;
- Post-exposure prophylaxis; and
- Hepatitis B vaccination.

Not only are these measures the human right of health workers, but a safe working environment will also contribute to retaining health workers who fear HIV-infection (see below).

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10 *Healthy and valued health workers are essential to save health systems in sub-Saharan Africa.* International Council of Nurses calls for immediate access to treatment for all HIV-positive health care workers in sub-Saharan Africa. Geneva, ICN, December 2005 (Press Release).

3.2 "Train"

In many countries, the AIDS crisis has created requirements for large numbers of health-care workers who are appropriately trained. Strategies to expand numbers and maximize the efficiency of the existing workforce must be implemented across high-burden countries. Emergency measures, such as the temporary recruitment of expatriate workers, may need to be considered.

Pre-service training

Estimates and plans for enlarging the health workforce to meet the needs of the UA response must be made at country level and integrated into overall education and HRH planning, budgeting and national poverty reduction strategies. Planning may include the expansion of medical and nursing schools and the recruitment of new staff.

In addition to expanding numbers, pre-service training must be revised to include AIDS competencies for all categories of health-care workers. Countries must identify competencies required and train all health workers to met AIDS-specific needs in harmony with the demands of other priority health programmes.

In-service training

In-service training presents opportunities to both empower health workers to deal with HIV and AIDS, and to maximize efficiency in delivering HIV services in the health workforce.

WHO has pioneered "a public health" approach to AIDS service delivery that is both decentralized and integrated, and maximizes the efficiency of the current health workforce. The Integrated Management of Adult and Adolescent Illness (IMAI) training approach provides short, efficient training courses that teach health-care workers essential skills.

The model promotes an integrated service delivery model that covers the continuum of HIV prevention, care and ART in the community—at first-level facilities and district hospitals. The IMAI approach helps to alleviate human resource limitations by shifting tasks such as full management of uncomplicated HIV management to nurses; treatment support, drug refills and simple monitoring to the community, and by empowering patients in self-management. It also supports the involvement of people living with HIV and AIDS both as expert patient trainers and as members of clinical teams.

Task-shifting from more specialized to less specialized health workers (i.e. from specialists to physicians; from physicians to nurses, from nurses to community workers) has an important role to play in maximizing health-system capacity. People living with HIV (PLHIV) also play a valuable role in providing feedback to health professionals and increasing treatment compliance.

Training PLHIV and lay people to perform counselling and other services represents an important way both of expanding human resources for health and of building bridges between the public health system and the community. The challenge here is to expand resources without compromising quality of service. A standardized and systematized programme for training lay health workers has to be considered to guarantee minimum standards of care.

Clinical mentoring is an important part of the IMAI approach. It is a cost-effective system of continual practical training that fosters professional development. A clinical mentor is a clinician with substantial experience in prevention, AIDS treatment and care who is able to provide continual mentoring to less-experienced health workers, both in the form of regular site visits and by continual telephone and e-mail consultations.

The IMAI approach has been adopted by 29 countries. Other countries and projects, for example Malawi and the Free State province of South Africa, have implemented other service delivery models that include integration, decentralization and task-shifting.

3.3 "Retain"

This includes national and international policies and strategies to manage migration; workplace strategies and policies to reduce the "push" factor in migration and to support HIV-positive health workers. It also includes incentives to retain health professionals in the public health system.

Comprehensive guidelines on health services and HIV/AIDS have been drawn up by the ILO and WHO [11] that cover many of the points below. The implementation of these guidelines in high-burden countries will go a long way toward retaining the existing workforce.

Migration

The global discourse on managing migration has advanced considerably in the past two years and there is a range of initiatives and players exploring policy options needed to manage migration of health-care workers from low-income to high-income countries. The International Organization for Migration (IOM), WHO and the ILO have been central to these. Policy options that have been discussed include: [12]

- Harnessing the Diaspora to strengthen workforce capacity by, for example, return of qualified nationals, exchange programmes and mechanisms to attract trained professionals to their country of origin;
- Ethical codes of recruitment that recognize the loss of human capital for low-income countries and the need for various forms of compensation. These can take the form of bilateral or multilateral agreements;
- Human resource information systems and a database for the health sector and international migration of skilled workers;
- Developing exchange programmes through bilateral training agreements;
- Recruiting from abroad to provide temporary relief for shortages.

Much of the discussion and policy work has focussed on migration from low-income to high-income countries. However, in the AIDS sector, migration from the public health system to better-resourced private sector and NGO AIDS projects in the same country or region is a potentially greater problem, and is not well documented. For example, in the Masaka region of Uganda, doctors have been lost from 10 out of 21 to private projects in the past one and a half years.[13] Specific strategies to manage migration within the AIDS sector may have to be considered.

Workplace issues

Improving stress and countering burnout is central to retaining health-care workers in high-burden countries.

The ILO/WHO guidelines include the following aspects:

- the provision of appropriate staffing levels;
- reforming shift patterns;
- work rotation;
- promotion and personal development;
- early recognition of stress;
- development of communication skills for supervision;
- staff support groups; and
- time away from the workplace.

Many programmes offer psychosocial support and counselling to health workers. The Free State provincial ART programme in South Africa, for example has identified a number of key strategies to improve staff morale and motivation that have been successful in retaining staff. Central to these are leadership, encouragement and support of national, provincial and district health management. This includes regular "support visits" to sites by provincial staff as well as continual clinical mentoring.

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11 *Joint ILO/WHO guidelines on health services and HIV/AIDS.* Geneva, ILO, 2005. (TMEHS/2005/8)

12 *The migration of health care workers. The need for coherent policies and management frameworks.* Geneva, IOM, December 2005

13 Telephone interview, Dr Mugisha, January 27.

The IMAI training includes sessions on team-building and skills to prevent and manage stress and burnout.

Support for HIV-positive staff and families

Workplace policies that guarantee job security, prohibit discrimination, and support HIV-positive staff must be developed and implemented. These will have the added spin-off of motivating staff to access testing and counselling; care and treatment facilities, and other prevention services. They include:

- access to social benefits such as sick pay, insurance and other statutory benefits;
- practical adjustments such as extended sick leave, modification of tasks and jobs, rearrangement of working hours, part-time work and flexible return-to-work arrangements.

3.4 Financial incentives

Financial incentives have been proposed as a mechanism to retain staff in the public health sector. For example, the UNAIDS Resource Needs document envisages donor support to low-income countries to reduce the wage differentials with middle-income countries, by providing wage benefits for skilled staff. Such a programme would only be viable if applied across the health sector as a whole, and would be very costly (the “AIDS quota” alone is estimated at US$ 1.561 million for three years).[15]

One example of such an approach is the Malawian Government’s Emergency Human Resources Programme, which is funded by DFID and the Global Fund. It includes: improving incentives for recruitment and retention of Malawian staff by 52% gross salary increases for 11 selected professional and technical categories; external stop-gap recruitment of physicians and nurses; and significant expansion of domestic training capacity. Up to US$ 98 million will support salary top-ups, with a further US$ 35 million for improved staff housing, and US$ 64 million earmarked for expansion of training capacity. By the end of 2005, some 5400 doctors, nurses and other key staff were receiving the salary top-up and there had been a reduction in the outflow of staff from the public sector.

3.5 Non-financial incentives

Non-financial incentives may be more practical and cost-effective in low-income countries. These include career and training opportunities, transport and accommodation and other benefits, treatment access for family members.

4. NEXT STEPS – PROCESS

A broad health workforce plan in the context of AIDS will have to operate at many levels, and with a wide range of partners. Coordinated action is needed at local, district, country, regional and global level; by health-sector personnel, national government departments, bilaterals, multilateral organizations, donors, NGOs and the private sector, etc. These need to be identified and understood.

The first step will be to convene a consultation of key partners and actors. WHO recommends that this be held in May 2006 in Geneva. The aim of the consultation is to agree on broad processes and structures. The hosting agency or body will also need to be agreed at this stage.

Some immediate issues to be considered concern the alignment or integration of the AIDS Health Workforce Initiative with current global HRH initiatives. As far as the three components of the strategy are concerned, key actors and agents, at different levels (multilateral, national, etc.) will have to be identified according to their comparative advantage. For example, at multilateral level the agreed division of labour for AIDS[16] prescribes the roles of different international agencies engaged in AIDS-related activities. At country level, key ministries and relevant bodies, such as the National AIDS Authority will need to be identified. The role of the private sector, NGOs, faith-based organizations (FBOs), community-based organizations (CBOs) will vary according to the action, but models for collaboration will need to be explored.

Other steps to be completed before moving to implementation are:

- To draw up a complete menu of the different elements of all three components of the "Treat, Train, Retain" plan.
- To identify the elements that are already part of the core business of partners (or should be), and how these can be integrated and strengthened in their continuing work.
- To identify elements of the initiative that are new, and how these could be developed and implemented. In some areas (e.g. tailoring prevention campaigns to health professionals), additional development may be required. Some questions may need to be answered by operational research.

Given this initiative's wide reach, it will be necessary to prioritize actions. For instance, priority countries could be identified based on need, political will and current engagement with the issue. Malawi and Mozambique, for example, are both high-prevalence countries, and are already actively engaged in HRH reform.

Key actions could also be prioritized. This could be guided by the Working Group of the Global Steering Committee for Human Resource Capacity and Health System Strengthening. This group, facilitated by UNAIDS, is engaged in identifying priority actions for the global community to undertake in relation to health systems strengthening (and other challenges towards UA). Their selection is based on country and regional consultations, which has obvious benefits.

4.1 The comparative advantage of WHO

WHO has been an active player in the recent initiatives around human resources for health, and has made this issue the subject of the *World Health Report 2006* and World Health Day. In particular, the Evidence and Information for Policy Cluster (EIP) in WHO has played a leading role in the global dialogue around HRH and has also housed and led the African Working Group on African Regional HRH Observatory for the first year. The Human Resources Department of the EIP cluster has also led the Transitional HRH Working Group, which has reported to the High Level Forum on HRH in Paris in 2005. WHO/EIP and the WHO Regional Office for Africa HRH division have also worked closely with the African Union/Nepad to advance HRH action on the continent. At country level, the WHO Regional Office for Africa HRH division has been working with Member States to analyse their HRH situation and plan new strategies.

Thus WHO expertise will be essential in ensuring that the AIDS Health Workforce plan is aligned with the current global HRH movement, and that new activities will be integrated into ongoing activities.

The WHO/HIV department is widely acknowledged as the technical leader in the field of HIV and AIDS treatment and care. Experience gained in rolling out ART during the "3 by 5" programme has provided both the impetus and expertise for scaling up and enhancing human resources for AIDS. Based on the experience of "3 by 5" and in particular the lessons learnt from district-level implementation of the IMAI package, the WHO/HIV department has a comparative advantage in several areas. Many of these are the new or neglected elements, such as:

- Advocacy, design and implementation of priority prevention, treatment and care programmes for health workers;
- Advocacy, policy and implementation of a "public health" approach—involving decentralization and integration as well as task-shifting, which will be central to expanding human resources for AIDS.
- Revision of current training programmes—at pre-service and in-service levels to include modules that will empower health workers to care for their own health in a time of AIDS.

5. CONCLUSION

The crisis in human resources for health is an obstacle to attaining both the goal of Universal Access to AIDS services, and other MDGs. A broad, multi-faceted AIDS Health Workforce plan is an obvious way to break the vicious circle between weak health systems and the impacts of the AIDS epidemic in high-prevalence countries. It also provides an entry point to align "health systems approaches" and "priority disease approaches"—to the benefit of both.

