

# **HIV/AIDS and the Workforce Crisis in Health in Africa: Issues for Discussion**

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This paper summarizes the key issues confronting human resources (HR) in the health sector in sub-Saharan Africa and the role that HIV/AIDS has played in exacerbating this crisis. Section I reviews the causes and consequences of this crisis. Section II focuses on the effects of the HIV/AIDS epidemic on the crisis. Section III analyzes the constraints faced by recent health initiatives in addressing HR issues. Finally, Section IV provides recommendations on how donors and other partners can address HR issues in a more intensive, sustained, and concerted manner.

## **I. The Health Workforce Crisis**

*“African governments pretend to pay their health workers and health workers pretend to work.”*

– Anonymous African civil servant

African countries have always faced shortages in health workers relative to other regions, but this problem became severe starting in the late 1990s. It is believed that the trained health workforce in Africa has stagnated or declined over the past decade due to high levels of attrition and insufficient annual production. Much of the problem of scarcity of workers occurs in the civil service, with many countries (e.g., Ethiopia, Malawi, Zambia and Zimbabwe) already facing unfilled positions. Twenty-two African countries have only 1 doctor per 20,000 people or more; 16 countries have only 1 midwife per 10,000 people or more. These figures are worse than they seem, for they hide severe rural/urban imbalances (USAID, 2003).

Because of scarcities and geographic imbalances, health service utilization remains low, especially in rural areas and poor urban informal settlements. Human resources—those involved in service delivery and in program management—are a critical input to rapidly expand coverage, access and utilization of HIV/AIDS and other health services. Unless donors and partners devote their attention on health workforce issues, African countries are not going to meet their Millennium Development Goals in health.

### **A. IMMEDIATE CAUSES**

The immediate cause of the HR crisis is budgetary difficulty, in part due to the fiscal squeeze imposed by structural adjustment programs. Part of the blame also goes to government restructuring and civil service reform programs with their undue emphasis on the numbers of workers in the civil service, rather than the skill-mix needed to deliver a specified set of health services. A significant part of the blame rests on governments themselves, who have traditionally focused on employment creation (thus absorbing a large pool of unskilled workers, and therefore accounting for a large payroll burden) rather than upgrading the salary of the few health professionals in their roster. Less obvious is the role played by donors in expanding the health facility network through “development funding” rather than sustaining the health workforce through “recurrent funding” of salaries and incentives—a misguided thrust that has left in its wake understaffed or demotivated workers.

## **B. UNDERLYING CAUSES**

### **1. Misguided HR Production Policies**

The HR crisis is a symptom of deeper causes and erroneous policies that governments adopted, sometimes with implicit donor support. In the guise of better quality of care, community health nursing programs were abandoned in the early and mid-1990s in favor of professional nurses, who preferred to be hospital-based and would soon be lured to other countries. In Malawi, Zambia, and Zimbabwe, this misguided policy caused the nursing crisis in these countries. Decades-long poor support for tertiary education in general, and donors' preference for funding expensive but delimited (since disease-specific) in-service training rather than preservice training, also contributed to the shrinking flow of young entrants to the health workforce, while aging workers continued to be trained. Governments' near monopoly of medical, nursing, and midwifery education also contributed to the poor production of health workers, as governments became unable to fund the training programs during a budgetary crunch, and few donors were willing to come to the rescue. In general, many countries are too poor to maintain a decent medical and nursing school: for instance, 6 out of 39 African countries have no medical school and 21 countries have only one medical school.

### **2. Poor HR Systems and Incentives**

Weak personnel systems and, in many cases, the politicization of the recruitment, deployment, and promotion process contribute significantly to a health workforce that achieves lower than its potential. Highly centralized personnel decision making, lack of codes of professional conduct or weak enforcement of them, non-existent job descriptions, poor annual performance assessment, irregular or scant information on key areas of health policy given to employees—all these factors add to poor staff morale, aside from the obvious ones of low pay, delayed pay, unequal pay, poor work incentives, and lack of complementary inputs (drugs and medical supplies) to do one's work. Inadequate community or consumer involvement in the activities of health facilities is also a major shortcoming of African health systems.

