CONSEIL NATIONAL DU SIDA
25-27 RUE D'ASTORG
75008 PARIS
T. 33 [0]1 40 56 68 50
F. 33 [0]1 40 56 68 90
CNS.SANTE.FR

REPORT INTERNATIONAL EN

2005 JUNE 14TH

THE HUMAN RESOURCES CRISIS IN SOUTHERN COUNTRIES: A MAJOR OBSTACLE TO THE FIGHT AGAINST HIV

Commission Leader: Mr. Willy Rozenbaum

Commission Members:

- Mr. Didier Fassin
- Mr. Jacques Gradt
- Mrs. Chantal Lebatard
- Mr. William Lowenstein
- Mrs. Véronique Nahoum-Grappe

Rapporteurs: Mr. Marc Dixneuf, Mr. Anthony Poncier

The pandemic of HIV/AIDS infection is now a devastating wave sweeping through many developing countries. Sub-Saharan Africa is the hardest hit, but the epidemic is also developing rapidly in Asia[1], Latin America and Eastern Europe. Whereas anti-HIV programmes initially focused on prevention, access to healthcare and treatment are now also an integral part of their strategy.

Following on the appeal launched by the President of France[2], against the dominant opinion at the time, Conseil national du sida, came out, in a report[3], in favour of global access to antiretrovirals in Sub-Saharan Africa. The Global Fund to Fight Aids, Tuberculosis and Malaria, combined with the very sharp decline in anti-retroviral prices, helped initiate therapeutic care for a few hundred thousand patients in Southern countries. The 3x5 Initiative, launched by the World Health Organisation (WHO) on 1 December 2003, which aims to provide 3 million AIDS patients in poor countries with anti-retroviral treatment by the end of 2005, is a move in that direction. Coverage for access to antiretrovirals has improved, but has little chance of attaining that objective[4]. Yet funding for the fight against the disease at the global level increased threefold between 2001 and 2004[5], and the increase is expected to continue[6]. France has even proposed that the said funding be kept up, using a specially-instituted international tax.

However, while money and medicine are necessary, human resources are critical to providing the care. The challenge they represent, now a priority, has become at least as important as ensuring access to antiretrovirals. Yet, the dearth of workers has only grown worse, as much quantitatively as qualitatively. The growing trend toward emigration in health workers, several decades of under-investment in human resources and reforms in the economy and sector limiting recruitment and salaries are the triggers behind this. In addition, come the impact of HIV/AIDS, which considerably increases the workload, putting workers at greater risk of contamination and, therefore, affecting their morale.

---

[1] An increase of nearly 50 % between 2002 and 2004 in the number of people living with HIV.

[2] Speech by Jacques Chirac at the Opening Ceremony of the Tenth International Conference on STD/AIDS in Africa, December 1997.

[3] *Vers une nouvelle solidarité. Pour un accès aux traitements antirétroviraux des personnes vivant avec le VIH en Afrique subsaharienne*, Report followed by recommendations, CNS, 10 December 1998.

[4] It increased from 440 000 people treated in 2004 to 720 000 in December 2004. *The Lancet*, "Predicting the Failure of 3 by 5", Volume 365, Number 9471, 7-13 May 2005, p. 1597.

[5] Sources of funding include domestic expenditure, bilateral donors, multilateral institutions and the private sector.

[6] France, along with other countries, has promised to increase its public development aid (PDA) to 0.7 % of its gross domestic product (GDP) by 2012. Currently, France is at 0.44 % of GDP, a level far lower, in particular, than that of all of the European Union's Nordic countries..

In order to halt the increase in mortality and decrease in life expectancy[7], the number of health workers needs to be greatly increased, yet in reality, it is falling sharply. This major crisis jeopardises the Millennium Development Goals (MDG)[8]. In the face of such a challenge, an urgent and energetic response must be given, one in which the French authorities must participate, whether through their cooperation actions or as members of international organizations.

Conseil national du sida wished to delve further into the human resources crisis in Southern countries. It therefore sought to identify the main causes and determining factors behind the said crisis and to put forth various strategies in an attempt to turn that trend around.

