

Speech

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**The Global Health Workforce Alliance
Global Forum on Human Resources for Health**

**Plenary session: Partnerships and linking for
action**

Kampala, Uganda 5 March, 2008.

**Dr Peter Piot
UNAIDS Executive Director**

Thank you Sigrun – and thank you for inviting me here today.

I came to Kampala for three reasons. Firstly, this Forum is one of the most important meetings in public health to take place this year. We are starting to build a coalition to address one of the greatest obstacles to health.

Secondly, I am here to pledge the firm support of UNAIDS to this initiative.

Thirdly, it is time to de-polarize this debate. Whether we invest in the AIDS response or in strengthening health systems. It is not a question of one or the other. Even when it comes to AIDS, it is not simply a question of strengthening health services but also community mobilization. We must not forget about people or health outcomes

The issue of human resources for health is complex. But we all know it's not a new one. I lived it myself in the mid-70s in rural Zaire. But nor is it limited to Africa. Last week I was in India where this is an enormous maldistribution of human resources for health.

The shortage results from decades of under-investment by governments, donors and international agencies. It has been intensified by globalization, but globalization may also bring some of the solutions. Responsibility for the current situation is shared – between donors, national governments, NGOs, research organization and international organizations among others. We therefore have a shared duty to address it. That's why this afternoon's panel, with its focus on partnership, is so vital.

The debate we are having now is long overdue. And a major reason for its happening at all is AIDS!

One of the peculiar characteristics of AIDS is that it exposes injustices. AIDS - more than any other issue - has thrown a spotlight on the urgent need to strengthen human resources for health, for three reasons. Firstly, AIDS represents a significant burden on health systems. In some countries, half of all hospital beds are occupied with patients with AIDS-related illnesses. Secondly, to expand ART, and to make ART sustainable, we need strong health systems. Thirdly, being a health worker does not protect you from becoming infected. Botswana, for example lost approximately 17% of its healthcare workforce to AIDS between 1999 and 2005.

There have been good examples of how AIDS investment has helped overcome the human resources for health crisis. I remember well going to Malawi in 2004 with Sir Suma Chakrabarti, then Permanent Secretary of the UK's DFID. AIDS had brought the health workforce literally to its knees. There was no way it could cope. It was an emergency that required exceptional measures. DFID and other donors financing the sector agreed to fund a groundbreaking initiative, the Emergency Human Resources Programme, to top up salaries for nurses and other health care workers as an incentive

not to leave the country. This was totally novel: donors usually resist paying salaries, but in this case we managed to break the taboo. I'm glad to say that the Global Fund to Fight AIDS, Tuberculosis and Malaria is now supporting this programme.

This is just one example of another characteristic of AIDS: it forces us to do things differently. WHO's "Treat, train, retain" initiative for health-workers with HIV is another new and pragmatic approach. I don't know of any other programme that starts by addressing the health of the workers involved. It provides wins all round – to the health workers themselves, to the people who need their services, and to the health sector as a whole. So, when we are talking about strengthening health systems, let's first make sure that people stay alive! But good partnerships require more than processes. There are too many partnerships that are not enough about results and outcomes.

AIDS funding and programming enhanced essential infrastructure for health facilities. Where HIV services have been integrated into existing service delivery sites, AIDS money helped renovate health facilities, upgraded clinics and laboratories and provided training opportunities for health care workers.

AIDS has also helped promote "task shifting", an old concept/idea in public health – moving responsibility for certain tasks to other health-workers and community members to free up doctors and nurses to take care of other patients and to deliver other essential health services. Here in Uganda, there is an increasing trend for people living with HIV to take on tasks such as counseling for testing, adherence support, treatment literacy and to produce good quality outcomes. In Kenya, several organizations have been implementing prevention, treatment literacy and home based care programmes, which are led by people living with HIV at the community level. Women Fighting AIDS in Kenya, supported by UNICEF in Kisumu and Port Reitz General Hospitals, trained PLWHAs who were then used as PMTCT champions to provide counseling to ante-natal mothers and their partners.