Most countries also lack a long-term HR/training plan for health workers and established criteria for training, which results in haphazard training programs, politicization of training slots especially for out-of-the-country programs, repetitive training (often the same persons being trained over and over), and training being viewed primarily as opportunities to augment salaries. The huge resources spent by donors especially on in-service training should be viewed with concern, especially in light of poor evaluation of their impact on coverage and service improvement.

### **3. NGOs and Liberalization**

The promotion of NGOs as alternative health service providers has not helped matters, and may in fact have contributed to the HR crisis. In many cases, NGOs merely poach from the civil service, especially for experienced program managers. In addition, preservice training programs have not been geared to dramatically increase production of health workers to meet the shift in demand for workers by NGOs. The differential take-home pays of government and non-government health workers (including project-funded government workers), sometimes doing comparable work, have also soured the work environments in many countries. The friction is especially harsh on the side of civil servants who rightfully feel that official development assistance should also benefit government workers. These systemic problems are not being addressed, reducing the feasibility of achieving well-intentioned goals of public-private partnerships.

The rapid liberalization of medical practice is also shaking the HR environment. The lack of clear policies on private practice of medicine results in dual-practice doctors attending to their private patients, often in public facilities, at the possible expense of poorer “government” patients.

### **C. EXOGENOUS FACTORS**

The globalization of the health service industry merely fed on the frustrations of African health workers. Media reports of the African medical and nursing brain drain are staggering. Key affected countries are Ghana, Kenya, Malawi, South Africa, Sudan, Uganda, Zambia, and Zimbabwe. An international solution to this problem is needed in light of the forecasts of large long-term shortage of nurses in Western countries (e.g., CNAC, 2002 and U.S. DHHS, 2002), the reverse subsidy arising from the out-migration of African health workers to countries that do not pay for their training, and human rights issues engendered by African governments’ considering restrictions of labor movement.

## **II. The Impact of HIV/AIDS on the Health Workforce**

HIV/AIDS adds a heavy burden on the already fragile state of the African health workforce. The immediate effects of HIV/AIDS are to increase the demand for health services and for the workers who deliver them, and to reduce the supply of full-time equivalent health workers. Less obvious effects are the risks of reducing the quality of health services due to the overwhelming demands on the health system at a time when its capacity is being overburdened, the impact of perceived risk of HIV/AIDS infection on the current as well as the next generation of health workers, and the possibility of reducing the stock of (health) workers in the future unless the large number of orphans and vulnerable children receive care and support.

### **A. EFFECTS ON THE DEMAND FOR HEALTH WORKERS**

“Demand” in this paper is used loosely; in most cases, it refers to “need” or “requirements.” Most Africans afflicted with HIV/AIDS are too poor to articulate their health needs or requirements into effective demand.

The demand for health workers is a derived demand for health and related social services. Despite the magnitude of the HIV/AIDS pandemic, there has been very little effort to quantify and forecast the need for additional health and related workers on a sector-wide and on a country-by-country basis. Initial effort is being done in Chad and Tanzania, but this has not been extended to other countries. In contrast, the education sector has come up with several models to forecast the need for teachers in Africa arising from the impact of HIV/AIDS on the likely stock of teachers and number of children. The neglect of modeling the HR implications of the disease on the health sector merely reflects the overall neglect of HR issues overall, which are often deemed to be “too big” or “too complicated” and beyond any single donor’s ability to solve. Given these data shortcomings, this paper provides only “soft” information on the various factors affecting the demand for HIV/AIDS services.

#### **1. Increased Demand for HIV/AIDS Prevention and Control Services**

This includes a full range of services such as behavior change communication, safe blood supply, voluntary counseling and testing (VCT), and prevention of mother-to-child transmission (MTCT).

Many of these interventions are being merely “piggybacked” on existing health services using existing health workers, who are already overwhelmed. Scaling-up would necessarily require preservice training of an additional cohort of health workers for deployment in either government or the private sectors. To establish the planning parameters, there is a need to develop programmatic indicators translating these services into their required HR numbers and skill complements, projected to a national scale and using information from pilot sites employing good practices.