The Issue of Human Resources in Southern Countries

The crisis in human resources for healthcare can generally be defined as a very large lack of healthcare providers in the Southern countries. In Africa, it is considered that the number of care providers would need to be increased threefold in order to reach the MDGs[9]. That dearth is made worse by the often greater frequency in the HIV-infection epidemic among health workers. For lack of free access to healthcare, they have already begun to pay a heavy toll to the disease, which has caused the death of more than half of them in Malawi, for instance[10].

The poor split in workers between rural and urban areas makes the situation even worse. A very heavy concentration of physicians can be found in the cities, while most of the population lives in the countryside. In Senegal, over half of all doctors live in Dakar, home to only 20 % of the Senegalese population[11].

Lastly, the extent of medical science in these countries is ill-suited to local realities or often obsolete, when compared to medical progress elsewhere, due to a lack of resources and training.

Though this situation can vary from one region or country to the next, Conseil National du Sida has chosen to focus on the countries least-equipped in human resources for healthcare, where the development of public services is of critical importance.

Commitment amongst public-sector health workers is waning

The waning commitment amongst health workers can be seen mainly in the high absentee rates, owed in large part to the issue of salary. The very low wages provided – USD 75 per month, for a nurse in the Philippines, for example[12] – have led workers to compensate for their income through any number of methods. Two decades of reform in the economy and the sector have given rise to public expenditure ceilings and frozen pay scales for civil servants, who do not necessarily receive the said pay every month. Moreover, any hope that they may rise on the professional ladder, thus improving their income and receiving recognition for their efforts, is futile, as the promotion and career management procedures are not subject to clear criteria. Moving up the ladder is more often a matter of knowing the right people than having the right skills or providing high-quality care. In Africa, 40 % of the health workers have already left the health sector for other activities[13].

That shortfall has led many workers to turn to other means of livelihood, such as working in private practice during hours that are normally supposed to be dedicated to public service. In Cameroon, since 1994, salaries have dropped by 70 %, such that a non-tenured doctor earns around USD 45 per month[14]. For this reason, resorting to private practice has become a universal trend. In

---

[7] Joint Learning Initiative, *Human Resources for Health: Overcoming the Crisis*, October 2004, p. 26 :

http://www.globalhealthtrust.org/report/Human_Resources_for_Health.pdf

[8] Kofi Annan: 2 June 2005 Press Release. "Stopping the AIDS epidemic is a vital condition to achieving the Millennium Development Goals", SG/SM/9903. It aims to reduce, by 2015, poverty and hunger, and remedy poor health, inequalities between the sexes, under-education, lack of drinking water and environmental deterioration.

[9] 2nd Summit on Health in the MDGs, December 2004 in Abuja*: Addressing Africa's Health Workforce Crisis: An Avenue for Action*. http://www.hlfhealthmdgs.org/Documents/AfricasWorkforce-Final.pdf

[10] Internal CNS hearing.

[11] World Bank Report: *World Development Report 2004: Making Services Work for Poor People in 2003*, p. 177.http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2004/07/30/000012009_20040730102437/Rendered/PDF/268950French.pdf.

[12] Stephen Bach, July 2003, International Migration of Health Workers : Labour and Social Issues, p. 10. http://www.ilo.org/public/english/dialogue/sector/papers/health/wp209.pdf

[13] 2nd Summit on Health in the MDGs, December 2004 in Abuja: *Health Workforce Challenges: Lessons from Country Experiences. http://www.hlfhealthmdgs.org/Documents/HealthWorkforceChallenges-Final.pdf*

[14] Internal CNS hearing.

Cambodia, it goes so far as to account for 90 % of workers' income. These practices have led to very costly absenteeism. For instance, it is estimated that Bogotá hospitals lose USD 1 million per year[15].

Other methods are also used to compensate for the shortfall, such as entering training programmes or taking on assignments funded by international institutions. In Mali, ward administrators spend more than half of their time there[16].