We also see, particularly here in Africa that faith-based organizations play a major in the fight against AIDS providing vital HIV care and treatment services. For example, Christian hospitals and health centers are providing about 40% of HIV care and treatment services in Lesotho and almost a third in Zambia. In other countries, the formal and informal private sector is also very important.

AIDS has brought in new resources, to benefit not only HIV programmes but health systems more widely. Take for example the Haitian "accompagnateurs" – community workers who have been brought into the health workforce through the AIDS programme. Or in Rwanda, HIV treatment and care was integrated with regular health services, resulting in better coverage for maternal and child health according to a study by Family Health International (FHI) presented at last year's PEPFAR Implementers

Meeting in Kigali. Les Mutuelles de Santé is another example of financing scheme to mobilize resources for health services.

So I have serious issues with the current wave of statements like “There’s too much money going to AIDS” or “Donors should prioritize health system strengthening”. They completely ignore the growing body of evidence that AIDS expenditure strengthens the health sector and contributes to broader development programmes, besides the fact that AIDS programmes are having measurable results, saving millions of lives. Indeed, AIDS has been an advocate for health systems strengthening.

They also seem to assume that dealing with HIV is mostly about treatment. It isn’t! For every one person we put on antiretroviral therapy, another four or five become infected with HIV. If we don’t radically enhance HIV prevention, demands for treatment will just keep on growing, placing an even greater burden on health systems in the future.

And prevention – except for PMTCT – is far more than a health issue. Prevention is a community based action. Effective HIV prevention derives from a range of multi-sectoral interventions (governments, nongovernmental organizations, faith-based organizations, the education sector, media, the private sector and trade unions and people living with HIV).

A lot of the recent surge of funding started as a direct consequence of the AIDS epidemic. AIDS advocacy did not only succeed in mobilizing money, but it also highlighted the profound disparities in health services that separated the developing countries from the developed world. It is however true that there are examples where AIDS related activities and AIDS funding are taking away health workers from other tasks. AIDS funding created new and more interesting job opportunities for doctors and nurses with NGOs and foreign aid agencies and thus can be a drain on the public sector. We have seen it happening in Malawi and in Zambia where focus of disease programmes shifted to HIV. However, and certainly in the heavily affected countries, the AIDS burdens for health services is also a reality. We need to find common solutions and ways of working together.

This brings me to my next point. AIDS has taught us about the critical value of partnerships. Tackling AIDS is one of the toughest challenges the world faces today. Like dealing with climate change, it’s tremendously complex - way beyond the capacity of any single sector or institution. It’s one of those issues that jolts us out of our comfort zone, and forces us to create new alliances with a variety of constituencies – across sectors and at state and non-state level.

UNAIDS itself is a joint programme. We are working with a wide range of constituencies – government, scientists, business, labour, and the media. One of the most important partnerships of all has been our relationship with civil society. It was the activists who kick-started the AIDS movement. Without them, we wouldn't have achieved anything like the progress we've made. It's thanks to these partnerships that we have been able to mobilize political momentum around AIDS, to leverage funding to \$10 billion per year.

In the twelve years since UNAIDS was created, we've learnt a lot about partnerships. We've seen the advantages of being able to convene diverse actors from public, private, and non profit sectors – all with different strengths. They have the potential to achieve spectacular results – way beyond anything they could hope to achieve on their own.

But coordination and accountability are still important. That's why UNAIDS established the Three Ones principles, as a framework for partnerships on AIDS. Just to remind you, these are: one agreed national action framework, one national coordinating authority and one agreed monitoring and evaluation system.

The lessons we've learnt through implementing the Three Ones are salutary – and very relevant to the aims of this Alliance. The Agenda for Action is right to highlight the need for “national responses to be guided by a national leadership that convenes all actors around one agreed national effort”, and to point to the importance of accountability. The challenge is to engage serious commitment at all levels – in-country, in donor capitals and international organization headquarters. This requires time and effort. But it will be time and effort well spent.