## **2. Increased Demand for AIDS Treatment**

This includes the full range of services such as provision of antiretroviral (ARV) drugs and requisite laboratory services, provision of drugs for opportunistic infections (OI), patient monitoring and compliance, nutrition counseling, and psychosocial support. Proponents of a more holistic approach would argue for the inclusion of activities to reduce stigma and discrimination, promote human rights, and establish a supportive community environment as inherent elements of an organic ARV program (Van Praag, 2001). Whether an ARV program opts for a “core” or a “comprehensive” set of interventions, one thing is clear: they require dramatic increases in health workers. In Zambia, the government’s aim to scale up ARV treatment of all provincial hospitals is being hampered by the inadequate number of both labs to do CD4 counts and clinicians to perform the tests (Huddart, et al, 2003).

The implications of AIDS treatment are often glossed over with respect to the full-time-equivalent workers needed: (1) Relative to non-AIDS patients, AIDS patients are more intensive users of health services in terms of frequency of visits, time spent with the health worker, number of tests and procedures, and days of hospital confinement. (2) Because of the nature of the prescribed therapy, they also require closer monitoring of patient compliance. (3) Without an AIDS vaccine, AIDS will continue to be a chronic disease requiring long-term care and support. It thus lends itself to a “disease management” approach of care, where much of the therapy is the responsibility of the patient (with the usual “incentive” issues related to compliance, especially when the patient begins to feel better) even as a regular interface with the provider is needed. (4) AIDS-related opportunistic infections have made previously well-controlled diseases such as malnutrition, tuberculosis, diarrhea, skin diseases, and other ailments explode as health problems, also requiring additional health workers. (5) The issues of stigma and discrimination makes AIDS not just a disease but a major social problem, requiring not only health workers but other complementary workers as well—legal specialists, social workers, and skilled community facilitators and counselors—all in short supply in Africa.

## **3. Increased Demand for Related Care and Support for AIDS Patients**

The increasing need for home-based care and hospice services has direct implications on the types of health workers needed (e.g., skilled care-givers who may be relatives or friends, as well as community health workers who can provide palliative care and psychosocial support). Thus, high-prevalence countries face the daunting task of producing workers in the entire range of the skill spectrum: highly skilled professionals who can diagnose and treat AIDS patients; lab technicians and nurses; and trained care-givers. Already, lay counselors and volunteers are providing a significant volume of care and support services, as in Zambia, but their standard of performance continues to be low relative to the acceptable standard of care (Huddart, et al, 2003).

#### **4. Crowding Out of Non-HIV Patients in Higher-level Health Facilities**

Hospitals overwhelmed with HIV+ patients are turning away non-AIDS patients, or are referring them back to lower-level facilities. Some hospitals are refusing non-AIDS patients due to limited beds, as in South Africa (Russel, 2000). In other cases, HIV-negative patients are being admitted at later stages of their illness, as in Kenya (UNAIDS, 2000). In outpatient settings, health workers are seeing non-HIV patients at a much later stage of their illness, or patients themselves may be willingly delaying seeing a health provider. These patterns of provider and patient behavior have adverse consequences on the results of treatment, as exemplified by the increased mortality being seen among non-HIV patients in a Nairobi hospital. Because of these increasingly common observations, African governments and donors need to re-strategize on the types of additional health facilities and health workers that they need so that critical non-HIV interventions do not lose priority.

#### **B. EFFECTS ON THE SUPPLY OF HEALTH WORKERS**

Most African countries have been unable to produce, employ, and retain adequate numbers of health workers even before the AIDS epidemic, for reasons discussed in Section I. Thus, the AIDS epidemic merely tightens the HR supply problem through the following interrelated ways.

##### **1. Reduction in the Supply of Health Workers Due to Deaths**

One model estimates that a country with a stable 15 percent HIV prevalence can expect that between 1.6 and 3.3 percent of its health workers will die from AIDS annually. In Malawi, it is estimated that the annual death rate among health workers increased from 0.5 percent in 1985 to 3 percent in 1997, a six-fold increase (Abt and HEARD, 1992). These attrition rates may look small, but when applied on an annual basis to a diminishing stock of health workers, their combined effect after a few years is large. Thus by the late 1990s, deaths already account for more than 40 percent of all attrition of nurses in Zambia and Malawi.