Private practice, combined with paid training programmes, have made actual full-time service in the public sector a thing of the past for most health workers in Southern countries. The population is the first to be hurt by this decline in the public sector, for the benefit of the private sector, as is the case in South Africa, where three out of every four doctors work in the private sector –which only 20 % of the population can access[17].

Where this does not suffice, as is often the case, more expeditious methods are applied: creating false jobs and selling medication that should have been provided free of charge are two ways of increasing everyone's income.

Moreover, the lack of security in the profession, like the non-existence of basic protection from accidental blood exposure, exposes many care providers to greater risk of contamination from infectious agents, including the AIDS virus. In certain regions of Africa, over half of all health workers are contaminated with the virus[18].

For this reason, taking into account the general setting described above, in their day-to-day work in the public sector, health workers display a certain degree of slackness in common acts, increasing the risk for all parties, in particular the risk of abuse and violence toward patients[19].

The "Migratory Carousel"

In addition to the public sector's waning commitment, available human resources are also affected by the migration of health workers. The said migration can be likened to a carousel, with several paths breaking away from the poorest regions to the wealthiest regions, at the local, regional or international level.

The issue of salary leads many healthcare professionals to avoid establishing themselves in or leave rural areas where supplementary income sources are non-existent, in particular for lack of wealthy clientele capable of paying for private medical visits during public service hours. Moreover, the lack of services (schooling, drinking water, etc.), and the lack of access to training and education are all factors contrary to health workers' establishing themselves in rural areas. The situation has become such that, in certain rural areas of Africa, the non-governmental organisations (NGOs) are the only sources of healthcare for the population, as no local public healthcare service exists[20]. For example, the former capital of Tanzania, Dar-es Salaam, is home to thirty times more medical workers than any other rural district in the country[21]. On average, there are 160 nurses for every 100 000 individuals across the nation, but only 6 per 100 000 in rural areas[22].

More eager to serve in urban areas than in rural ones, the workers do not always find sufficient income in the cities to fulfil their needs. This is where migration toward wealthier countries in the region becomes a possible response. South Africa is one of Africa's main medical human resource pools, yet 80 % of the doctors working in its countryside are foreigners, from such countries as Zambia or Zimbabwe[23]. However, it is the Western countries that attract the largest number of aspiring expatriates. It should be noted that a doctor or nurse would earn 25 times more in Australia or Canada than if he continued working in Zambia[24].

---

[15] Paulo Ferrinho, Wim Van Lerberghe, Inês Fronteira, Fátima Hipólito et André Biscaia, *Human Resources for Health*, 27 October 2004, "Dual practice of the health sector: review of the evidence". http://www.human-resources-health.com/content/2/1/14

[16] *Ibidem*.

[17] Katharina Kober, Wim Van Damme, *The Lancet*, Vol 364, 03 juillet 2004, "Scaling up access to antiretroviral treatment in southern Africa : who will do the job?", p. 105.

[18] 2nd Summit on Health in the MDGs, December 2004 in Abuja: *Health Workforce Challenges: Lessons from Country Experiences*.

[19] Yannick Jaffré and J.P. Olivier de Sardan, *Une médecine inhospitalière*, Paris, Karthala, 2003, 464 pages.

[20] Paulo Ferrinho, Wim Van Lerberghe, Inês Fronteira, Fátima Hipólito et André Biscaia, *Human Resources for Health*, 27 October 2004, "Dual practice of the health sector : review of the evidence".

[21] Internal CNS hearing.

[22] 2nd Summit on Health in the MDGs, December 2004 in Abuja: *Health Workforce Challenges: Lessons from Country Experiences*.

[23] *Emigration des personnels de santé : Les deux facettes de l'émigration des personnels de santé vers les pays riches.* http://www.ilo.org/public/french/bureau/inf/features/03/healthworkers.htm

[24] Marko Vujicic, Pascal Zurn, Khassoum Diallo, Orvill Adams et Mario R Dal Poz, Human Resources for Health, 28 April 2004, "*The role of wages in the migration of healthcare professionals from developing countries*". http://www.human-resources-health.com/content/2/1/3

The working conditions offered by Northern countries, even though benefits are not always equivalent to those offered to host country nationals, whether in terms of salary, job security or material conditions, explain why there is such eagerness to go abroad.

