

Human resources in scaling up HIV/AIDS programmes: just a killer assumption or in need of new paradigms?

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Introduction

In the countries hardest hit by HIV/AIDS, the pandemic's onslaught on the health workforce institutes a vicious circle that puts the health services under ever-greater pressure. Unfortunately, these services have little reserves left and chronic deficiencies regarding training, recruitment and retention in the medical professions, unequal distribution and poor skill mix strain their performance. With the international agencies now bankrolling the scaling up of ART and the price of drugs dropping continuously, the health workforce stands to make or break any programme.

Thyolo district in Malawi provides a sobering reality check. With an estimated adult HIV prevalence of 20%, close to 50,000 adults and children out of an estimated population of 475,000 inhabitants were presumed seropositive in 2003 and 7,000 persons suffering of AIDS and opportunistic infections [1, 2]. Besides a mission hospital with eight dispensaries, there is a Ministry of Health (MOH) district hospital with 9 health centres. In August 2003, the MOH staff consisted of six clinical officers, two registered nurses and 21 enrolled nurses. MSF-Luxembourg supports a HAART pilot project among other activities and employs 2 (expatriate) doctors, 3 clinical officers and 14 nurses, some of whom recruited in neighbouring districts. At the end of 2003, eight months after the start, 385 patients were on ARV treatment in Thyolo district¹. This represents an annual uptake capacity of about 600 new patients. In this setting, the "perfect" programme, treating all AIDS patients, would have an annual uptake of about 7,000 patients, accompanied by a corresponding increase in staff. But then, this scenario does not even consider the need to provide preventive interventions, nor taking care of the unabated other health problems like malaria, tuberculosis and reproductive health, with which the health services have to deal on a permanent basis.

Two fundamental issues are therefore emerging. The short-term priority is to adapt the health service delivery and organisation to make the best use of current resources, for example by considering integration of ART care in existing TB directly observed therapy programmes [3]. Basically, new delivery models should allow for delegation of tasks to lesser-qualified health workers and lay persons, supervised by the increasingly scarce professionals.

However, the long-term priority is to institute effective human resource policies to train and retain the required health workers. In Malawi, where the vacancy rate in public health services is estimated to be around 60%, simply topping up the public servants' salaries and hiring some expatriate professionals won't do to fill in chronic and structural deficits.

A call for paradigm shifts

The hard decisions governing the human resource policies in the health sector are taken not in the Ministry of Health, but in the Public Service Commission and the Ministry of Finance. Through their aid programmes, international agencies are important actors too. Poverty Reduction Strategy Papers (PRSP) are a good indicator of the importance given to the health workforce by both governments and international actors. Disappointingly, a review of the PRSP-Heavily Indebted Poor Countries (HIPC) initiative in 6 selected African countries shows that in the best case the human resource crisis is merely acknowledged and that an in-depth analysis of the issue and how it relates to civil

¹ A. Chantulo, personal communication

service conditions is conspicuously absent [4]. A recent World Bank review came to the same conclusions [5]. In south-eastern Africa, where entire societies are in a process of what De Waal calls social involution of a scale probably unprecedented in human history [6], this silence is deafening. What we need now is paradigm shifts and approaches that used to be politically correct in other times urgently need to be reconsidered.

On a macro-level, the opportunities offered by PRSP need to be maximally exploited and should include a human resource development plan that rallies all the stakeholders. Recruitment ceilings imposed by Structural Adjustment Programmes and similar donor-imposed conditions need to be lifted, while the global initiatives like the Global Fund should actively seek to contribute to the expansion and stabilisation of the health workforce. Simultaneously, approaches to expatriate technical assistance that used to be 'developmentally' sound in past conditions now simply reduce the effectiveness of international aid. In high prevalence countries, autonomous sustainability of programmes can no longer be a constraining condition. Importing health professionals from countries with excess capacity for clinical and managerial roles is a short-term priority, if the funding flow is not to exceed the absorption capacity. All the while, innovative service delivery models need to be developed, whereby the challenge is to think outside the box of the pilot setting.

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