##### **2. Reduction in the Full-time Availability of Health Workers Due to Absenteeism**

Lost workdays from sickness, funeral attendance, and caring for sick relatives and friends have become common in Africa. As much as 25 percent of nurses in Southern Africa are HIV+, according to one study (Harvard and Hastlegrave, 2000). In Lusaka, Zambia, HIV prevalence among nurses was already as high as 44 percent in 1992 (Derveeuw, 2001). Absenteeism begins well before workers develop full-blown AIDS. Studies indicate that the average person living with AIDS can be absent from work for up to 50 percent of his/her final year of life.

Calculations from Botswana show that if the average health worker uses just 60 days of sick leave in his/her last year of life, the health sector could lose up to 31,000 workdays in 2005 (or around 155 full-time equivalent workers). Using a full 6 months of sick leave, these lost workdays could reach 57,000 in 2005 (or around 285 full-time-equivalent workers). These are staggering numbers: the message is that policymakers who use only the actual number of workers in their roster should begin to make policies on the basis of full-time-equivalent workers, for the number of workers in the roster gives a deceptive picture of their actual availability to provide health services.

### **3. Reduction in the Productivity and Full-time Availability of Health Workers Due to Job Burnout and Low Morale**

Work-related stress arising mostly from the magnitude of the HIV/AIDS caseload reduces the availability and productivity of health workers. Key factors in engendering job burnout are: (1) the sheer volume of HIV/AIDS patients that need to be dealt with; (2) significant expansion in the role of health workers, many of whom have to bear medical, testing, counseling, and other new responsibilities for which they are untrained; (3) being inadvertently blamed for severe shortages in drugs, equipment, and supplies arising from the scale of the epidemic and bottlenecks in the health system; (4) sociocultural or moral objections to the prescribed health interventions (condoms); (5) inadequate workers' knowledge and attitudes on HIV/AIDS for standard services such as counseling and testing; and (6) stigmatization of the disease that inhibits open discussions that can lead to less stressful work environments (Masini and Mwapeta, 1993; Drysdale et al., n.d.). The introduction of new and more complex therapies (such as ARVs) could also be stressful, given the number who need to be treated.

Few studies have quantified the effects of job burnout on the availability and productivity of health workers. In Hlabisa District, KwaZulu-Natal, South Africa, overwork limited nurses' ability to provide quality care (95 percent of the respondents), to maintain adequate occupational safety (95 percent), and to be sensitive to their patients' needs (86 percent) (Unger, Welz, and Haran, n.d.). More pointedly, the same respondents felt significantly more stressed working with HIV+ patients than with non-HIV patients. Stress is certainly a factor that explains the large vacancy rate in nursing posts (30 percent in hospitals and 20 percent in clinics) in Hlabisa during the period of study, 1998 and 2001.

### **4. Potential Reduction in the Supply of Health Workers Due to Perceived HIV Infection in the Workplace**

One study suggests that occupational risk among health staff through injuries from duty is minimal (de Villiers, 2000). However, transmission risks and exposure to opportunistic infections increase where crowding is serious, where needles and other instruments are not always sterilized or are re-used, and where providers lack rubber gloves, soap, and other disinfectants—a situation that is all too familiar in Africa. Even with safe blood banks, a transfusion can infect recipients with Hepatitis B or HIV through exposure to infected equipment.

These factors feed the fear of health workers about nosocomial infection, a perception that is being buttressed by a recent review suggesting that HIV infections in Africa may not be explained fully by sexual and vertical transmission but is linked to unsafe medical care (Gisselquist, Rothenburg, Potterat, and Drucker, 2002). In a Uganda study, 20 percent of physicians and nurses surveyed reported being frightened of taking care of HIV+ patients (Mungherera et al., 1996). No data exists on how this perception is causing workers to shift jobs within the health system from direct patient care to administrative or other tasks, to move to areas with less HIV prevalence, to leave the health service completely, or to migrate outside the country, factors that can reduce the number of current health workers especially those involved in patient care. More important, such fear factor can also cause fewer entrants into health service training programs.