In conclusion, by capturing global energy and commitment towards Universal Access to AIDS services, this plan has the potential to galvanize global action around health systems strengthening.

Annex B: TREAT

Health workers in high-prevalence countries experience the full impact of HIV and AIDS, both in their work and in their personal lives, where they experience illness and death as do those for whom they care. This human tragedy, which literature extensively documents,[1] has the additional effect of weakening the very health systems that are needed to deliver HIV services.[2]

Health workers, including the large force of community workers who deliver services, must be protected from HIV and AIDS. This is their right as well as a necessary strategy to safeguard the health systems that are needed to deliver health services, including antiretroviral therapy (ART), towards universal access.

This paper describes elements of a comprehensive package of prevention, care and treatment for health workers. It also outlines some of the major financial, policy, technical and research challenges that such a programme will entail. As a rapid review of relevant issues and current practice, this paper is by no means comprehensive, and indicates a further research agenda. The joint WHO consultation on *AIDS and Human Resources for Health,* which includes a wide range of participants, is proposed as an opportunity to expand on the information provided here.

1. HEALTH WORKERS AS A VULNERABLE GROUP

Sexual transmission of HIV is the major cause of HIV among health workers in high-burden countries. Since the majority of health workers are women, they experience the additional vulnerability that comes from gender inequality and biological factors.

It could be assumed that health workers are better informed about HIV and AIDS than the general population and are therefore more able to protect themselves from infection. However, there is little research to bear this out: AIDS-related illness and death is a major cause of wastage of health workers in high-burden countries.

In some ways health workers can be seen as even more vulnerable—both to HIV and to the impacts of AIDS—than the general population that they serve. First, health workers experience HIV risk in health-care settings. Second, once infected, it may be difficult for health workers to make use of treatment and care programmes even though they may be offered to them in their workplaces.

1.1 The health workplace in the context of AIDS

The health workplace in high-prevalence countries presents particular risks and challenges for health workers. The increased workload, the fear of infection, the lack of adequate health and safety provisions and the lack of HIV/AIDS-specific training: all these add up to an enormous burden for health workers who suffer emotional, psychological and physical stress. This in turn leads to a situation where occupational transmission of HIV is an increasing possibility.

The World Health Organization (WHO) estimates[3] that 2.5% of HIV cases in health workers worldwide are a result of needle-stick injuries. One authoritative study involving 20 countries suggests that health workers experience between one and nine needle-stick injuries a year.[4] Research also suggests that needle-stick injuries are very common and may be underreported. Two South African studies showed that junior doctors were most vulnerable—with up to 91% reporting needle-stick injuries and 45% reporting occupational exposure to HIV—and this was attributed to exhaustion and inexperience.[5]

1 *Evidence base for the impact of HIV upon health systems.* London, John Snow International UK and Health Systems Research Centre, 2003. (http://www.who.int/whr/2005/chapter2/en/index2.html, accessed 7 July 2006).
2 *Treat, Train, Retain,* Discussion paper, Geneva, World Health Organization, 2006.
3 *World Health Report 2002.* Geneva, World Health Organization, 2002.
4 *Needlestick injuries.* Geneva, World Health Organization, 2002. (http://www.who.int/occupational_health/topics/needinjuries/en/index1.html, accessed 8 July 2006).
5 HIV injury study causes alarm among doctors. *Archived HIV/AIDS News.* Cape Argus, 25 June 2003, (http://www.learnscapes.co.za/hivnews2003.htm, accessed 7 July 2006).
Karstaed AS, Pantanpwitz L. Occupational exposure of interns to blood in an area of high HIV seroprevalence. *South African Medical Journal,* 2001, 91(1):57-61.

One study[6] by WHO and the International Council of Nurses (ICN) in two health facilities showed that 17% and 22% of health workers did not report needle-stick injuries.

Particular groups of health workers, such as midwives and surgeons, are also at risk from procedures that involve blood and other body fluids. Other categories of health workers are at risk when cleaning blood spills, body handling and disposal, laundry and waste management. In general lack of gloves, safe means to dispose of sharps and other commodities, as well procedures to observe standard precautions put health workers at risk of occupation transmission.

Research indicates that health workers may overestimate the risk of occupational transmission, but this in itself is an additional cause of stress.

Health workers and tuberculosis (TB)

Recent increases in rates of tuberculosis (TB) among health workers, as well as hospital-based outbreaks of multidrug-resistant TB among HIV-infected patients have led to concerns about the risk of TB transmission in health-care settings. HIV-positive health workers are at greater risk, since HIV promotes progression to active TB both in people with recently acquired infection or with latent TB infection.

1.2 Barriers to accessing services

Stigma

Not only are health workers at greater risk of HIV transmission at the workplace, once infected, they may find it difficult to access the services they need.

At the opening of the Namibian HIV/AIDS Workplace programme in 2004, Permanent Secretary for Health and Social Services, Dr K Shangula, summed it up in this way:

Although health workers are in the same environment where counselling and treatment, care and support are provided to HIV/AIDS infected and affected people, it is difficult for them to use these services probably due to stigma and discrimination attached to HIV/AIDS. This therefore results in them having to suffer in silence.

While there is much research on stigma experienced by people living with HIV (PLHIV) in the health system, the impact of such stigmatizing attitudes on health workers own health-seeking behaviour has not been closely examined. However, many in the field believe that this “internal stigma”, is the single most important obstacle to health workers accessing HIV services.[7] One study suggested that nurses fear disclosure more than they fear infection itself.[8]

Surprisingly, it appears that stigma, and stigmatizing behaviour, may be more severe among professional health workers than among non-professionals. One comprehensive study in South Africa showed that 50.5% of professionals believed that there was stigma attached to HIV in their workplaces, in comparison with only 22.7% of non-professionals. Both groups identified the behaviour of staff, as well as the secrecy surrounding the disease, as the most important indicators that AIDS was stigmatized.[9] The study goes on to discuss the impact of this on the health-seeking behaviour of patients, but does not consider the effect on health workers themselves.

Discrimination

In some countries health workers risk discrimination and loss of employment if they are known to be HIV-positive. In this context, fear of disclosure is a major barrier to accessing HIV services. Concerns over confidentiality related to care and treatment for HIV-positive health workers are real and need to be addressed to allow these individuals to access services.

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6 Wilburn SQ, Eijkemans G. Preventing needlestick injuries among healthcare workers: a WHO-ICN collaboration. *The International Journal of Occupational and Environmental Health,* 2004 Oct-Dec, 10(4):451-6.

7 Telephone interviews with Drs Okello and Nxumalo-Nkambule (National coordinators of treatment and care, Testing and counselling in Swaziland), and Dr Mugisha (Regional Superintendent, Masaka Region, Uganda).

8 *Implementing the comprehensive care and treatment programme for HIV and AIDS patients in the Free State: Sharing experiences.* Conference Report. University of the Free State, South Africa, March 2005.

9 Shisana O, Hall E, Maluleke K. *The impact of HIV/AIDS on the Health Sector.* Study No 2, HSRC, MEDUNSA, MRC, 2003.

The health worker–patient relationship

Stigma and discrimination in the health-care setting is part and parcel of attitudes in the surrounding community. HIV-positive health workers may fear damage to their professional relationships if their HIV diagnosis is disclosed. This is a complex problem, rooted in concerns about loss of status, which may arise from "standing in the same queue" as their patients.[10] Health workers may also fear stigma and discrimination from service users if their HIV status is known. Research suggests that health workers also fear disclosure to colleagues, both for personal reasons and for fear of losing their jobs.[11]

Health workers are a vulnerable group

As we have seen, health workers are on the front line of the HIV epidemic—not only because of their profession and workplace, or the fact that the majority are women dealing with gender-based vulnerabilities to HIV—but because their working and personal lives are intimately tangled in the complex and little-understood phenomenon of AIDS-related stigma. It is for all these reasons that health workers must be added to the list of vulnerable groups commonly identified as priority groups for targeted HIV and AIDS interventions.

2. UNIVERSAL ACCESS FOR HEALTH WORKERS

During the early planning for expanding access to ART, priority access for health workers was discussed. However, today there are few countries with proactive policies to ensure that health workers access HIV and AIDS services. This is not a financial challenge, but one of advocacy, policy and programming.

Universal access to prevention, testing and counselling programmes for health workers must be endorsed by stakeholders at all levels. Normative guidelines at global level may facilitate policy and implementation at national and local levels.

The practical or implementation challenges for universal access for health workers may need to be solved at local and national levels. In cases where the availability of ART is geographically restricted or in short supply, special access for health workers may be warranted.

The specific barriers and opportunities for ensuring that health workers as a group do access services must be addressed. Far from raising ethical issues, this relatively inexpensive strategy is justified as it will benefit patients and communities and will support scaling up health services to the general population.

2.1 Strategic approaches

Programming in this area has so far been limited and piecemeal. However, there are a number of different, but complementary, strategic approaches that may be used to operationalize a "Treat" campaign for health workers at country level.

Social dialogue

The International Labour Organization (ILO) and WHO have drawn up comprehensive guidelines on health services and HIV/AIDS.[12] These are intended for governments, public and private employers, workers and their representatives, professional associations and other groups involved in the delivery of health care.

10 *Healthy and valued health workers are essential to save health systems in sub-Saharan Africa.* International Council of Nurses calls for immediate access to treatment for all HIV-positive health care workers in sub-Saharan Africa. Press Release. Geneva, International Council of Nurses, December, 2005. (http://www.icn.ch/PR21_05.htm, accessed 7 July 2006).

11 Interviews with 30 South African nurses by Lehman and Zulu reported in Health-E News 18/07/05. (http://www.health-e.org.za, accessed on 7 July 2006).

12 *Joint ILO/WHO guidelines on health services and HIV/AIDS.* Geneva, ILO/WHO, 2005.

These guidelines provide a framework for managing HIV in the workplace, including the needs and rights of HIV-positive health workers. They provide a basis for practical policy, and cover legislation, policy development, labour relations, occupational safety and health and other technical subjects. The guidelines cover a wide range of workplace policies for managing occupational risk, as well as health workers' rights to confidentiality, no mandatory testing, non-discrimination, prevention, care and support.

The ILO supports social dialogue between employers, health workers and governments as a mechanism for introducing and managing HIV and AIDS policies in the workplace. Social dialogue includes negotiation, consultation and information-sharing, with the goal of building consensus between government and social partners in the world of work.

In order to create an enabling environment for social dialogue, fundamental principles and rights at work must be recognized. Health workers and their representatives should be given the means and training to participate effectively in the process and thereby contribute to establishing a safe and healthy working environment, introducing HIV/AIDS programmes and reforming the general health sector.