The high migration rate is facilitated by certain countries that have adapted their training systems to those of the North in order to allow such an exodus, but now find themselves more vulnerable to losing workers, such as Ghana, where 50 % of graduates migrate after 4.5 years and 75 % after 9.5 years[25]. This trend does not affect only Africa. Nursing school curricula in Bangladesh and the Philippines are based on those of English and American schools, with coursework taking place in English, such that it is the English-speaking countries that benefit most from this trend. In the Philippines, out of 7 000 nurses trained, 70 % leave the country, while there are 30 000 positions unfilled[26].

In 2002, over half of the doctors and nurses active in Great Britain had been trained abroad. In 1998, foreign nurses accounted for only 25 %[27]. The trend does not seem ready to reverse itself. It is estimated that Great Britain will nearly double its number of nurses by 2008. Moreover, the Northern countries are having trouble keeping their own doctors in rural areas, while migrants are often willing to establish themselves there[28]. In summary, the Western countries that are also experiencing a shortage of health workers, faced with the same desertion of the countryside, offset that shortage by absorbing health workers from the South.

In addition to these workers' being hired by Northern countries, there is intense competition between the various international programmes (tuberculosis, malaria, mother-child healthcare, etc.) to build up skilled teams, which will thus no longer be available to provide care in their countries of origin. Yet there are no think-tanks within the WHO regarding the role of international agencies in capturing the said workers[29].

This trend, with workers transferring from the South to the North, entails a very high cost for Southern countries. From a purely financial standpoint, it is said to be estimated at USD 4 million annually, at the least[30]. From the human perspective, a potentially negative effect has been found on the replacement of the healthcare workforce, which must, moreover, cope with insufficient training capacity.

To witness, in Sub-Saharan Africa's 47 countries, there are a total of 87 schools of medicine. Eleven countries do not have one, and 24 have only one; none of the schools provides full training[31]. For lack of resources, only a few of them are equipped with laboratories, computers with an Internet connection, and subscriptions to scientific journals. In addition, in most of the schools, the course of study is not suited to the issues the country faces, but is instead based on Western courses of study, too often favouring theory over practice.

All of these factors (training issues, working conditions, emigration, etc.) have considerably undermined the presence of health workers in the field and their public service mission with patients. The aim is thus to find a strategy in order to reverse that trend.

Different response strategies to increase human resources in healthcare

Given this crisis background, the possibility of "substituting" health workers is already being raised by the United States. France cannot afford to bypass discussions on possible action of that kind, all the while bearing in mind that it could only a first transitional step that must lead to a skills and technology transfer.

A number of different solutions are also being considered, and they must not all come from donor countries nor be imposed on a top-to-bottom basis. Through its cooperation offices and the international agencies to which it belongs, France can offer solutions without interfering in Southern countries' national policies, and contribute to establishing local strategies.

Financial and technical aid from France and the international donor community

---

[25] *The Manager*, 2004, Volume 13, Number 2, "Tackling the crisis in human capacity development for health services", p.3. http://www.msh.org/resources/publications/manager.html

[26] *Emigration des personnels de santé : Les deux facettes de l'émigration des personnels de santé vers les pays riches.*

[27] *Ibidem.*

[28] Marko Vujicic, Pascal Zurn, Khassoum Diallo, Orvill Adams et Mario R Dal Poz, *Human Resources for Health*, 28 April 2004, "The role of wages in the migration of health care professionals from developing countries".

[29] Internal CNS hearing.