## **5. Reduction in the Supply of Program Managers**

Few data are available on how HIV/AIDS has reduced the stable of program managers in the health sector. Anecdotal evidence suggests that many of the experienced program coordinators, facility chiefs, project directors, and managers have died, retired, or changed jobs, leaving little institutional memory. Many donors feel this is a major problem that is underappreciated by government counterparts. Poor absorptive capacity can be traced to the inadequate number of skilled program managers who are adept in both donor and government procedures for planning, executing, and disbursing donor funds.

## **6. Reduction in the Number of New Entrants to the Health Workforce**

HIV/AIDS can directly reduce the number of new health workers as more students die of AIDS. In Mozambique, as much as 20 percent of student nurses died of HIV in Tete Province and 8.6 percent in Zambesia Province in 2000 (Derveeuw, 2001). The “fear factor” can also dissuade potential students from entering medical, nursing, or midwifery courses. Finally, the AIDS-impacted reduction in enrollment rates in elementary and secondary schools provides the uneasy prospect of generally lower intakes into health-science training programs at a time when the need for these professions is increasing. These factors need to be analyzed and modeled to provide guidance on HR planning.

## **C. RESOURCE AND OTHER IMPLICATIONS OF THE HR IMPACT**

Apart from the obvious humanitarian costs of HIV/AIDS, there are massive resource implications of the adverse impact of HIV/AIDS on HR management, including:

### **1. Increased Resources to Meet the Cost of Employee Benefits**

Little effort has been devoted in the public sector (and in some cases, the NGO health sector) to calculate the resources needed to meet health worker benefits such as paid sick leaves, disability entitlements, direct health service benefits or health insurance coverage, funeral expense subsidies, and survivorship benefits. Because their HR systems are so weak, most African governments have been ill-prepared to deal with these problems, the knotty issues that they engender, and the alternative options that are available to address them (e.g., direct provision of HIV preventive treatment, care and support services versus contracting out, or purchase of health insurance coverage). As far as can be ascertained, donors have been reluctant to pick the tab on some of these benefits, in part because there is very little quantitative data to make informed decisions.

### **2. Increased Resources to Meet the Cost of Replacing Lost Health Workers and Expanding the Workforce to Meet the Increased Demand for HIV/AIDS Services**

This complex problem involves interrelated aspects of formal/informal training, pre-/in-service programs, and the incentive system needed to retain health workers.

### *a. Pre-service Training*

Years of neglect have left schools of medicine, nursing, midwifery, and public health in a state of disarray. A survey of nursing education in Africa revealed that subjects are often taught by non-specialists, and the number of nursing tutors is rapidly declining due to poor working conditions (University of Natal, 2000). Students in many African medical and nursing schools learning by rote, providing little opportunity to question and explore. Preservice training programs often lack the transport and travel funds needed to fulfill curriculum intentions for field practice. Thus, over the last decade, the standards of training have fallen, and current students are ill-equipped to work at the frontline of public health.

Some training programs also experience problems of getting training candidates. In many countries, secondary schools are unable to produce enough entrants for medical, nursing, midwifery, and laboratory courses due, among other things, to weak science and math education at the primary and secondary levels. Even in South Africa, with better secondary school preparation than other African countries, the drop-out rate in nursing programs has been reported to be as high as 30 percent, due in part to financial reasons, aside from poor preparation in high school. The persistently low enrolment of girls in secondary education also explains the low intake of nursing programs, which usually attract more women than men.

The need for preservice training or other approaches to bring new full-time-equivalent workers into African health systems cannot be overemphasized. For instance, scaling-up the Zambia AIDS treatment program to fulfill the country's Global Fund proposal requires 1,510 doctors and 597 pharmacy technicians for ARVs and 4,792 counselors for VCT (Huddart, et al., 2003). The current numbers are nowhere near these figures.