Caring for the carer

Broad professional organizations representing large numbers of health workers have embarked on programmes and initiatives to protect their members at risk of HIV and AIDS. "Caring for the carer" initiatives are implemented at international, regional and national levels. For example:

- Public Services International (PSI), a global trade union federation that represents 20 million public-sector workers, is developing a policy and strategy for health workers and is encouraging affiliated trade unions to take this forward. The aim is to strengthen the health sector and advance workers rights in the context of HIV and AIDS by involving workers in implementing the ILO/WHO guidelines.
- The International Council of Nurses is working with affiliated nursing associations to prioritize the needs of health workers in high-prevalence countries. For example, in Swaziland and Zambia, dedicated wellness centres for health workers are being established (Box 1).
- The SADC AIDS Network of Nurses and Midwives is committed to the promotion of "caring for the carers to care" in southern Africa. They are developing a regional plan for the reduction of occupational risks, advocacy for equipment and knowledge on universal precautions and post exposure prophylaxis (PEP). They are also involved in lobbying health ministries and governments for safe and flexible working conditions for HIV-positive nurses and midwives; and lobbying for antiretrovirals (ARVs) for nurses and midwives. At national level, professional associations are developing strategies to protect their membership from HIV and AIDS. For example, the Democratic Nurses Organization of South Africa (Denosa) has adopted the "caring of the carer" model, which involves awareness campaigns at health facilities in targeted districts, motivational talks by people living with HIV AIDS (PLHIV), and creating nurses support groups. They also aim to establish Employee Assistance Programmes in each public hospital. Denosa is working collaboratively with the Canadian Nurses Association and with the Zambian and Botswana Nurses Association to develop best-practice models.

Mainstreaming

Mainstreaming AIDS is a process that enables development actors to address the causes and effects of AIDS in an effective and sustained manner, both through their usual work and within their workplace.

The United Nations Development Programme (UNDP), as well as UNAIDS, bilateral donors and others have been working on both the theory and the practice of mainstreaming AIDS activities into national and sectoral development plans. AIDS mainstreaming processes have been initiated in over 80 countries.

Mainstreaming AIDS into the health sector would include an appraisal of the impact of HIV and AIDS on the health workforce, and as such provides a mechanism for embedding health worker "Treat" programmes in national development plans.

National AIDS Authorities and the relevant government ministries are also encouraged to work together to address AIDS in national Human Resources for Health (HRH) plans.

3. ELEMENTS OF THE "TREAT" PACKAGE

The full package of interventions to provide prevention, care and support as well as treatment for health workers will need to be determined by country-level conditions, policies and priorities.

Ministries of health, the national AIDS authorities and other relevant ministries could work together to ensure the creation of an enabling institutional environment for health-worker prevention, care & support and treatment programmes.

Underlying the success of such programmes will be measures to build the confidence of health workers to access HIV services. It will be necessary to increase educational efforts for both health workers and managers that underscore the importance of confidentiality and informed consent. Measures to ensure non-discrimination for HIV-positive health workers will also be essential.

3.1 Targeted campaigns for health workers

Educational materials, including posters and audiovisual material specifically targeting health workers should be available in all health-care settings. Regional campaigns may increase cost-effectiveness here.

Challenging stigma

Stigma awareness modules for the general population are part of most in-service and pre-service training for HIV and AIDS, such as the WHO Integrated Management of Adolescent and Adult Illness (IMAI) training programme, which has been adopted by 29 countries. Aimed at reducing stigmatizing behaviour and discrimination towards service users, these modules could be adapted to relate more directly to health workers' own lives.

In addition, more proactive stigma campaigns may have to be designed especially for health workers. The use of peer educators and HIV-positive role models could be considered to motivate health workers to go for testing and take up treatment.

Prevention (sexual transmission)

Educators have commented that health workers feel that prevention messages aimed at the general population are not relevant to them. "We need innovative ways to address the needs of health workers, and health facilities need to be very proactive in basic prevention," say Drs Okello and Nkambule, Directors of the testing, counselling, treatment and care programmes of the Swaziland Government.[13]

While most health workers understand the way HIV is transmitted and prevented, research shows that they may not apply this learning in their own lives. For example, one study in Rwanda showed that condoms were stigmatized by health-care workers and only 17% used them regularly.[14]

The current climate, in some areas, where condom promotion is being restricted to "marginal groups," may be re-stigmatizing condom use and this must inevitably compound the problem. In general, ABC messages could be seen as patronizing for professionals, and thus admitting failure may be extremely difficult. Peer-led prevention campaigns could be considered here.

Facility-based "Know your Status" campaigns could be designed to encourage health professionals to take up testing. Novel approaches to HIV testing may be applicable in health-care settings, but would have to be carefully canvassed with health workers themselves. Programmes that involve group pre-counselling, self-testing with rapid kits, and post-counselling via mobile telephone have been suggested for universities and some workplaces.

The issue of confidentiality and fears of disclosure and resultant stigma and discrimination are the major challenges here.

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13 Telephone interview 6 April 2006.

14 Rahlenbeck SI. Knowledge attitude and practice about AIDS and condom utilization among health workers in Rwanda. *Journal of the Association of Nurses in AIDS Care.* 2004, 15(3):56-61.

3.2 Preventing workplace transmission

Health-care workers need access to proper information, training and an uninterrupted supply of commodities to prevent workplace transmission of HIV. Occupational Health and Safety management systems must be established in all facilities according to the principles of the ILO Guidelines on occupational health management systems.

All clinical teams should have access to sufficient gloves, aprons, sharps boxes and other waste disposal, PEP kits, etc.

Studies show that even when commodities are available, there may be a lack of adherence to standard precautions by health workers. This and other health workforce management issues need to be addressed, (for example, absenteeism and long working hours that result in stress and fatigue and increase the risk of needle stick injuries.) Workplace issues are discussed further in the *Retain paper.*

Post exposure prophylaxis (PEP)

With the expanding access to ARVs, post-exposure prophylaxis for health workers is more generally available. However, there is evidence to suggest that uptake of PEP is limited, as health workers are reluctant to be tested for HIV.[15] In one study, nurses explained that they mistrusted hospital measures to ensure the confidentiality of their test result (which would indicate prior HIV status).[16]

In settings where ARVs are rationed there needs to be a separate supply of drugs for PEP (e.g. PEP kits). There is also a need for specific clinical and managerial training for PEP.

Needle-stick injuries

WHO and the ICN have been working since 2003 to implement pilot programmes to reduce sharps injuries in health workers. The programmes are based on the WHO Toolkit *Behaviour change strategy to achieve a safe and appropriate use of injections.* It provides technical and political guidance to health workers, administrators and politicians in order to promote injection safety.

Pilot programmes are being implemented in Egypt, South Africa, the United Republic of Tanzania, Viet Nam and other countries.

Tuberculosis (TB)

Intensified TB case-finding should be established for health workers, and isoniazid therapy given to those with latent TB infection as part of a package of care.

In low-income countries the risk of health workers acquiring TB could be significantly reduced if governments, health authorities and health-care workers themselves make infection control a high priority. Each health facility should have a TB control plan supported by all stakeholders, which include administrative, environmental and personal protection measures to reduce transmission of TB.

Administrative measures should include early recognition, diagnosis and treatment of TB suspects. Environmental protection should include maximizing natural ventilation. Personal protection should include the protection of the HIV-positive health worker from possible exposure to TB, for example a transfer from medical wards, along with isoniazid therapy.

15 Eric Schouten, Malawi, personal communication.

16 Zelnick J, O"Donnell M. The impact of the HIV/AIDS epidemic on hospital nurses in KwaZulu Natal, South Africa: Nurses" perspectives and implications for policy. *Journal of Public Health Policy,* 2005, 26(2):163-185..

3.3 Care and support

Health workers in high-burden countries need care and support programmes to enable them to work effectively. Interventions to prevent, detect and respond to burnout and stress are essential. Counselling should be available when needed, and HIV-positive health workers, in particular need access to ongoing counselling and support services.

Psychosocial services are the key element here, but access to clinical mentors who can give advice and support may also contribute towards reducing isolation and easing stress (see Train paper for more on clinical mentoring).

Female health workers also need protection from rape and gender-based violence particularly those who work night shift. Health workers who are ill with AIDS-related diseases may also need home-based care. Their families should also be provided with support and counselling services.

Peer support networks and groups for HIV-positive health workers may be an effective strategy here.

3.4 Universal access for health workers

Separate sites

Strategies to reduce demand-side barriers to uptake of testing, counselling, treatment and care will be essential to ensure universal access for health-care workers. One model that is being proposed is the establishment of separate centres where health workers can access AIDS services without fear of disclosure.

The first example of such a programme is currently being piloted in Swaziland, with the establishment of specialized centres for health workers (Box 1). The International Council of Nurses is also working on a similar programme with the Zambian Nurses Association.

Box 1. Wellness centre for health workers

Although ARVs are now available in all hospitals and health centres across Swaziland, it was found that health workers were not accessing these facilities due to fear of stigma or discrimination.

To overcome this, an HIV and TB Wellness Centre of Excellence for HIV-positive health workers and their families is being established to provide comprehensive HIV and TB treatment, health services and training for all infected health workers and their families. It is to be situated in Manzini, capital city of Swaziland. Outreach teams will also offer home-based care. In the second phase, centres will be rolled out to three regions of the country and in the third phase, they will be established nationally.

A long-term goal is to eradicate the stigma associated with HIV so that health workers may be reintegrated into the national HIV and AIDS programmes.[17]

The idea for this programme came from the Swaziland Nurses Association and the International Council of Nurses, and has been embraced by the Swaziland national government. It has become a key component of the health sector response to HIV/AIDS spearheaded by the Swaziland National AIDS Programme.

Other less costly strategies to cater for the needs of health workers for confidentiality have been considered. For example, in one area of Uganda, health workers are able to access treatment and care at neighbouring sites where they have less fear of disclosure to colleagues. However, reportedly, this has not been very effective.[18]

17 Telephone interview with Drs Okello and Nkambule.

18 Telephone interview, Dr Mugisha, Superintendent of Maska District, Uganda

4. FINANCIAL AND RESEARCH IMPLICATION

To plan and cost a package of prevention, care & support and treatment for health workers it will be necessary to have an accurate assessment of the extent of HIV and AIDS among health workers and the numbers requiring treatment. This should include community workers engaged in HIV/AIDS service delivery.

A rough estimate can be made using national prevalence rates as a basis, though the South African research suggests that this method may produce an overestimate.[19] Comprehensive country-based surveys will reveal more accurate statistics but will be costly and time-consuming.

4.1 Costing "Treat"

Accurate costing of a package for prevention, care & support and treatment for health workers can only be done at a national level.

Global estimates for a "treat package" would include estimates for the following:

- targeted prevention (peer education) campaigns for health workers;
- targeted testing and counselling;
- targeted "Know your status" campaigns:
- treatment for HIV-positive health workers;
- PEP and universal precautions;
- stigma campaigns; and
- separate sites for health workers.

4.2 Research needs

The accurate targeting of a "Treat" package for health workers will require continuing research to understand how health workers themselves understand their problems and needs. This may require additional research in the form of focus groups, interviewing and participatory action research. Operational research will also be needed to answer key questions.

Some of the questions that require research are:

- Are health-care workers taking up HIV and AIDS services that are available to the general population? If not, what are the major barriers, e.g. disclosure to patients, colleagues, job security?
- What is the extent of access by different categories of health workers, including community workers?
- What is the relationship between stigma in the community and stigma in health-care settings?
- What actions can be taken to preserve confidentiality for health workers in a care setting?
- Are prevention and stigma campaigns aimed at the general population effective for health workers? If not, how can campaigns be targeted effectively?
- Are current approaches to stigma sensitization/training for health workers effective ways of addressing "internal" stigma?
- Are separate sites a cost-effective way of providing access to health workers?
- Are site-swapping schemes an effective way of ensuring confidentiality for HIV-positive health workers?
- What are the key factors that jeopardize health workers in the workplace and what are the solutions to these?

19 The Human Resources Steering Committee (HRSC) health survey found that 16.3% of health workers were HIV-positive in comparison with the national antenatal HIV prevalence rate of 27.9%.

