HIV/AIDS and human resources

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One reason why HIV/AIDS is a for-midable foe is its capacity to attack the body's immune cells. Life-prolonging antiretroviral drugs are efficacious be-cause they can block viral assault on the host's defence system. We are beginning to recognize that, parallel to biological action, the HIV/AIDS pandemic also attacks the human capacity and social defence systems. By destroying the fabric of health systems, the spread and impact of the epidemic is hugely augmented.

In a recent report from the Joint Learning Initiative (JLI), over 100 global health leaders called HIV/AIDS a "triple threat" to human resources for health (*1*, *2*). Firstly, HIV/AIDS increases the burden of disease, thus imposing heavier workloads. Work volume and complex-ity also escalate as new technology such as antiretroviral therapy is introduced. Secondly, HIV/AIDS decimates the workforce by subjecting health workers to the risk of viral contamination. Some African countries may lose as much as 20% of their workforce to HIV/AIDS in coming years (*3*). Thirdly, health workers have to cope with the psycho-logical stress of administering palliative care. Unable to heal their patients, over-worked terminal care workers feel utterly powerless and suffer from low morale, burn-out and absenteeism. In the hardest hit countries, this triple threat is overwhelming a workforce already depleted by chronic underinvestment and decimated by out-migration of highly skilled professionals.

Adequacy of the workforce has emerged as "the single most serious obstacle for national treatment plans" (*4*). The JLI offered three key recom-mendations: mobilizing the workforce, building health systems, and strength-ening the knowledge base. Rapid mobilization is an imperative because of severe worker shortages. JLI analyses showed that sub-Saharan Africa, with an estimated 600 000 doctors, nurses and midwives, needs at least one million additional skilled workers to even begin

approaching the health-related Mil-lennium Development Goals. Clearly, bridging this massive gap cannot await the lengthy education of doctors and nurses but must rather concentrate on briefly trained community-based workers, a solution that has been demon-strably effective in Africa and elsewhere (*5*, *6*). This will require massive educa-tion and training along with expansion of fiscal space, positive working environ-ments, and deregulation of restrictions that block delegation to para-profes-sionals. Because there is no blueprint, a learning-by-doing approach should be adopted following an iterative process of field action, assessment and adjustment. Historical experiences demonstrate that such mobilization is feasible, and popu-lar movements spearheaded by political leadership have been successful.

Priority disease control programmes usually deploy workers through vertically integrated systems with strong support and supervision. In many situations, this deployment can improve health systems, producing new energy, more resources, motivated workers, better information, and higher demand among clients (*7*). In contrast, single-minded pursuit of crash programmes — such as some experiences in malaria, smallpox and family planning — can retard or even weaken health systems. This recurring debate over vertical versus horizontal programmes is, we believe, a false dichotomy (*8*, *9*). Surely, the shared challenge is how to tackle devastating diseases while building sustainable systems. Three approaches are worthy of pursuit. First, while focused programmes aim to achieve their narrow targets, they should also articulate explicit health system goals that should be tracked and for which the programme should be held accountable. Second, priority pro-grammes should invest in human capital by earmarking investment funds for pre-service education. Just as they harness trained workers, they must also invest in the future workforce, if for no other reason than to ensure their own sus-

tainability. Third, priority programmes should synchronize their staff assign-ments, training and tasks within national health plans. Workforce configurations will be dictated by country circum-stances; rather than fragmenting the workforce, priority programmes should build coherence through harmonizing the management, working environ-ments, and career structures of health personnel, who are the key drivers of health action. Reciprocating these three approaches by priority programmes should be complementary action speci-fying time-bound pragmatic health outputs of horizontal systems.

In some countries, more than half of public health expenditure is now coming from foreign sources, and more than half of this investment is for priority diseases (*10*). Dependence on foreign funding carries the risk of creating chaotic marketplaces among international funds, programmes and donors. Ultimately, all harmonization or competition among these actors will evolve around how the workforce is configured to pursue priority action. Each initiative has its own modality for planning and operations and each invariably claims responsiveness to country preferences. Unfortunately, we currently lack methods or measures to guide the translation of the positive potential of priority programmes into practical policies. Guidelines backed by measurable indicators for harmonizing HIV/AIDS and health systems activi-ties in countries are urgently needed. National governments, multilateral agencies, bilateral donors, global initia-tives, private philanthropy and non-governmental organizations should forge a compact to follow a road map that strengthens the human capacity of social defence systems against what is surely the premier global health chal-lenge of the 21st century. ■

References
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1. Joint Learning Initiative. *Human resources for health: overcoming the crisis.* Cambridge (MA): Harvard University Press; 2004.

2. Chen L, Evans T, Anand S, Boufford JI, Brown H, Chowdhury M, et al. Human resources for health: overcoming the crisis. *Lancet* 2004;364:1984-90.

3. Tawfik L, Kinoti S. *The impact of HIV//AIDS on health systems and the health workforce in sub-Saharan Africa.* Washington (DC): SARA Project, USAID Bureau for Africa; 2003.

4. Kober K, Van Damme W. Scaling up access to antiretroviral treatment in southern Africa: who will do the job? *Lancet* 2004;364:103-7.

5. Dovlo D. Using mid-level cadres as substitutes for internationally mobile health professionals in Africa. *Human Resources for Health* 2004;2:7.

6. Arachu Castro A, Farmer P. Understanding and addressing AIDS-related stigma: from anthropological theory to clinical practice in Haiti. *American Journal of Public Health* 2005;95:53-9.

7. Elzinga G, Dieleman M, Dussault G, Chowdhury M: *Workers for priorities in health.* Amsterdam: Joint Learning Initiative, KIT Publishers; 2005.

8. Mogedal S, Stenson B. *Disease eradication: friend or foe to the health system?* Geneva: World Health Organization; 2000. WHO document WHO/V&B/00.28.

9. Melgaard B, Creese A, Aylward B, Olive J-M, Maher C, Okwo-Bele J-M, et al. Disease eradication and health systems development. *MMWR* 1999;48(SU01):28-35.

10. Smith O, Bennett S, Stillman K, Schneider P. *Health systemwide effects of the Global Fund in Benin and Ethiopia.* Paper presented at: 15th International AIDS Conference, Bangkok, Thailand, July 2004.