The problems of formal preservice training are daunting, but given the demands of the HIV/AIDS epidemic, they cannot be ignored. A concerted, multidonor effort is needed to "fast-track" training programs, including use of more cost-effective options, such as distance education, modular approaches and ladder-type curricula, Web-based learning, and off-campus/on-site programs. Unfortunately, few investments have been made by donors in this area, even with repeated pleas from the most affected countries, such as Malawi, for donor assistance. Donors have been ill prepared to respond because of their inflexible funding portfolios, lack of staff knowledgeable with HR and tertiary education issues, continuing institutional denial of the problem, and tepid interest in multidonor efforts.

### *b. In-service Training*

Throughout the past two decades, donors have preferred fragmented, disease-specific in-service training programs. Despite wide acceptance of the health technologies being taught in these programs, little effort has been done to include these courses in the formal preservice curriculum. Where such curriculum reforms have been done, they have taken such an onerous amount of time and resources that donors are losing interest in further supporting these efforts. As a result, "hotel workshops" regularly occur, taking health personnel from their jobs, and reducing the already scant supply of full-time-equivalent workers. No analysis has been done to quantify these losses of full-time-equivalent workers from these in-service training programs.

*c. Informal Learning Systems and Networks Including Mentoring, Peer Education, and Electronic Connectivity*

This area has been much ignored, but it could offer the most cost-effective way of knowledge diffusion. Unfortunately, with the HIV/AIDS epidemic and labor out-migration, much of these informal systems are disappearing as large numbers of senior staff who have technical and institutional memory have died, are sick, or have left the service.

The possibilities of large-scale knowledge sharing in HIV/AIDS and other diseases through electronic connectivity remain severely underexplored in Africa, despite falling costs of computer hardware and burgeoning Websites devoted to health and HIV/AIDS. As African countries need to “leap-frog” the information divide, donors need to look more seriously into this area.

*d. Improving the Incentive System Needed to Keep Health Workers Motivated*

There is an emerging consensus that traditional civil service rules are too inflexible to provide the necessary incentives to make workers perform optimally. A more flexible environment could improve performance, not only for civil servants but for NGO service providers as well. Among the options that countries and donors could consider are the following: (1) Shift towards results-oriented performance management, in lieu of the traditional input-oriented management. This requires a clear definition of staff responsibilities and performance and oversight. (2) Permit clinical staff to conduct private practice for specified periods of time on a selective basis and contingent upon clear policy guidelines for such practice. (3) Permit agency work (i.e., “casual work”) basis during unexpected staff shortages or annual peak activity periods. (4) Permit contracting arrangements with alternative providers. (5) Provide greater authority and better information to local managers for personnel management and employee relations. This can be implemented in health facilities being decentralized or given autonomy. (6) Explore options for civil-service de-linkage and health service commissioning.

There is a burgeoning literature on some of these options, especially health service contracting which can be easily applied to HIV/AIDS services such as VCT, MTCT prevention, and ARV and OI treatments and associated tests. However, there is very little information on costs of services, resource requirements, program impact, and best practices.

### **III. Constraints of Current Programs and Initiatives in Dealing with HR Issues**

#### **A. USAID HIV/AIDS PROJECTS**

USAID-supported NGOs and PVOs working in HIV/AIDS face major challenges in addressing the longer-term requirements of HR and capacity development. The key constraints identified by these partners are: (1) limited understanding of NGOs/PVOs of what human capacity development entails; (2) needless competition among USAID cooperating agencies for funding and human resources, and inadequate partnering with local institutions; (3) disconnect between the institutional perspective of donors who insist on short-term measurable outcomes and the more complex and longer-term requirements of sustainable HR development in health; (4) narrow project earmarks that prohibit fund recipients to conduct cross-sectoral work and short project

time-frames that inhibit cooperating agencies to invest in HR development, which, by its nature, is long-term; (5) nonexistent or weak linkage between PVO/NGO activities to the national HIV/AIDS strategy; and (6) limited information or poor dissemination on good practices in HR among NGOs/PVOs and the larger PHN community (USAID, 2002).