Box 2. Health workers as researchers

One example of participatory action research in this area, illustrates the potential of the methodology of health workers as researchers. An investigation of occupational health and safety in South Africa's municipal clinics [20] was conducted by a multi-partner group consisting of Samwu, the largest municipal trade union in South Africa, and the Industrial Health Research Group, based in the School of Public Health and Family Medicine at the University of Cape Town. The study gathered evidence on the existence and functioning of workplace health and safety committees; the election of health and safety representatives; workplace occupational health & safety (OH&S) activities as well as clinics' capacity to deal with the HIV/AIDS epidemic and to implement programmes to protect health workers from exposure to occupational HIV. Union members were trained in research techniques, interviewing health workers in 38 municipal clinics. They found a situation of employer abuse and neglect of the health and well-being of health workers. Facilities, commodities and OH&S management were woefully inadequate, despite policy and paper commitments. One interesting aspect of the findings was the extent to which health workers accepted poor conditions, trauma and stress.

The research methodology had the effect of stimulating activism around the problems being investigated. "As activist investigators, the participant researchers in this programme not only explored the prevailing attitudes, behaviours and practices of OH&S but, in doing so, also began to challenge the silence and neglect that characterizes that culture." The researchers agreed that the research itself became a first step in transforming the culture of OH&S in municipal clinics.

Operational research will be needed to answer some of the questions about implementing a targeted "Treat" strategy for health workers. Current and new strategies and programmes will also need to be subjected to ongoing monitoring and evaluation.

5. AN ACTION PLAN FOR "TREAT"

A consultation is proposed as a first step in drawing up an action plan for the treatment, prevention and care of health workers in the worst-affected countries. It is hoped that a global perspective will emerge from the process.

Key questions for this process are:

- What are the priority elements of "Treat"?
- What must be done at global, national, regional, country and local levels to advance this programming?
- What actions, strategies and programmes are new, and which ones need to be strengthened?
- How can the work best be divided according to comparative advantage?

Identifying the roles of:

- International organizations—United Nations agencies; financial organizations; donors and other bilateral organizations; international labour organizations; international professional organizations; international nongovernmental organizations (NGOs); expert and technical groups;
- National government—ministries; national AIDS authorities; HRH planners;
- Civil society organizations such as trade unions; NGOs; faith-based organizations (FBOs); community-based organizations (CBOs); networks and organizations representing PLHIV.
- National professional organizations

THE ESTABLISHMENT OF A "TREAT" WORKING GROUP IS PROPOSED TO TAKE THIS INITIATIVE FURTHER.

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20 IHRG, SAMWU. *Who cares for health workers?* Municipal Services Project. Occasional Papers Series, Number 8. January 2005.

Annex C: TRAIN

The AIDS crisis and the commitment to scaling up services towards universal access have put new demands on human resources for health in the worst-affected countries. There is an urgent need both to train new health workers and to maximize the AIDS competency of the existing workforce. Training must be adapted to country realities and a "public health" model of service delivery that is practicable and equitable.

This AIDS-related plan must be contextualized within broader country-led plans to overcome shortages of human resources for health. The WHO *World Health Report 2006* identifies a range of strategies to enhance the health workforce through its lifespan of "entry – workforce – exit". The simple goal is to "get the right workers with the right skills in the right place doing the right things."

This paper describes some of the strategies that have been proposed to train health workers, community workers and people living with HIV (PLHIV) to deliver HIV services to their maximum capacity within a "public health" model of service delivery. As a brief review of the issues, the paper is not comprehensive, but aims to outline some key technical, policy and research challenges. The WHO consultation on "AIDS and Human Resources for Health" is seen as an opportunity to take this discussion further and identify concrete next steps. Key entry points and potential partners will be identified.

1. A "PUBLIC HEALTH" APPROACH

The challenge of expanding access to AIDS services in resource-limited settings has created the need for innovative delivery models appropriate for country needs and the realities of weak health systems. In its assessment and recommendations to the United Nations Secretary General, The Joint United Nations Programme on HIV/AIDS (UNAIDS) Global Steering Committee on Universal Access has recommended that countries should adopt "alternative and simplified delivery models to strengthen the community-level provision of HIV prevention, treatment, care and support, including measures to enable the shifting of tasks, from more specialized providers such as the prescribing of drugs, HIV testing and counselling and behaviour change communication to nurses, educators and community workers, including people living with HIV.[1]

WHO has gone some way towards developing a public health approach to HIV services that focuses on treating more, mainly poor people, and on promoting a dramatic increase in efforts to prevent HIV transmission.[2]

Technical aspects of this approach involve standardized and simplified systems—drug regimens, clinical decision-making, laboratory management, toxicity management and drug resistance management. This simplified approach enables a radical departure from traditional delivery models that depend on specialist health workers, and facilitates the deployment of less skilled professional cadres. It involves shifting the responsibility for tasks from more specialized to less-specialized health workers; for example from specialist HIV physicians to doctors; from doctors to nurses, from nurses to trained members of the community (including PLHIV) and, most importantly, to patients themselves through self management. Task-shifting to the lowest suitable cadre of worker, not only is a main principle of good chronic care, but also expands the human resource pool, maximizing the availability of more skilled workers.

Operationalizing a public health approach further requires that HIV services are delivered outside of specialist tertiary centres down to district hospitals, primary health-care centres and the community. The experience of "3 by 5" suggests that the main service providers are the district and primary health-care teams, usually led by a non-specialist doctor or medical officer. To maximize effectiveness, routine follow-up care also needs to be delivered as close to the home as possible.

Another key element of the public health approach, essential for long-term sustainability is the integration of all HIV services within existing health services at district level.

1 *Scaling up prevention, treatment, care and support.* Note by United Nations Secretary-General, March 2006, Recommendation 3.1.

2 Grubb I, Perriens J, Schwartlander B. *A public health approach to antiretroviral treatment: overcoming constraints*. Geneva, World Health Organization, 2003.

WHO strongly advocates a public health model for the integrated, decentralized management of HIV and AIDS. This model has already been accepted and adapted in many countries and has enabled them to integrate comprehensive HIV and AIDS prevention, care and treatment within existing health services.

A public health delivery model is not only the key to maximizing human resources for AIDS services, but is also a prerequisite for equitable access to services for the poor, and those in remote areas. This kind of delivery model, which is integrated and decentralized, is also the key to expanding access to AIDS services in a way that strengthens the health system.

The public health approach has significant implications for the training of health workers, which are discussed further below. Specialized antiretroviral therapy (ART) centres, tertiary institutions and expert HIV physicians will still play an important role in the management of HIV/AIDS patients. They will be needed to provide treatment and care for complex cases, and for those who failed treatment. Centres of excellence will still be needed to contribute to pre-service training and clinical mentoring for district level facilities.

1.1 Task-shifting

Task-shifting is one of the central tenets of the public health approach and good chronic care as it expands the skills of less specialized cadres of health workers and enables them to complement (and not replace) doctors and HIV specialist physicians. The training of nurses to deliver ART in the context of a clinical team (including doctors on-site or off-site) and a district referral network is part of perhaps the only viable strategy to enable scaling up towards universal access.

In 2003, the international consultation on the scaling up of ART to achieve “3 by 5” recognized the need for task-shifting, and the important role of PLHIV, in delivering services. The consultation recommended that nurses be trained and authorized to initiate ART, and that the regulatory or legislative steps to facilitate this be undertaken in countries. While there are many successful pilot programmes they are largely a result of informal agreements at district and local levels. These need to be brought to scale and formally accepted and embedded in appropriate health legislation. Training must be standardized to assure quality control, and must be followed by ongoing training and mentoring.

Task-shifting also enables the inclusion of non-professional cadres such as lay health providers, community health workers and PLHIV as permanent, paid members of the clinical team that includes a nurse and an on-site or off-site doctor. With appropriate training they are able to deliver services to their peers, thus expanding human resources and improving patient flow. Peer programmes conducted by PLHIV, may indeed be the only way of reaching vulnerable and marginalized groups such as sex workers, injecting drug users and mobile populations.

The training of lay people to perform a range of services represents an important way of expanding human resources for health, of providing good chronic care and of building bridges between the public health system and the community. PLHIV can make a huge contribution to the quality of services provided in the public health system. The empathy and insight of peer providers establishes a bond of trust and credibility that enhances treatment adherence, and prevention and care programmes.

The key challenge here is to expand human resources without compromising quality of service. A standardized and systematized programme for training non-professional cadres to guarantee minimum standards of care must be considered.

While task-shifting is proposed as a strategy to expand the health workforce, such a system, if implemented on a national level, would require the training of large numbers of existing health workers in new skills, as well as the recruitment and training of large numbers of community workers. The human resources needed for implementing this training must also be considered.

There are many other issues that require attention, such as the criteria for recruitment of community workers and pay scales. It may be necessary to establish a global working group to examine the implications of task-shifting and identify the concrete steps required to advance it at country level.

1.2 People living with HIV (PLHIV), an untapped resource

In most countries affected by the epidemic, there are large numbers of groups and networks of PLHIV who are active in delivering AIDS services. A recent literature review[3] suggests that the majority of these groups are involved in prevention, health promotion and advocacy. Of those that are involved in treatment programmes, the majority are delivering counselling, treatment support, adherence counselling, testing and home-based care.

The authors of the review argue that PLHIV constitute a large untapped resource for expanding the health workforce to deliver ART. "Expert patients" could be trained to deliver services in addition to the support roles currently envisaged. The authors propose the formation of national networks of PLHIV that can act as "expert patients" or ART Aides and provide professional services.

A careful identification of tasks may enlarge the repertoire of these "expert patients" so that they also conduct HIV tests, CD4 counts, follow-up of uncomplicated patients, basic care, monitoring and more.

The implications of task-shifting, for the medical profession and for the expert patients, must be discussed at global and national levels. This includes the identification of tasks appropriate for the "task-shifted" cadres and how these roles may be regulated and certificated.

Learning from experience

This proposed model of using expert patients/ART Aides or lay health workers much more substantively in HIV programmes may benefit from lessons learnt in the long history of community health worker programmes. For nearly four decades, primary health-care models have incorporated community-based health workers trained to perform tasks alongside professional health-care workers. A recent desk review[4] suggests that while these programmes were generally cost-efficient and added value to public health systems, they did not live up to the expectation that they could be scaled-up to become integral to public health services. The authors suggest that financing and political challenges were the main causes of this failure. As hidden costs emerged in the scaling-up process, it became clear that these programmes were not an inexpensive alternative to primary health care, but a complementary activity to be integrated into the district health system. Political commitment to primary health care faltered, and in an era of structural adjustment and declining resources for health, funding was not forthcoming for additional activities.

The lessons from history highlight the importance of understanding the full financial, policy and training implications of a plan to integrate a new cadre of health workers into already-fragile systems. However, the urgency of the current AIDS crisis has created new opportunities for health sector reform, with political commitment and donor funding now at unprecedented levels.

Voluntarism versus payment

Over the decades, the issue of voluntarism has been the subject of continuing debate. The initial idea of the community or village health worker assumed the existence of a pool of willing volunteers, but lack of payment has emerged as an important cause of attrition of community health workers in many programmes.

This issue is particularly relevant to community workers providing HIV services. Securing their sustained commitment will require appropriate payment consistent with basic national wage structures.

The issue of payment for "expert patients"/ART Aides must be discussed and debated, and normative guidelines established at a global level. Payment for community health workers is not only a retention strategy and a human rights issue, but should also be seen as contributing to broader development and poverty reduction strategies.