[30] Amy Hagopian, Matthew J Thompson, Meredith Fordyce, Karin E Johnson et L Gary Hart, Human resources for health, 14 December 2004 : « The migration of doctors from sub-Saharan Africa to the United States of America: measures of the African brain drain ». http://www.human-resources-health.com/content/2/1/17

[31] *Ibidem.*

France, through its cooperation actions and the Ministry of Foreign Affairs, its decentralised cooperation at the local level, as well as through the international organizations to which it belongs, can provide aid that needs to be implemented over both the short and long terms. While that aid needs to be based on reliable data, all of the existing literature on the human resources crisis underlines the lack of information or the poor reliability thereof. Therefore, in order to fully understand how healthcare systems work, what the training requirements are, and what the needs are on the ground, in order to better coordinate, it is important to support research into social science in order to better grasp who the healthcare workers are, how they work, how the local hospitals operate, how funding is structured, etc. At the national level, the Ministry of National Education, Higher Education and Research could lend this angle to the programmes conducted by Institut de recherche pour le développement (IRD) and Agence nationale de recherche sur le sida (ANRS). As the same type of funding exists at the both the local and European levels, making use of that funding would make it possible to increase the number of research projects carried out on the topic.

The prospect of intensive hiring cannot be considered without reflecting on the issue of training. Training health workers is a relatively long process, whether nurses (three years) or doctors (five years). Moreover, training staff cannot be both on the field and in the schools. Beyond initial training, the issue of continuing training must also be addressed. It is estimated that knowledge about HIV/AIDS in Africa's rural communities are 15 to 20 years behind[32]. There is no continuing training culture. Training programmes are few in number, short in length and minimally coordinated, if at all. It remains desirable that such training programmes integrate a section on the quality of care for individuals, and the importance of the patient-care provider relationship, in order to limit the risk of workers being violent to their patients. The training programmes also need to lead to diplomas and be subject to evaluation.

The aforementioned short-term measures will remain insufficient, however, if no in-depth work is carried out in the longer term. It is the whole of the educational system that needs to be reformed if training is to be provided to a larger number of healthcare professionals. Primary and secondary education need to be made a priority, by including massive female recruitment, as women currently have very limited access to education, but also by taking care to ensure greater social and ethnic diversity. This includes developing infrastructures, as well as giving greater value to instructor remuneration. All of the aforementioned responses can be supported by France's cooperation efforts.

France must continue to fund local training programmes as it already does through the Ministry of Foreign Affairs[33] and decentralised cooperation, and encourage the French Agency for Development (AFD) to continue in the same direction. At the same time, despite the Ministry's current tendency to repatriate its technical workers, France could look at changing its policy in this area. In the short term, one possible solution would be to call upon coopérants to fill instructor positions. They would train workers who, in turn, would be able to pass that knowledge on, and thus create a chain of knowledge. The cooperation programmes, in particular at the university level, will need to resolutely incorporate training in AIDS patient care into their priorities. Incentive could be given to establish twinning programmes between medical schools or nursing schools, through performance-based contracts subject to evaluation, but also equipped with financial resources. Coopérants could help upgrade and maintain medical knowledge in these countries, as part of initiatives such as ESTHER[34].

As a member of the European Union and multilateral organisations such as the Global Fund to Fight AIDS and Tuberculosis, the World Bank and other institutions, France can plead in favour of funding for such training programmes and promote the launch of an educational fund jointly financed by the local authorities and international aid. To enable the said training programmes to be effective, France, with the help of the international institutions to which it belongs, can also help the countries of the South share their practices and experiences, in order to find responses that truly come from the South. Two major thrusts shall be providing technical aid in developing the Internet, teleconferencing and distance learning, and making it possible to set up databases compiling the aforementioned experiences along with the latest innovations in research and prevention.

Measures such as these cannot be effective unless the reforms come with improved working conditions; otherwise, the health workers, once trained, will continue to emigrate. For a long time now, hiding behind macroeconomic contentions, the World Bank and the International Monetary Fund (IMF) have refused, and even condemned, investing in human resources[35]. That policy having turned out a failure, changes have begun to come about within the World Bank, reluctant on the matter up until now. Improving health workers income is another lever for bringing healthcare supply back in balance with demand, in particular in the rural areas. Hand-outs could be allocated to encourage health workers to settle in threatened areas, such as Ghana, where the World Bank has made it possible for salary levels to improve by 15 to 35 %[36]. Such measures can only be considered if they come along with improved coordination and regulation, prohibiting unofficial payments by patients, as has been the case in Cambodia, in an NGO-led programme[37]. Today, the Global Fund to Fight AIDS, Tuberculosis and Malaria has made it possible for a large component of current

[32] Joint learning initiative, *Human resources for health : overcoming the crisis*, October 2004, p. 113.