The narrow and disease-specific earmarking of USAID also inhibits its global and bilateral projects from addressing the cross-sectoral issues engendered by HR problems. The current unpopularity of nonproject assistance (which could have a major impact on civil service reform) and USAID's hesitance to participate in sector-wide approach (SWAp) funding (which could be designed to have a "basket" for staff recruitment and incentives) reduces the Agency's ability to deal with these HR issues on the policy front. In lieu of dealing with these macro issues, USAID's involvement has been limited to micro-level interventions, such as the development of HR tools (e.g., job aids), with minor impact on health systems. Finally, the Agency's approach of providing official development assistance through U.S. cooperating agencies rather than directly through African national governments, regional institutions, companies, or coalitions could inhibit USAID's role in policy dialogue on HR and related issues; it also limits the policy impact of such aid, because it is viewed by skeptical governments as not primarily benefiting them.

## **B. WORLD BANK MULTISECTORAL AIDS PROJECTS (MAPs)**

MAPs are aimed to dramatically increase access to HIV/AIDS prevention, care, and support, especially to vulnerable groups such as youth and women of child-bearing age. MAPs are designed to provide direct support to community-based organizations, NGOs, and the private sector for local HIV/AIDS initiatives. As of March 2003, 18 MAPs have been approved with total net commitment of US\$ 611.8 million (World Bank, 2003). In the couple of years that MAPs have been implemented, key issues have revolved around the difficulty of disbursing project funds due to capacity and organizational issues, and the continuing lack of health workers needed to scale up HIV/AIDS interventions. MAP program managers do recognize that sufficient time and resources must be devoted to capacity building, for supervisors as well as front-line workers (Zewdie, 2003)

## **C. DEBT RELIEF AND POVERTY REDUCTION PROGRAMS**

The IMF and the World Bank have approved debt-reduction packages for 26 countries, 22 of them in Africa, under the Heavily-Indebted Poor Countries (HIPC) Initiative. All of these countries are now spending more on social services than on debt servicing (on average almost four times as much), and all have shown a marked increase in the share of health and education in their budgets (IMF, 2002). It is not clear, however, how much of the increased health spending is being used to ease the HR crisis in Africa. Only seven of the 22 African countries committed to address health personnel issues in their Poverty Reduction Strategy Papers: Burkina Faso, Malawi, Mali, Mozambique, Niger, Rwanda, and the Gambia (World Bank, 2002). It is clear that these countries need to be monitored on how they have performed on their HR commitments. For countries without specific HR commitments, policy dialogue is required to get the HR agenda into the annual planning of HIPC resources. Modest technical assistance may also be needed by countries contemplating to program some of their debt relief funds for HR preservice training, recruitment, deployment, or workers' incentives.

## **D. SECTORWIDE APPROACHES (SWAPS)**

Sectorwide approaches in health have been adopted in Ghana, Uganda, Tanzania, and Zambia and are being considered in Malawi, Mozambique, and other African countries. A key feature of these SWApS is the “district basket” which finances the agreed-upon recurrent health expenditures, including (in some cases) civil servants’ salaries. While this funding mechanism has improved budget predictability and transparency of donor commitments, it is not known to what extent it has actually improved the retention, geographic distribution, and performance of health workers. The Uganda SWAp appears to be yielding better staff performance. This is an issue that needs to be better documented.

## **E. GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA**

The Global Fund is not designed to address broader health systems issues. However, it does allow use of funds for HR development directly pertaining to the prevention, control, and treatment of the three diseases under its mandate. The Guidelines on Proposals states that “systemwide/cross-cutting aspects may include system development activities that benefit the fight against at least two or three of the diseases, such as human capacity development, infrastructure, etc. Particular focus should be given to demonstrate how the program will ensure adequate human resources are made available and developed, based on an analysis of the appropriate numbers of professional staff and the appropriate mix of skills and capabilities necessary for sustainable program implementation.”

Despite this liberal guideline on the use of GF resources for HR, only 22 percent of the expenditure commitments for approved projects in Round 2 are for HR, including training and planning (Bennet and Fairbank, 2003). In Africa, where the HR problem is most severe, human resource development does not receive commensurate attention. Out of the 77 African proposals in Rounds 1 and 2, 45 did not deal explicitly with critical HR issues of recruitment, staff incentives, and pre-service training problems. Instead, technical (in-service) training and general capacity building predominate as proposed HR activities.