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3 Kober K, van Damme W. Expert patients and AIDS care. *A literature review on expert patient programmes in high-income countries, and an exploration of their relevance for HIV/AIDS care in low-income countries with severe human resource shortage.* Antwerp, Department of Public Health, Institute of Tropical Medicine, March 2006.

4 Lehmann U, Friedmann I, Saunders D. Review of the utilization and effectiveness of community-based health workers in Africa. *Joint Learning Initiative on Human Resources for Health and Development*, February 2004.

Terms of engagement

The public health approach outlined above proposes the integration of non-professional cadres into clinical teams. Other models for creating linkages between community groups and the health system may be more appropriate to local and national conditions. At the very least, WHO proposes that district health coordinators should be aware of the activities of nongovernmental organizations (NGOs), faith-based organizations (FBOs) and community-based organizations (CBOs) in their area and facilitate cross fertilization and referrals to provide optimal service to patients.

The rich experience of NGOs[5] also provides valuable insights into different models for the relationship between community actors and the public health system. For example, in Zambia a formal partnership between the Zambian Ministry of Health (MOH), the Zambian Network of People with HIV/AIDS and CBOs facilitates community engagement at two sites where PLHIV deliver adherence support and prevention services. In Ukraine, the principal recipient of Global Fund is an international NGO that has been engaged in training and supporting the public health system to deliver ART. In Burkina Faso, a strong link between the public health system and a flagship NGO treatment facility has developed to the advantage of both.

The relationship between existing PLHIV groups/CBOs and the public health system must be given serious attention and models to facilitate and formalize this relationship advanced at global, regional and national levels.

2. IMPLICATIONS OF THE PUBLIC HEALTH MODEL FOR "TRAIN"

2.1 Pre-service training

Scaling up AIDS services towards universal access will require both qualitative amd quantitative changes to pre-service training for health workers.

Expanding the workforce

Estimates and plans for enlarging the health workforce to meet the needs of the move towards universal access must be made at country level and integrated into overall education and human resources for health (HRH) planning, budgeting and national poverty reduction strategies.

Plans to enlarge the health workforce will often need to include the expansion of training facilities to support the production of greater numbers of health workers. These include doctors, clinical officers, nurses, pharmacists, trained counsellors, laboratory staff and community health workers.

The particular service delivery model deployed will influence both the numbers and the training of additional health workers. While the public health approach allows for fewer doctors, it requires a larger number of nurses and lower-level cadres who will need additional training.

Limited shortages may be met by strategies to increase class size or reduce training time at training institutions. Widespread shortages, as exist in most sub-Saharan African countries, will require more comprehensive strategies such as the development of new training institutions and regional cooperation.

In some countries, the AIDS and HRH crisis has led to emergency strategies to recruit medical workers from abroad.

Members of the diaspora could be engaged to contribute to the expansion of the workforce, through short- or long-term voluntary return schemes, when the expertise does not exist locally.

Increasing graduate numbers or recruiting new health workers from abroad are not the only ways of increasing human resources for health. The *World Health Report 2006* also discusses broader strategies to maximize efficiency and performance of the existing health workforce. Strategies to eliminate corruption and ghost and absentee workers may also expand resources for health.

5 *Human resources for health exist in communities*. International HIV/AIDS Alliance, 2005. Available at (http://www.aidsalliance.org, accessed 2 July 2006)

Integrating AIDS competencies

Although significant efforts have been undertaken over the past two decades to include HIV and AIDS in the pre-service curriculum for health-care workers, there is concern that this has not always kept pace with rapidly evolving care and treatment practices. This means that many graduates need to undergo further training before being fully operational in HIV care.

A public health approach to HIV should be integrated into the undergraduate curriculum in low-resource, high-burden countries. The socially responsible curriculum focuses on the most common and serious health needs of the community served; the "real-life" responsibilities of different cadres of health professionals and the "real-life" availability of diagnostic tools, drugs and equipment particularly at peripheral level health facilities. Task-shifting also requires that the curriculum be adapted to teach new skills to mid-level cadres.

Further work is needed to develop adequate materials for teaching HIV and AIDS at the pre-service level. A learning package on the skills needed to teach the new curriculum is also needed. Inter-regional meetings with partners and key countries with experience and interest will advance this process.

Valuable lessons have been learnt from the process of Integrating the Management of Childhood Illness (IMCI) into pre-service curricula.[6] This experience has shown that policy and advocacy issues need to be addressed concurrently with the curriculum-strengthening process. There is also a need, early on, to agree on methods of assessing competency and incorporating the assessment of the new HIV-related competencies into certifying exams.

WHO has begun working with training institutions in several sub-Saharan African countries to strengthen the educational capacity for HIV and AIDS at the pre-service level.

2.2 In-service training

In-service training presents opportunities to both empower health workers to deal with HIV and AIDS, and to maximize efficiency in delivering HIV services by expanding the health workforce.

Health workers may have had little formal training in HIV and AIDS. At district level they need a comprehensive set of training courses that allow them to serve the needs of the range of patients that they see.

Training for a public health approach should comprise modular training courses that include integrated acute and chronic HIV services for children, pregnant women, adolescents and adults. Modular training materials need to address each specific cadre—doctors, nurses, counsellors—and their roles at the different levels of the health system where they work. A toolkit for District Coordinators should support the organization and management of all relevant aspects of a comprehensive HIV/AIDS health-sector response at district level.

Training must be designed for rapid capacity-building. Training for each cadre should focus on only the tasks specific to that cadre within the clinical team, thus enabling the teaching of a large number of topics in a short time. The training must also be practical and skills-based, allowing health workers to put into practice what they have learnt immediately after returning to their facilities. The approach should support continuous training and allow for clinical teams in one region to be trained efficiently over several weeks or months.

An integrated approach has the advantage of strengthening basic services while scaling up HIV services. In this kind of training, health workers learn an approach to acute care that can be applied to the management of a range of common conditions. In this way, the extra resources made available for the scale-up towards universal access to HIV treatment can help build health systems rather than undermine other disease-control efforts.

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6 Scafer L, Diour E. Pre-service implementation guide: A process for strengthening pre-service education. Baltimore, JHPIEGO, 2002 (http://www.jhpiego.org/about/who.htm, accessed 2 July 2006).

One approach that has proven successful employes PLHIV as expert patient trainers in clinical sessions. Expert patient trainers are valued by trainees for providing authentic and honest feedback. In addition, the involvement of these cadres in the clinical team assists in reducing stigma and provides a needed bridge between health services and the community. There are also many benefits for the trainers as one expert patient trainer explained:

We help the practitioners because they told us they didn't know how to handle HIV patients and they didn't know how to access our emotional status and general care, but through this they have gained a lot. I think this has helped me to fight my stigma and accept my status. Before, I felt so shy. I felt bad. This training has made such a difference. I can speak out and I feel motivated. I can live a better, more positive life. I rejoice for it and am now a very happy person[7].

In addition to training less specialized cadres, the public health approach will also require a new complement of trainers of trainers.

2.3 Clinical mentoring

Clinical mentoring is a good system of continuing practical training that fosters professional development. It is critical to building successful district networks of trained health workers for HIV care and treatment in resource-limited settings. Mentoring should include both clinical and counselling mentoring and be integrated with and follow on from initial training. It should be seen as part of the continuum of education required to create competent health providers.

A clinical mentor is a clinician with substantial experience in prevention and HIV treatment and care who is able to provide ongoing mentoring to less-experienced health workers—both in the form of regular site visits and by ongoing telephone and if available, e-mail consultations. Members of the diaspora can contribute to clinical mentoring programmes through telemedicine.

A mentoring programme, standardized and simplified according to the public health approach, should be part of training scale-up. At the national level there is a need to advocate for ministries of health to allocate resources for mentoring via funds already allocated for training. A sustainable national mentoring plan cannot rely solely on "external" mentors—either expatriate or national experts. Though the lack of national expertise may mean that mentoring strategies begin this way, the long-term goal must be to create a national network of local clinical mentors.

2.4 Career development

The issue of career development for all health workers needs to be addressed. Career options for expert patients, ART Aides and community health workers would create incentives and minimize attrition.

Continual learning and enhancement of skills of all cadres of health workers will help ensure that health workers are able to provide high-quality care, and ensure that skills are appropriate to help achieve universal access as close as possible.

Innovative educational strategies that link in-service training with the formal education system could be mutually beneficial to both systems and could be considered a means to expand the health workforce and as a community development tool.

7 Barbara, a Ugandan expert patient trainer, on her involvement in the WHO IMAI training programme.

3. RESEARCH AND RESOURCE NEEDS

3.1 Research

Operational research will be necessary to confirm the efficacy of less specialized clinically trained staff and community health workers in performing new tasks.

Conducting research to demonstrate how different delivery models have an impact on the public health system—particularly how the public health model strengthens health systems—will be useful and help in advocating for the public health approach.

A review of lessons learnt from pioneering pilots and programmes using a public health model and task-shifting for ART delivery will guide policy and strategy.

3.2 Costing

Costing "Train" can only be done at country level and must be based on comprehensive national plans for HRH. Some global estimates and comparisons may be useful.

3.2.1 Pre-service training

Additional health workers to be trained in the different categories must be estimated. The numbers needed will depend on the delivery model employed.

The cost of training new professionals to scale up AIDS services must be included in broader national health training costs, including those for upgrading and expanding training facilities. Money from HIV/AIDS funding sources must be contributed to general HRH programmes.

3.2.2. In-service training

The cost of training doctors, nurses, expert patients and ART aides may be estimated on the basis of the Integrated Management of Adolescent and Adult Illness (IMAI) package.

3.2.3 Clinical mentoring

The cost of clinical mentoring plans must be estimated at country level.

3.2.4 Including PLHIV on the payroll

Appropriate salary structures for Expert Patient Trainers and ART Aides and other types of community health workers must be based on local conditions, including the pay scale at the health facility in which they will work.

4. TOWARDS AN ACTION PLAN FOR "TRAIN"

A consultation is proposed as a first step in drawing up an action plan for training health workers in the worst-affected countries.

4.1 Key questions for this process are:

1. What are the priority elements of "Train"?

2. What must be done at global, national, regional, country and local levels to implement this plan?

3. What steps must be taken to advance the task-shifting agenda, so that tasks and training appropriate for different cadres are standardized and quality is assured?

4. What are the main obstacles to this plan at global, regional and national level?

5. How can the work best be divided according to comparative advantage?

4.2 Identify the roles of:

- International organizations—United Nations agencies; financial organizations; donors and other bilaterals; international labour organizations; international professional organizations; international NGOs and networks of PLHIV; expert and technical groups; diaspora organizations;

- National governments—ministries; National AIDS Authorities; HRH planners;

- Civil society organizations such as trade unions, NGOs, FBOs, CBOs and organizations representing PLHIV.

- National professional organizations

THE ESTABLISHMENT OF A "TRAIN" WORKING GROUP IS PROPOSED TO TAKE THIS INITIATIVE FURTHER.

Annex D: RETAIN

There is mounting evidence that HIV and AIDS, in the worst-affected countries, are a major source of "wastage" or loss of health workers. Apart from the very high losses to illness and death, large numbers of health workers leave overburdened public health systems for more rewarding jobs in other countries and other sectors.

In response to this situation, a powerful coalition of stakeholders,[1] in which African leaders have a strong voice, have committed to finding ways of retaining appropriately trained health workers in the places where they are needed. Country-based strategies to strengthen the health workforce throughout the working lifespan of entry-workforce-exit are seen as essential to the retention of health workers, as is the management of health worker migration.