I began today by saying that addressing the shortage of human resources for health was a joint responsibility. It is something that no institution can tackle alone. It is complex, cross-sectoral and long-term. And, like AIDS, it is not a quick-fix problem and there is no one solution that fits all. This may be a major reason why so little has been done before. Another reason may be the fact that the current crisis of human resources for health is also a highly political issue and therefore any possible solutions need to have full political support. But coming together in this alliance is in itself a tremendous step forward. There is a lot at stake; therefore our response must address the emergencies of today and to draw up longer-term plans for the future.

The Agenda for Action offers a comprehensive menu of activities, but I want to suggest some very concrete actions where we can all work and benefit together.

The first is that we must build partnerships far beyond the public sector. Partnerships are crucial for the success of any solution. We must also look at the critical role of non-state actors in the provision of services and their role in the training of human resources. In

many countries, 40 to 60% of health services are delivered by the private sector. We have to establish more private/public partnerships with greater engagement of the private sector, beyond workplace programmes. Equally, in many countries, particularly here in Africa, many clinics and health centers are run by faith-based organization. We need to bring them all into the policy dialogue of health services provision.

The second is to engage the full participation of civil society. As I mentioned earlier, civil society has been at the heart of the AIDS response from the very beginning. And its presence there has been vital. Not only does civil society activism mobilize action, but community members are an invaluable source of knowledge about what works and about how to reach people. We must listen and learn from them, and at the same time invest in building their capacity to deliver alongside that of public sector.

The third is for health ministries to make improving human resource management a priority. This is implicit in the Agenda for Action. But I think we need to spell it out more clearly. Today's crisis has come about for two reasons. Lack of investment and lack of management. There's a lot to do, but one of the first steps should be to establish incentives for performance and raise health-worker morale.

Fourth, we need to work together to question and challenge our concepts of fiscal space, predict medium term expenditure frameworks and the suitability of salary supplementation. We have to involve ministries of finance in the discussions of solutions. We should also work together with the World Bank and IMF on these constraints.

There is also the need to address the issue of public sector pay and work conditions. To address issues such as poor infrastructure, lack of equipment and drugs, long hours and heavy workloads and lack of career development in addition to poor remuneration. This needs to be combined with putting human resources for health on the agenda of civil service reform and donor willingness support and invest in supplementing health workers' salaries and training. Donors and countries should consider the lessons learnt from the Malawi experience.

These issues are at the heart of any assessment of countries' ability to scale up the response and the achievements of the MDGs. They are relevant for all of the health MDGs and need close examination and a common assessment of the risks and opportunities.

We can be very ambitious, but need clear targets, goals and a partnership, where put the institutional interest aside. Fight for common good and common goal. We need to re-set the rules and to put into practice what has been discussed globally at country level. Every research programme must include overhead (/indirect costs for strengthening

capacity. This is starting to be done among largest investors in health (GAVI; GF; PEPFAR etc).

We also need to find a practical way to compensate low and middle-income countries that are losing their skilled staff in whose education they have invested.

The final – and most relevant for this afternoon’s session - is to be serious about applying the Three Ones principles, for all parties to come together and align around a single strategic plan for strengthening human resources for health that focuses clearly not just on process but on results. One National AIDS Coordination authority and one agreed country-level monitoring and evaluation system. Such a framework has been invaluable for a well coordinated AIDS response. We are not there yet, but we have made progress.

If we make progress on action plan, it will be because we have worked together. It is through diversity we will succeed. Pragmatic approach is needed, one step at a time, and strong leadership which will hold us together. I believe we have that leadership.

That may sound ambitious. But if we can come back in a year’s time and say we’ve made progress in these four areas, the world’s health workforce will look a lot more robust than it does today – and its population will be fitter as a result.

We have to act now and “to work together to ensure access to a motivated, skilled, and supported health worker by every person in every village everywhere.” Dr. *LEE Jong-wook*

Thank you.