[33] Internal CNS hearing.

[34] Ensemble pour une Solidarité Thérapeutique Hospitalière En Réseau.

[35] Internal CNS hearing.

[36] Joint Learning Initiative, *Human Resources for Health: Overcoming the Crisis*, October 2004, p.121.

[37] World Bank Report: *World Development Report 2004: Making Services Work for Poor People in 2003*, p. 128.

aid to be dedicated to human resources. France must support this approach before the French Development Agency, its national resource-allocating agency, under bilateral partnerships, as well as with other partners, such as the European Union.

This aid needs to be coordinated in order to remedy the lack of consistency that sometimes exists between the various international donors[38], and come along with more effective means of monitoring where the funds end up, as in certain countries, this sometimes does not match the original intention.

While higher salaries might slow down the emigration of health workers, hiring policies in developed countries also remain to be redefined. Using hand-outs to encourage school directors and university deans in Africa to send their recent graduates to the North is not an acceptable solution[39]. France has an important role to play in this respect. In 2000, only 4 % of all physicians working in France were foreigners[40]. Yet the use of doctors of foreign origin is on the rise, with the figures increasing by 7.2 % between 2002 and 2003[41]. Yet, while demand is rising, France is not the developed country that absorbs the most human resources from developing countries. It could therefore offer incentive to other countries by promoting a good practice policy less conducive to luring local physicians away, including in the international agencies to which it belongs[42]. France could also lend its support developing countries' requests that an international fund be set up to manage the financial compensation paid to developing countries for the health workforce provided to wealthy countries[43].

One of the avenues explored over the past several years to help international organisations and national governments in their healthcare missions is that of public-private partnerships (PPP)[44]. The idea is that the private sector's expertise can help overcome the financial or organisational obstacles that the public sector encounters. Looking at the drain on health workers from the public sector to the private sector, it is clearly motivated in part by the companies that provide medical coverage to their employees through private clinics or practices. Should it be decided that PPPs will be implemented in response to the crisis in the health workforce, all the while taking into account how attractive companies are to health workers in the public sector, France could encourage its companies to consider public-private partnerships that would help strengthen the public sector and its increase its salaries, rather than drawing in its employees without any compensation. At the very least, the PPPs discussed will need to take into account the role of companies in the workforce drain, in order to provide a response to it.

However, whatever the measures initiated by France and its donating partners, if the Southern countries do not fully commit by investing in the necessary structural reforms, no progress will have been made in addressing the issue.

The need for structural reform in the South's existing practices

Fist and foremost, developing countries should look at the conditions under which active health workers are required to serve. Protection, fair compensation and recognition for a job well done are all fundamental factors in reversing the current health workforce drain on the sector or country. One priority is to improve safety conditions: this means buying gloves for the workers, incinerators for the syringes, etc., but also promoting free access to post-exposure prophylaxis, not to mention therapeutic care over the long term[45], which would considerably change the relationship with the patients.

The issue of training, and more generally speaking, that of education, is expected to also be a priority for local governments. Education at the primary and secondary levels is the breeding ground for future health workers. Yet, if only in Africa, only 39 % of women have access to secondary education, and it is thus essential to compensate for this imbalance. Some countries have begun to take action, such as Malawi, which has set up remedial courses to make up for the weaknesses of secondary education. This has made it possible to increase the number of students enrolled in medical schools by 20 to 60 per year, thereby fostering local

---

http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2004/07/30/000012009_20040730102437/Rendered/PDF/268950French.pdf

[38] Internal CNS hearing.

[39] *Ibidem.*

[40] Study n° 34, Conseil national de l'ordre des médecins, November 2001, "Démographie médicale française, situation au 1er janvier 2001" p.37.

[41] Study n° 37, Conseil national de l'ordre des médecins, December 2004, "Démographie médicale française, situation au 1er janvier 2004" p.139.

[42] Joint Learning Initiative, *Human Resources for Health: Overcoming the Crisis*, October 2004, p.107.