This paper[2] reviews some of the major strategies proposed to manage loss of health workers from the public health system and reduce the "push" factors that fuel it. It aims to identify both the role of the AIDS sector, and AIDS-specific retention strategies in this broader scenario.

The joint WHO consultation on "AIDS and the health workforce" is intended as a step in the mapping of relevant players and activities in this area, and identifying and aligning HIV/AIDS components with broader health worker retention strategies.

1. AIDS AND HEALTH WORKER RETENTION

Scaling up AIDS services towards universal access will depend on having enough appropriately trained health workers in the places where they are needed. WHO has estimated that an extra 100 000 health workers would be needed just to reach the 3 million treatment target [3]. Even in a "public health model" [4] of service delivery these will include specialist physicians, managers, doctors, nurses, pharmacists and laboratory technicians and counsellors, along with a larger number of ART aides (trained community members).

However, in many countries, human resources for health (HRH) are already stretched to the breaking point. And to add to this, each year large numbers of health workers leave the health workforce, temporarily or permanently, for a wide range of reasons. A study of 250 health workers in four African countries showed that poor pay and bad living and working conditions were the major reasons for migration.

As well as migrating to countries that offer better conditions and prospects, health workers are also leaving the public health sector for better paid jobs in private or nongovernmental organization (NGO) health and AIDS programmes, and other sectors. This is common in the worst-affected sub-Saharan African countries, but has also been noted in eastern Europe and other regions.

Strategies to retain health workers in a functioning health system will be essential to achieve as close as possible the goal of universal access to AIDS services. These strategies must address the "push" factors of low wages, unacceptable working conditions, poor career prospects and low morale in the health sector. Policy and programmes to manage migration from the health sector, and to make constructive use of the skills of the health diaspora will also be critical here.

A wide range of actors is already engaged in the debates around managing health worker retention, particularly in the field of international migration. The challenge now is to better understand the relationship between AIDS and health worker retention, and to mainstream AIDS into current policy, strategy and programming. This will be essential not only to meet, as close as possible, the goal of scaling up to universal access to AIDS services, but will contribute to strengthening health systems for all of those who use them.

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1 A Global Health Workforce Alliance comprising major HRH actors within and beyond the health sector was launched in April 2006.

2 *Treat and Train* papers in this series discuss other strategies to address health worker wastage, such as prolonging the lives of HIV-positive health workers or improving their career paths.

3 Treating 3 million by 2005. Making it happen. The WHO strategy, December 2003.

4 The "public health model" outlined by WHO, an integrated decentralized model, is described in the Train paper.

Box 1. African Health Ministers Resolutions on Human Resources for Health (HRH)

In February 2006, the East, Central and Southern African Health Community's 42nd Regional Health Ministers' Conference made several resolutions regarding health worker retention.

Member States were urged to:

- *Adopt a common position on compensation for health workers recruited by developed countries;*
- *Develop financial and non-financial strategies to encourage the retention of health professionals.*

The secretariat was urged to:

- *Support member countries in conducting appropriate research on HRH, e.g. in retention, effects of out-migration, work-load studies and promote evidence-based best practices;*
- *Develop guidelines for ethical recruitment and compensation for health workers.*

2. ELEMENTS OF "RETAIN"

While some of these strategies are AIDS-specific, many are much broader HRH issues.

2.1 Reducing the "push" factors

There is much that source countries can do, and are doing, to retain health workers and reduce the "push" factors for migration. Some of these are broader incentive schemes and strategies to improve the lives and working conditions of health workers, others relate more specifically to HIV and AIDS.

Strategies to provide prevention, treatment, care and support as well as training and career development may also be seen as important retention strategies and are discussed in accompanying papers ("Treat" and "Train").

To date, most initiatives at country-level have been piecemeal and ad hoc, but the growing urgency of the health workforce crisis is catalyzing a more comprehensive approach, where retention strategies are part of broader plans to strengthen health systems. For example, the Governments of Malawi and Zambia have devised bold national strategies that operate at national and district levels—including massive increases to health budgets, supplementing the salaries of health professionals, and educational and other soft incentives to retain health workers.

For comprehensive health system plans to be sustainable they must be costed and funded, and embedded in national development plans. The Malawi Emergency Plan, for example, is included in the national Poverty Reduction Strategy Paper. This will require joint planning, and cooperation between HRH teams, National AIDS authorities and the relevant government ministries.

Box 2. Malawi's Emergency Human Resources Programme

In April 2004, the Malawi Ministry of Health called for urgent action to retain current staff. The six-year Emergency Human Resources Programme includes providing financial incentives for existing staff of up to 52% gross salary increases, stop-gap external recruitment of physicians and nurses, significant expansion of domestic training capacity, and non-monetary incentives.

The programme is supported by the Global Fund to Fight AIDS, TB and Malaria, the United Kingdom Government and other donors. It is estimated to cost about US$ 278 million—up to US$ 98 million for salary top-ups, US$ 35 million for improved staff housing and US$ 64 million for expanded training capacity.

By the end of 2005, over 700 new staff had been recruited and there had been a reduction in the outflow from the public health sector.

Financial incentives

The need for better remuneration ranks as the primary reason for health worker migration from many countries[5]. It is also a major cause of exit to private and NGO AIDS programmes and jobs outside the health sector.

Raising salaries in the public sector can be difficult and costly. In some cases ministries of finance set public expenditure ceilings. In others, salary levels may be set for all civil servants by public service commissions, who may not wish to raise salaries in only one sector.

Despite these difficulties, some low-income countries have dramatically increased the pay of public sector health workers in recent years. In some countries, such as Kenya, Malawi and Uganda, salary increases have been applied across the board. In others, such as South Africa and the United Republic of Tanzania, they have been awarded to particular priority groups such as those with scarce skills, or rural health professionals.

Selective application of financial incentives may create inequalities that lead to demoralization in the workforce, and must be carefully considered. Objectives and target groups need to be carefully defined. Ideally, health workers and their representatives should be part of any financial incentive scheme.

Calculating the size of the salary increase (incentives, grants or top-ups) to stem migration is challenging. Health workers' salaries in most low-income countries are so low that they cannot realistically be brought into line with those in rich countries.

Other sorts of allowances are valued by health workers and may be used in combination with salaries and non-financial incentives to retain valuable human resources. These include bonuses, travel and housing subsidies, loan schemes, child care allowances, school fees and social protection packages.

The urgency of the health workforce crisis in worst-affected countries has prompted various agencies to discuss top-up grants or wage benefits for those delivering AIDS services. For example, UNAIDS has calculated for wage benefits (for nurses and doctors) of "five times higher" to reduce the wage differential with middle-income countries[6]. The challenges this creates must be discussed at global level as well as country level.

The AIDS emergency in itself has fuelled action on the part of national governments and donors as regards the financial implications of retention programmes and this should be maximized by all players.

Non-monetary incentives

Non-monetary incentives are valued by health workers and may represent more cost-effective retention strategies at country level. Incentives include improved living conditions (housing, electricity and water), free transport, education subsidies for health workers and their children and other benefits.

5 *World Health Report,* 2006. Geneva, World Health Organization, p99.
6 Resource needs for an expanded response to AIDS in low- and middle-income countries. Geneva, UNAIDS, August 2005.

Opportunities for continued learning and career advancement may be effective retention strategies (See “Train” paper). Trained health workers must be rewarded by new posts and pay scales if training is to be of value.

For health workers in high HIV prevalence countries, priority access to prevention and care programmes as well as confidential treatment for themselves and their families may be particularly valued (See “Treat” paper).

Social protection and other support schemes may also provide a good incentive for HIV-positive health workers to stay in the public sector and not migrate to northern countries.

Improving the workplace

Workplace issues are high on the list of “push” factors in health worker migration. Improvements in infrastructure and supplies that health workers need to do their work will help in retaining health workers, as will improved management practices and good leadership. Better organization of work leads to decreased workload and better patient flow, which contribute to improving the morale of health workers.

Good managers motivate their staff and find inexpensive ways of rewarding them, such as tea during night duty, holidays and days off, flexible working hours, study leave and planned career breaks.

Team work and participatory decision-making also improve the morale and motivate health workers. Interviews with health workers suggest that many would be satisfied with poor salaries if they were simply receiving the rewards of a job well done. Indeed, the most effective route to job satisfaction may lie in proper appreciation and acknowledgement—which cost nothing at all.

AIDS-specific workplace issues

Fears of occupational transmission of HIV are a cause of out-migration from the health services.

Health-care workers need access to proper information, training and an uninterrupted supply of commodities to prevent workplace transmission of HIV. Occupational Health and Safety management systems must be established in all facilities and all clinical teams should have access to sufficient gloves, aprons, sharps boxes and other waste disposal, post-exposure prophylaxis (PEP) kits, etc.

The availability of psychosocial support and counselling may also do much to relieve the stress of caring for people with HIV, and subsequent burnout, which causes some health workers to leave the health system.

These and other AIDS-specific workplace issues are outlined in detail in the Joint International Labour Organization (ILO)/WHO Guidelines on health services and HIV/AIDS. The implementation of these guidelines through social dialogue will do much to stem health worker migration (this is also discussed in the companion paper “Treat”).

On the plus side, the increased availability of antiretroviral therapy (ART) has been cited in many studies as a source of job satisfaction for health workers.

2.2 Managing migration

The WHO *World Health Report 2006* [7] recommends a range of strategies to manage health worker migration and mitigate its negative effects. Actions are needed in source countries, in receiving countries and internationally.

A wide range of stakeholders, from governments, regional organizations, employers and trade unions to professional organizations, diaspora migrant associations, donors and international agencies have already begun implementing diverse strategies to manage migration. There is a need for a comprehensive mapping and evaluation of these strategies.

A key challenge in managing the international migration of health workers is the need to balance the rights of individual health workers to migrate, against rights to health care in their home country. Balancing the rights and responsibilities of source and receiving countries presents other challenges.

7 WHO (2006). *Working together for health. World Health Report 2006,* Geneva, World Health Organization.

2.3 Codes of practice, ethical guidelines

In recent years the recruiting practices of receiving countries have come under attention, and about a dozen codes of practice for ethical recruiting have been proposed at national and international levels. While these set important norms for behaviour among key actors, they are not legally binding. For example:

- The Commonwealth Code of Practice for the International Recruitment of Health Workers of 2003, contains a strong emphasis on the mutuality of benefits, and includes the proposal that receiving countries compensate source countries for loss of skills and human capital.
- International professional organizations such as the International Council of Nurses and the World Family Doctors Association (Wonca) have drawn up guidelines on ethical recruitment that their members can use for advocacy with employers and governments.

There have been many calls for the strengthening and enforcement of Codes of Practice to manage health-worker migration. For example, in December 2005, Public Services International (PSI) mounted a campaign for ethical recruitment (international migration and women health workers) with a network of 16 countries. They are calling for the development of a WHO Code of Practice for the international recruitment of health workers.

Codes of Practice adopted by individual receiving countries may be easier to enforce. The United Kingdom Government, one of the largest employers of migrant health professionals, has led the way with a Code of Practice for the international recruitment of healthcare professionals. It stipulates that 150 low-income countries will not be targeted for recruitment unless explicit bilateral agreements have been reached. Although this was extended to private employers in 2003, it seems not to have stemmed the flow of African health workers to the United Kingdom.

Several source countries are also discussing policy and guidelines to manage international migration.