The Global Fund did approve a few African proposals to provide staff salaries and other incentives (Ghana TB) or to recruit new staff (Burundi HIV/AIDS, Rwanda HIV/AIDS, Botswana HIV/AIDS, and Sudan TB), but these were invariably for NGO activities. As far as can be ascertained, no African government has proposed for similar arrangements for civil servants. The difference in the treatment of nongovernment and government health workers with respect to incentives and recruitment under the Global Fund need to be addressed.

## **F. NEW PARTNERSHIP FOR AFRICAN DEVELOPMENT (NEPAD)**

NEPAD’s Strategy for Health includes many areas where HR can be supported, including: (1) developing an implementation strategy to offset the brain drain; (2) supporting training centers to expand and improve surveillance, data management and lab techniques; (3) improving lab capacity for testing drug resistance in HIV/AIDS and major diseases; (4) programming for advanced learning in health policy formulation; (5) feasibility planning for continent-wide communications network in health; (6) strengthening the capacity of five regional structures; and (7) strengthening public broadcasters’ contribution to health literacy.

## **IV. Ways Forward**

Given the multiple dimensions of the HR problem, initiatives can be launched from many angles and levels. The following list suggests some actions for moving forward.

### **A. HR ASSESSMENT AND PLANNING**

- Country assessments and rapid appraisals of the HR situation
- Modeling the impact of HIV/AIDS on the demand and supply of full-time equivalent health workers, and quantifying the HR deficits by major cadres in the short- and medium-term
- Planning overall HR requirements by country, focusing on HIV/AIDS needs for prevention, treatment, care, and support

### **B. REVIEW AND REFORM OF DONORS' HR POLICIES**

- Re-examining donors' and governments' policies on preservice and in-service training to reform them and to ease policy and institutional bottlenecks
- Advocating for needed change of Global Fund rules so that HR incentives issues are given more prominence by country applications; developing appropriate monitoring indicators for HR
- Exploring longer-term and multisectoral frameworks for NGO/PVO donor grants so that they can include HR activities in their work programs

### **C. REVIEW AND REFORM OF GOVERNMENT HR POLICIES AND SYSTEMS**

- Conducting policy review on HR, focusing on inhibitory factors for better HR management
- More vigorous dialogue with the major multilateral funding institutions (i.e., World Bank, IMF) to re-evaluate their positions about continuing squeeze being placed on already fragile civil service
- Improving the critical human resource management systems of Ministries of Health, NGOs, and other service providers

### **D. PROJECT MANAGEMENT**

- Retrofitting existing health projects so that they address, within their mandates, HR issues; insisting that new projects undertake a thorough institutional and HR analysis
- Better management of donors' cooperating agencies to eliminate duplication of HR-oriented efforts
- Providing cross-donor support, where needed, so that large initiatives (e.g., MAPs, poverty reduction programs, SWApS) can disburse funds for HIV/AIDS and other diseases
- Using "underutilized" HR approaches to augment management- and professional-level cadres, e.g., retired medical executives who are willing to relocate for specified periods of time abroad; South-South exchanges; and technical aid corps programs

## **E. FINANCING OF HR INITIATIVES**

- Rounding up needed donor and government investments to address the large HR deficits, and fast tracking agreed-upon training programs
- Providing assistance to governments and NGOs to meet their financial commitments on staff benefits to HIV/AIDS health workers
- Providing needed financial and other support to critical HR ideas in NEPAD's strategy and similar African initiatives

## **F. KNOWLEDGE MANAGEMENT**

- Documenting and diffusing good HR practices, especially on incentives and retention
- Exploring alternative cost-effective modalities of knowledge diffusion and management on HIV/AIDS, including electronic connectivity of key HIV/AIDS staff, and stronger informal peer/professional networking
- Better understanding of the role of communities in managing health workers specifically, and health services generally, and using such knowledge in the design of scale-up projects



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