[43] 2nd Summit on Health in the MDGs, December 2004 in Abuja: *Health Workforce Challenges: Lessons from Country Experiences*

[44] Buse K., Walt G., "*Global Public-Private Partnerships", "Part I – A New Development in Health?*", BWHO, 78(4), 2000, pp. 549-561. "*Part II – What Are the Health Issues for Global Governance ?*", BWHO, 78(5), 2000, pp. 699-709. Buse K., Walt G., "*Globalisation and Multilateral Public-Private Health Partnership : Issues for Health Policy*", in Lee K., Buse K., Fustukian S. (eds), Health Policy in a Globalising World, Cambridge, Cambridge University Press, 2002.

[45] Internal CNS Hearing.

recruitment[46]. Access to a university education in the field of health could be built on a scheme under which the future graduate would be required to work a certain number of years in his own country, in exchange for which his education would be paid for. In the countryside, this could even apply to only the first year following graduation, as is done in countries such as Cuba[47] thus making it possible for the poorest populations to enter higher education. However, such restrictive measures are often eluded if they do not carry, at the same time, incentive measures.

Regional exchanges between Indian Ocean countries already exist to locally train medical workers[48]. More broadly speaking, in the South, the lack of medical schools can be made up for by sending students to other Southern countries, better equipped in terms of medical education, such as Cuba, where 9 000 students from 83 countries have already been trained.

Nonetheless, it takes time to train workers and there are areas where medical workers are direly lacking. This is why developing countries call upon foreign workers. To illustrate, since 1960, over 67 000 Cuban healthcare professionals have served in 94 countries. They are paid a Cuban salary and receive, from their host country, a monthly bonus of USD 100 and a stipend for all of their housing, food and transport needs[49].

Some countries, when they do not call upon such outside labour, use substitute health workers to perform duties that go beyond the limits usually set by their status and training background. Such substitution is found particularly in rural areas, with two main forms seen:

- workers are entrusted with certain specific tasks and must report on them to physicians. This allows the doctors to delegate work, all the while supervising their teams' undertakings. Under this system, a growing number of nurses and healthcare officers have replaced doctors in providing first aid[50].

- workers fully replace other workers, following training courses that vary according to country. In Ghana, general practitioners can replace specialists after an 18-month training programme. In Tanzania, a number of different substitution programmes exist with different levels of training, with the most qualified workers entitled to enter medical school. This prevents possible discouragement in workers when they feel they cannot improve, whether in terms of salary or skills[51].

This substitution system slows down emigration, as the diplomas are not recognised at the international level. The shorter training programmes are not as costly and substantiate a slightly lower salary level. Access to higher qualifications, combined with experience in the field, provides for greater social diversity, including workers from the local population. As they are better integrated in the communities, they lower the amount of domination and violence that can exist in the relationships. Trained locally, the substitute workers tend to remain where they work, even in rural areas.

However, the substitution scheme primarily uses an already-existing workforce, even though it expands their range of skills. In order to truly enlarge the workforce, other forms of cooperation need to be sought with the local community population, in particular in rural areas.

The use of community workers or traditional therapists trained and supervised in basic treatment (treatment for diarrhoea, health and hygiene education, family planning, prevention, nutrition, etc.) is central to many strategies experimented with to date[52]. The concept of substitution workers is present here as well. However, rather than calling on trained health workers, the system uses individuals form the community to perform relatively simple tasks. Their training is not of the same length, ranging from three days in Indonesia to three months in India[53]. Substitution makes it possible to free up time for health workers, who are more qualified and can use that time to carry out more technical activities. The community's role does not end there, especially when it funds, itself, a portion of the services that allow it to enjoy more benefits, transparency and responsibility on the part of the service providers, at a lower cost. However, to be optimal, the co-payment must be performance-based, and be portrayed as a contribution to the service providers' income, rather than as a way of making up for inadequate public funds. The concept of community-based inspection of healthcare performance levels has also been adopted by Vietnam and Bolivia, and has made it possible for the local governments to

[46] 2nd Summit on Health in the MDGs, December 2004 in Abuja: *Health Workforce Challenges: Lessons from Country Experiences*.