2.4 Bilateral agreements

Bilateral agreements can provide explicit and negotiated frameworks for managing health worker migration. For example, an agreement signed between the United Kingdom and the Philippines outlines a transparent and regulated recruitment procedure, and includes rights and duties of employers' organizations in both countries as regards costs of airfares and visas, etc.

Bilateral agreements may also extend beyond international recruitment, to include technical assistance and cooperation on health systems development. For example:

- A Memorandum of Understanding between South Africa and the United Kingdom provides for health professionals from one country to spend periods of work and study in the other country, to the benefit of both.
- The United Kingdom's agreement with Egypt includes programmes on mental health and care of the elderly, as well as fellowships for Egyptian doctors to be trained in the United Kingdom.
- An agreement between the Ministry of Health in Ghana and the Netherlands embassy allows Ghanaian health workers opportunities to train in the Netherlands. Ghanaian professionals working in the Netherlands and the European Union are able to transfer their knowledge and skills through temporary assignments in their home country.

The ILO's publication *Action programme on the International Migration of Health service workers,* the supply side, aims to identify and disseminate best practices through six case studies. Strategies for managing migration will be based on the ILO's social dialogue approach of consultation and negotiation between government, employers and workers.

2.5 South-South, regional agreements

Agreements between southern or less developed countries have been used as an emergency measure to reduce HRH shortages. For example, the Botswana Government recruited doctors from India and Cuba to assist them in meeting their targets for provision of ART. Agreements between regional bodies such as the European Union and African Union can also facilitate the management of migration.

2.6 Receiving country policies and strategies

Policies relating to annual targets, work permits, visas and licensing are used by receiving countries to regulate health-worker flow. For example, a bill being debated in the United States removes the limit on the number of nurses allowed to immigrate and is likely to have a negative impact on HRH in African countries.

A recent paper published in *The Lancet*[8] suggests a new way of looking at health-worker shortages in receiving countries. The authors reject the notion of major and enduring global health worker shortages that create high levels of effective demand in rich countries. By analysing health-worker flows in four Organisation for Economic Co-operation and Development (OECD) countries, the authors demonstrate that shortages are a result of specific policy measures of these countries, e.g. freezes for enrolment in medical schools, or quotas that regulate the graduation of medical students.

The authors argue that, just as these specific policy measures may have created shortages, other policy measures may be capable of reversing trends and avoiding the exploitation of low-income countries' scarce resources. Though the lagged nature of supply responses creates particular challenges for HRH, health-sector policy in receiving countries may balance the effect of global market forces.

2.7 International trade rules

Mode 4 of the General Agreement on Trade in Services (GATS) of the World Trade Organization (WTO) deals with the temporary movement of service providers between WTO member countries. To date, it has not been proposed as a means to regulate international migration of health workers. However, civil society organizations and others are concerned that the WTO rules will privatize and liberalize public services for the global market, with negative effects on poorer countries.

2.8 Diaspora programmes

It is estimated that around 40% of Africa's professionals now live outside the continent.[9] In recent years the focus has shifted from the negative aspects of this situation to an understanding of the development potential of the African diaspora. For example, their remittances alone are now estimated at US$ 160 billion; this is more than double the amount African countries receive in official development assistance (ODA).[10]

Innovative programmes to maximize the opportunities presented by the large numbers of health professionals among the African diaspora are being implemented. For example:

- The International Organization for Migrations' for Development in Africa (MIDA) capacity development programme[11] offers a wide range of options for mobilizing the contribution of the African diaspora. MIDA Health includes a database for skills in the diaspora as well as e-learning programmes, volunteer schemes and student exchanges.

8 Pond B, McPake M. The health migration crisis: the role of four Organization for Economic Cooperation and Development countries. *The Lancet,* 21 March 2006. (http://www.lancet.com, accessed 2 July 2006). Published online March 21, 2006 DOI:10.1016/SO140-673(06)68346-3
9 Africa Recruit. (http://www.africarecruit.com/healthcare/diasporapartners.htm, accessed 2 July 2006)
10 2004 figures quoted in *World Bank, Global Development Prospects,* 2006.
11 http://www.iom.int/mida/, accessed 2 July 2006.

- Africa Recruit, a London-based agency established by the Commonwealth Business Council represents both a practical and a virtual marketplace for stakeholders in human resources for Africa. They recently held an African diaspora health conference, which mobilized health-care professionals and resources for capacity-building in Africa.

The management and financing of AIDS diaspora programmes could also be undertaken by host countries, as part of their commitment to ethical recruitment.

Other programmes targeting the health diaspora create incentives for skilled professionals to return to their country of origin. For example the Philippines Overseas Employment Agency was founded in 1995 to promote the return and reintegration of migrants. Among the incentives are tax-free shopping for one year, business loans at preferential rates and eligibility for subsidized scholarships.

2.9 Retention of rural health workerfis

One of the challenges to providing equitable health services, including ART, is the retention of skilled health workers in remote rural areas. Some of the strategies that have been employed to do this are:

- Financial incentives for rural health workers;
- Training local workers in local languages and skills relevant to local conditions.

The inclusion of community members and people living with HIV (PLHIV) in clinical teams to deliver HIV services as a means to expand the health workforce may also prove to be an effective retention strategy.

Managing migration—an AIDS perspective

The AIDS epidemic has brought urgency and an added dimension for advocacy around the issue of health worker migration. This could be explored and developed in more concrete ways.

Donor countries that have been most proactive in HIV/AIDS funding are also those that receive health workers from AIDS-affected countries. The contradiction between the commitment to Universal Access by 2010 and the human resource crisis that is undermining the delivery of HIV services must be seen in this context. This may create new opportunities for consensus on ethical recruitment codes, and their enforcement. Bilateral agreements could also be extended to include technical advice and support on AIDS-related issues.

Diaspora programmes present another clear opportunity for strengthening the HIV/AIDS workforce in worst-affected countries. For example, AIDS competencies identified in the MIDA Health database could be mobilized for exchange visits or virtual learning. Clinical mentoring for AIDS workers is one service that could be offered via e-learning. Diaspora skills can therefore make a vital contribution to AIDS services.

The urgency of the AIDS crisis also provides a clear rationale, and advocacy messages for temporary and permanent return of health professionals in related fields. However, it is important that diaspora skills be used in the home country to strengthen existing capacity, and not to displace existing staff.

2.10 "Migration" from public to private/NGO AIDS sector

Though there is little research or hard data, anecdotal evidence from a wide range of sources suggests that the advent of well-resourced donor funded and NGO AIDS programmes is depleting HRH in the public sector of the worst-affected countries. For example, within one year the Masaka district of Uganda lost 10 of its 21 doctors newly trained in HIV skills, to NGO programmes in the region.

This kind of migration is undermining both AIDS and general services in the public health sector. For instance, a letter in *The Lancet* described a "secondary crisis" in Malawi's health-care system, as threatening curative services in the northern and central regions of the country[12]. In 2004, a 970-bed facility authorized to employ 520 nurses had only 169 nurses. Only 6 out of 38 posts for laboratory technicians were filled. The authors, all surgeons at the hospital, attributed this directly to staff leaving to join AIDS programmes.

There is clearly a need for comprehensive research on the nature and dimensions of this problem. However, there is enough evidence to suggest a need for discussion and debate between stakeholders in the private/NGO AIDS sector and the public health sector.

Strategies to mitigate harmful impacts may include:

- Robust advocacy for an integrated, decentralized delivery model for HIV/AIDS services;
- Clinical mentoring and exchange programmes between public and private/NGO sectors;
- A Code of Practice, or other forms of agreements governing the conduct of those delivering HIV/AIDS services outside the public sector;
- Vigorous strategies to remove the "push" factor for migration (see below).

As in the parallel scenario of the African diaspora, this kind of migration may present opportunities as well as losses. Health workers may learn new skills in these better-funded programmes, and may return with these to the public sector. This applies particularly to community and lay health workers.

However, while AIDS services may be strengthened in the long term by this kind of migration, the public-health sector in general may suffer. While solutions to this problem will have to be found at local and country level, the challenges posed by this situation may also benefit from discussion and debate at global level.

3. RESEARCH, MONITORING AND EVALUATION

As with other aspects of the TTR Plan, "Retain" suggests a wide research agenda. Some research priorities are:

- Out migration of health workers to private and NGO AIDS programmes. Hard data here are a precondition for discussion about strategies and policy to manage this situation.
- A comparative evaluation of the efficacy of ethical recruitment codes and bilateral agreements;
- A comprehensive review of country-based retention strategies;
- Continuing research, monitoring and evaluation of country-based retention strategies, particularly the evaluation of cost-effective soft incentives;

Participatory action research by health workers and their representatives may be a useful approach to understanding effective country-based retention strategies. For instance, a Public Services International (PSI) study of migration and health workers showed that health workers would prefer to stay at home if they could earn a living wage. Poor working conditions were prevalent and staff shortages and gender discrimination were other sources of dissatisfaction. The research also showed that health worker input was essential to health sector reforms.

12 Kushner A et al. Secondary crisis in African health care. Letter, *The Lancet,* 363:1478.

4. FINANCING IMPLICATIONS OF "RETAIN"

Retention strategies at country level must be integrated into national planning and budgeting. This will include embedding migration, AIDS workplace strategies, incentive packages and other retention schemes into national health-sector and development plans. The design of a package of financial and non-monetary incentives may only be done at country level, taking local conditions into account. However, it may be possible to make some rough global estimates for elements of this package. Although separate funding streams and mechanisms for AIDS are not recommended, it may be useful to see the money spent on incentives for staff delivering AIDS services as a proportion of the whole.

Costing at country level could include:

- Financial incentives;
- Non-monetary incentives;
- Diaspora incentive programmes;

5. AN ACTION PLAN FOR "RETAIN"

The WHO Joint Consultation on AIDS and Human Resources is proposed as the first step in drawing up an action plan for retaining health workers in the context of AIDS.

5.1 Key questions for this process are:

1. What are the priority elements of "Retain"?
2. How can and should the AIDS sector relate to broader migration policy and retention strategies?
3. What must be done at global, national, regional, country and local levels to advance the TTR plan?
4. Which actions, strategies and programmes are new, and which need to be strengthened?
5. How can the work best be divided according to the comparative advantage of different players?

5.2 Identifying the roles of:

- International organizations – United Nations agencies; financial organizations; donors and other bilateral organizations; international labour organizations; international professional organizations; diaspora organizations; expert and technical groups?
- National government – ministries; national AIDS authorities; human resource (HR) planners;
- Civil society organizations, such as trade unions, NGOs,faith-based organizations (FBOs) and community-based organizations (CBOs);
- National professional organizations.

THE ESTABLISHMENT OF A "RETAIN" WORKING GROUP IS PROPOSED TO TAKE THIS INITIATIVE FURTHER.

Annex E: FINANCIAL ISSUES

1. FINANCING

The urgency of the HIV/AIDS crisis has acted as a catalyst for commitment to AIDS services, and global funding has increased from US$ 2.1 billion to an estimated US$ 6.1 billion in 2004. This is projected to rise to US$ 10 billion by 2007[1].