[47] World Bank Report: *World Development Report 2004 : Making Services Work for Poor People in 2003*, p. 183.

[48] Internal CNS Hearing.

[49] Joint Learning Initiative, *Human Resources for Health: Overcoming the Crisis*, October 2004, p. 110.

[50] Delanyo Dovlo, *Human Resources for health*, 18 June 2004 : « Using mid-level cadres as substitutes for internationally mobile health professionals in Africa. A desk review ». http://www.human-resources-health.com/content/2/1/7

[51] *Ibidem*.

[52] Charles Hongoro et Barbara Mc Pake, *The Lancet*, Vol 364, 16 October 2004, "How to bridge the gap in human resources for health ?", p. 1454.

[53] Joint Learning Initiative, *Human Resources for Health: Overcoming the Crisis*, October 2004, p. 46.

grasp the main obstacles on the demand side and ensure that health services meet community needs. In Mali, Madagascar and Senegal, for instance, user associations employ, pay and carry out inspections of healthcare professionals serving local inhabitants, on a monthly basis[54].

The work carried out by the community is multi-faceted and no aspect should go neglected. Many people in patients' families, often women, provide psychological support and basic care for their loved ones. Such "invisible workes" [55] are an important source of labour. Likewise, patients' associations have been set up in certain countries, like Tanzania and Togo. They carry out work in prevention and look mainly at social aspects and support, insofar as the public healthcare structures are absent from that approach.

There also exist many associations with religious roots, experienced in medicine. In certain countries of eastern and southern Africa, they actually represent the largest potential source of healthcare. However, their religious principles do not always make it possible to take an approach combining prevention and healthcare. Nonetheless, the said associations offer a major human resources pool and it would be a mistake to ignore them. The United States have already come to realize this.

In summary, the strategies are manifold, whether in terms of the aid that the North can provide, or the solutions and innovative responses that the South can offer. It is only through the determination expressed on both sides and effective coordination between the two that the synergies necessary for concrete outcomes will emerge.

[54] World Bank Report: *World Development Report 2004: Making Services Work for Poor People in 2003*, p. 169.

[55] Joint Learning Initiative, *Human Resources for Health: Overcoming the Crisis*, October 2004, p. 43.

LIST OF INTERVIEWEES

Conseil national du sida wishes to express its warmest thanks to those who were kind enough to take part in International Commission hearings:

- Doctor Mario Dal Poz, Health Workforce Department, World Health Organisation (WHO), Geneva;
- Professor Bruno Dujardin, Head of "Health Policies and Programmes in Developing Counties" Unit, Free University, Brussels;
- Professor Gilles Dussault, Senior Health Specialist (Policy), World Bank Institute, Washington;
- Mr. Eric Fleutelot, Director of International Programmes, Sidaction (association), Paris ;
- Doctor Lieve Fransen, Head of Social and Human Development Unit, Directorate General on Development, European Commission, Brussels;
- Doctor François-Marie Lahaye, Project Coordinator, Health Office, Directorate General on International Cooperation and Development, Ministry of Foreign Affairs, Paris;
- Doctor Michel Lavollay, Senior Advisor, Private Sector, Global Fund for the Fight on AIDS, Tuberculosis and Malaria, Geneva;
- Doctor Jean-Elie Malkin, Advisor, Medical and Scientific Watch, Ensemble pour une solidarité thérapeutique hospitalière en réseau (GIP ESTHER), Paris;
- Doctor Henriette Meilo, President of DARVIR Therapeutic Committee and Doctor Margaret Sanga, Laquintinie Hospital, Douala;
- Mr. Pierre Morange, Yvelines MP, National Assembly, Paris;
- Doctor Claire Mulanga, Head Technical Specialist on HIV/AIDS and the Working World, International Labour Office Programme on HIV/AIDS and the Working World (ILO/AIDS), Geneva;
- Jean-Michel Sévérino, Director General and Mrs Marie-Odile Waty, Head of Health Sector, French Development Agency (AFD), Paris.