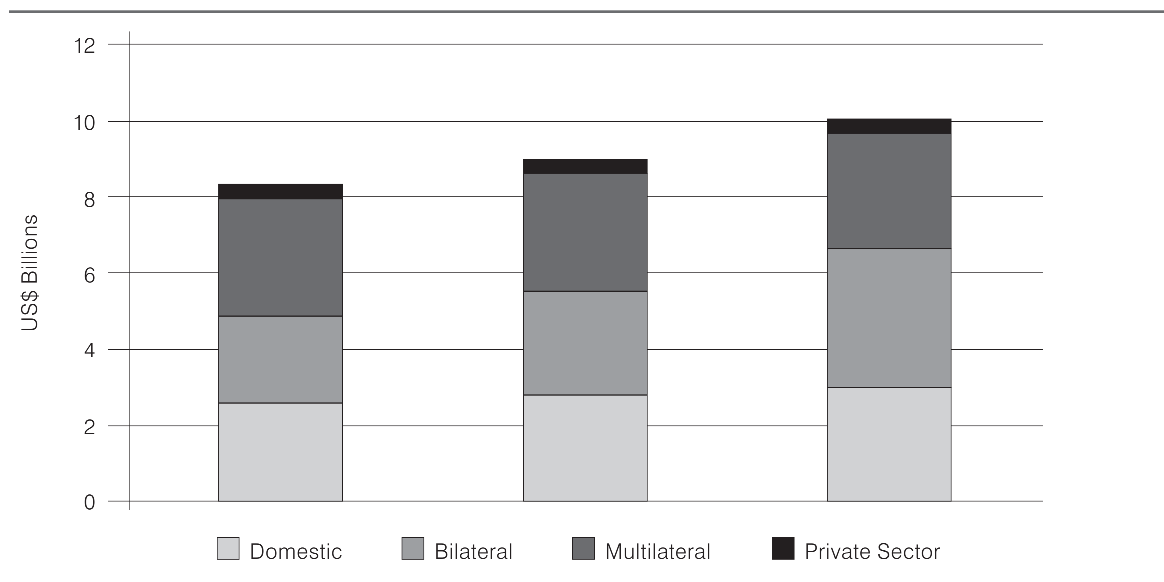
Despite this rapid growth in funding, the commitment to scale up towards universal access has brought with it far greater resource requirements than current projections allow. UNAIDS has estimated the resource gap[2] to be US$ 55.1 billion for the period 2006–2008. This must be seen in the context of the G8's 2005 pledge to increase all international development funding by an extra US$ 50 billion annually by 2010. This will bring the global total from US$ 80 billion to US$ 130 billion[3].

A comprehensive plan to strengthen human resources for AIDS will inevitably create additional resource needs over and above those for AIDS services.

Current sources and expansion potential

Based on current trends in expenditure and adjusted by known pledges and commitments, international spending is the largest and fastest growing component of AIDS spending.

Fig. 1. Projection of available resources for AIDS from all sources between 2005 and 2007



Major international funding commitments in 2004 were in the form of:

- Direct bilateral funding: of which the United Kingdom and the United States accounted for over 70% in 2004, with other donor countries choosing to channel funding through multilateral organizations;
- Global Fund to Fight AIDS, TB and Malaria;
- European Union funding; and
- The World Bank.

1 *Resource needs for an expanded response to AIDS in low- and middle-income countries.* Geneva, UNAIDS, August 2005.
2 This includes some health system and human resource requirements, but not all the elements of "Treat, Train, Retain".
3 Lob-Levt J, Affolder R. Innovative financing for human development. *The Lancet,* 2006, 367:952-955. (http://www.thelancet.com, accessed 2 July 2006).

The recent commitment to support the scaling up of access to AIDS services has shifted the focus from money for AIDS, to a commitment to strengthening the health systems that can deliver those services. For example:

- The Global Fund is now committed to proposals for health systems strengthening (HSS): 12% of Round 5 proposals were for HSS plans rather than AIDS, tuberculosis (TB) or malaria programmes.
- The European Union has planned a decade of action on Human Resources for Health (HRH) and has committed to supporting and financing national human resources plans.

This growing momentum should provide additional sources of funding for country-led "Treat, Train, Retain" plans.

Domestic spending accounts for a significant and growing part of the global resource response to HIV and AIDS. This includes public spending and out-of-pocket spending in the form of user fees, etc. In March 2006, African nations[4] renewed their pledge to raise health spending to 15% of their national budgets. However, progress on this pledge has been slow and the average domestic spending on health in low-income countries remained below 10% of national budgets.[5] Out-of-pocket spending currently accounts for much of domestic spending. This must necessarily be reduced if equity in access is to be assured—a precondition towards universal access to health and AIDS services. Constraints on public-sector spending may also limit future increases in domestic spending (see below).

New and untapped sources and mechanisms

The large amounts of funding necessary to achieve the Millennium Development Goals (MDGs) as well as the need for more predictable and sustained sources of aid has led to a global debate on innovative financing mechanisms for development.

International support for this was advanced at a March 2006 conference in Paris, attended by 93 States as well as international and nongovernmental organizations (NGOs). Participants reviewed many different options. Two proposed innovative mechanisms that are already in early stages are:

- International Finance Facility (IFF): This aims to front-load funding by raising finance through bond markets. A pilot for immunization is already underway, funded by 6 European countries, whose 20-year commitment will result in a steady and predictable flow of financing for immunization over the next 10 years.
- The air ticket solidarity levy: This tax on airline tickets has already been agreed upon by the United Kingdom and France. There were 11 other countries attending the conference that also indicated a willingness to implement the tax. A small tax on each airline ticket sold will raise an estimated 200 million euros a year in France alone. France intends to use this to purchase pharmaceuticals.

Other options proposed and reviewed at the Paris conference were:

- Other solidarity levies;
- Taxing financial transactions and reducing tax evasion;
- Migrant remittances;
- A humanitarian lottery;
- Voluntary initiatives, such as "Red", an initiative on the part of some global fashion leaders to raise sustainable funding for the Global Fund.

The Leading Group on Solidarity Levies, which includes 38 donor and low-income countries, has been created to fund development

4 Brazzaville Declaration.

5 *Fiscal Space and Sustainability from the Perspective of the Health Sector.* Paper for the High-Level Forum on Health MDGs. Paris, 15-15 November 2005. (http://www.hlfhealthmdgs.org, accessed 2 July 2006)..

2. ISSUES AND CHALLENGES

Financing for AIDS health workforce plans raises many of the broader issues and challenges around financing and development that have been discussed in international forums in recent years.

Fiscal space for health spending

First, creating fiscal space and sustainability for health spending presents a series of interlinked challenges that must be met if sustained progress is to be made. Fiscal space is defined as "the availability of budgetary room that allows a government to provide resources for a desired purpose without any prejudice to the sustainability of a government's financial position"[6]. In this broad definition of fiscal space, expanding health spending will depend on the actions of both donors and recipient countries.

Donor policies that allow for sustained fiscal space are those that ensure:

- Long-term commitments to scale up aid;
- Predictable and stable flows of financing;
- Coordinated and harmonized aid across donors to reduce recipient's transaction costs.

Recipient country policies and actions that create conditions for sustained fiscal space are:

- Affordable long-term investment and expenditure plans;
- Increases in aid accompanied by stronger tax efforts;
- Ability to finance any residual cash-flow variations;
- Ability to manage donor aid;
- Reallocation on budgets towards the health sector;
- Health systems that are efficient, effective and equitable.

Some health economists argue that it is the degree to which these conditions are present that will determine whether fiscal space for health spending can be sustained. The term fiscal space is often used more narrowly to describe deliberate policy constraints on public health spending. In order to preserve macroeconomic stability, international financing institutions and ministries of finance in some countries have imposed ceilings on public expenditure. These have resulted in moratoriums on recruitment and salary increases in the health sector, and have been a brake on health systems expansion particularly in sub-Saharan Africa. In some countries, this has led to an anomalous situation where unemployment of skilled health workers exists alongside an HRH crisis in the health system.

In many countries, however, the AIDS emergency has brought governments to a political commitment to expanding fiscal space for public spending on health, HIV and AIDS. This has resulted in bold emergency plans to expand health services or roll out towards universal access to antiretroviral therapy, and in different strategies to fund them. Some countries have diverted funding from other sectors to health. For example, Botswana has diverted funding from defence to AIDS. Another approach, used by the Malawi Government, is to seek a large injection of donor funding for comprehensive HRH plans. Zambia has chosen to use savings from debt relief to fund HRH.

For countries where public expenditure ceilings exist, a case may be made for the financing of "Treat, Train, Retain" and general health workforce plans to be accorded exceptional status. One contribution of AIDS actors to the global debate has been to demonstrate that the consequence of not doing this will be long-term damage to the economy as a whole.

WHO's World Health Report 2006[7] argues that negotiating fiscal space for the health workforce will require the international health development world to engage productively with ministries of finance, international finance institutions and major international stakeholders. Strengthened evidence on the health and economic returns on investment in the health workforce will assist in these negotiations.

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6 Fiscal space HLF paper (number 5).
7 *Working together for health. The World Health Report 2006.* Geneva, World Health Organization, 2006.

Sustained and predictable donor funding

Sustained, predictable and long-term donor funding will also be needed if low-income countries are to make ambitious plans to strengthen health systems and deliver universal access to health and AIDS services. The need for predictable funding is a requirement that “Treat, Train, Retain” shares with both HSS and with universal access to ART. Donor funding volatility has been the subject of continuing discussion and debate at the High Level Forums on Health MDGs and other forums. Solutions that are being discussed are long-term sector commitments by particular donors and establishing an Aid Guarantee Fund. New financing mechanisms such as the International Finance Facility (IFF) have also been suggested as a solution.

AIDS money versus health system money

The “Treat, Train, Retain” plan raises some unique funding and financing challenges that derive from the fact that it incorporates both AIDS-specific and general HSS elements. This could be seen as a new opportunity to harmonize funding for AIDS with funding for HSS.

For example, the activities envisaged in the “Treat, Train, Retain” plan can be divided into three types:

1. Interventions that strengthen health systems by protecting the health workforce from the impacts of HIV and AIDS. For instance, Universal Precautions, post-exposure prophylaxis (PEP); prevention and stigma campaigns; and ART for HIV-positive health workers and their families;
2. Interventions to strengthen health systems to deal with the epidemic by, for instance, increasing health workers competencies in HIV through pre-service and in-service training; task-shifting; training of people living with HIV (PLHIV) and expert patient groups, etc;
3. Interventions where an AIDS perspective or component is included in broader programmes. For example, migration of health workers or expanding pre-service training and facilities.

Each element of these elements could have different implications for the way AIDS funding relates to HRH funding. The activities in the last example above, for instance, raise the opportunity for AIDS funding to be directed to broader HSS. This could be done by using a formula similar to the one that the Global Alliance for Vaccines and Immunization (GAVI) has devised to fund HSS.

3. AN ACTION PLAN FOR FUNDING

The WHO Joint Consultation on AIDS and Human Resources is proposed as the first step in drawing up an action plan for funding the “Treat, Train, Retain” plan.

Key questions for this process are:

1. Is there merit in the exercise of drawing up a comprehensive global costing for “Treat, Train, Retain” plan; or should this be done at country level according to national HRH and AIDS plans or both?
2. What are the financing implications of the priority elements of “Treat, Train, Retain” plan?
3. Are some elements of “Treat, Train, Retain” planlikely to be more cost effective than others?
4. How can funding efforts for “Treat, Train, Retain” plan be harmonized with funding for broader HRH—at international level; at country level?
5. What needs to be done to enable governments to make ambitious plans to strengthen human resources for AIDS?
6. What needs to be done at global level to raise the necessary funding for “Treat, Train, Retain” plan?
7. Does the AIDS sector/”Treat, Train, Retain” plan have any special contribution to make to the broader debate on funding for HSS?
8. Is there a need for a special financing mechanism for “Treat, Train, Retain” plan?

Photograph: Michael Jensen

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