



Press Pack

Second Global Forum on Human Resources for Health Bangkok, 25-29 January 2011

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Introduction

Why is the Forum important?

“Almost a billion people in the world today have no access to health care. They live and die without ever seeing a health worker. This is a truly global crisis, affecting the rich and poor, in the north and south.”

Dr Mubashar Sheikh, Executive Director of the Global Health Workforce Alliance

The critical shortage of health workers is one of the major obstacles to improving child and maternal health, and fighting the diseases which affect the developing world.

Health personnel are at the core of an effective health system, and if unsupported and under-resourced they are often the weakest link in the delivery of healthcare. Without a massive scale up in this area, many countries will fail to reach the health-related Millennium Development Goals by 2015.

Mothers, children and those battling with HIV, malaria and tuberculosis are suffering needlessly because they simply lack access to a skilled health worker.

This issue needs to be addressed urgently if countries are to achieve MDGs 4, 5, and 6: the goals which aim to dramatically reduce child and maternal mortality as well as contain the spread of HIV and other major diseases.

Second Global Forum on Human Resources for Health

Bangkok, January 25-29, 2011

The Global Health Workforce Alliance (the Alliance) is providing international leadership by bringing together national governments, international agencies, NGOs and civil society to develop and implement effective solutions to the health worker crisis.

The Forum's principal theme - Reviewing progress, renewing commitments to health workers towards MDGs and beyond - highlights that renewed and sustained efforts are needed.

The Alliance convened the first ever Global Forum on Human Resources for Health in Kampala in 2008. This resulted in the adoption of the Kampala Declaration and Agenda for Global Action, a roadmap for solving the health worker crisis and a commitment to track country-level developments in human resources for health (HRH).

The Second Global Forum in Bangkok will showcase progress and challenges in the 57 countries facing the most severe health workforce shortages. Uniting the global health community to share knowledge and experiences helps establish shared commitment and action to resolve the HRH crisis. The Forum is co-hosted by the Global Health Workforce Alliance, the Prince Mahidol Award Conference, WHO and the Japan International Cooperation Agency.

The 1 000 participants will include key experts from around the world working to address the health workforce crisis. These include health ministers from the developing world and representatives from multilateral and bilateral agencies, NGOs, academic and research institutions, professional associations, the business community, civil society and health service workers.

Key conference sessions

The critical shortage of health workers is widely recognized as one of the most fundamental constraints to improving health. Uniting key figures from the global health arena helps showcase successful strategies, as well as open up discussions about the challenges involved in scaling up HRH.

These broader issues related to the crisis will be introduced in plenary sessions at the conference, while parallel sessions will focus more specifically on strategies to build a strong and productive health workforce.

Plenary Sessions

Building on the Forum theme of 'Reviewing progress, renewing commitments to health workers towards MDGs and beyond', plenary sessions will cover:-

- The progress report on the Kampala Declaration and Agenda for Global Action;
- Leadership, governance and coordination for universal access to supported health workers;
- Innovations in HRH that support the strengthening of health systems.

Main Conference sessions:

Plenary Session 1: From Kampala to Bangkok: Marking progress, forging solutions

The *Kampala Declaration and Agenda for Global Action* (KD/AGA) was adopted at the first Global Forum in Uganda in March 2008. It offers governments and other key stakeholders guidance on how to strengthen the health workforce. This plenary session will review progress made towards implementation of the Declaration and Agenda for Action over the past three years, focusing on the 57 crisis countries.

Plenary Session 2: Have leaders made a difference?: How leadership can show the way towards MDGs.

As the deadline for the Millennium Development Goals approaches, dynamic and effective leadership will be vital for countries to meet the health-related targets. This session delves into the leadership-related issues often confronted when managing complex and delicate environments, such as: competing priorities, contradictory purposes and the involvement of various stakeholders.

Plenary Session 3: Professional Leadership and Education for 21st Century

Training and deployment of health workers is a key global workforce challenge for poor and rich countries. Quality education is crucial to achieve the health-related MDGs, particularly for countries facing the most severe health worker shortages. This session will address the key challenges of professional education, and propose recommendations for health worker training in the 21st Century.

Plenary Session 4: Making HRH Innovation Work for Strengthening Health Systems

A variety of innovative work has been implemented in the areas of education and retention of health workers. While successful projects have the potential for adaptation to a number of health systems, other innovations have been short-lived. These concepts and lessons in HRH innovations for scaling up training will be reviewed, and related to country-level experiences.

Other sessions

- **Serving in the frontlines: personal experiences and country strategies for retention of health workers in rural areas**

In many HRH crisis countries, it is rural and remote areas that face the most acute shortages of health workers. These areas therefore risk lagging behind others in progressing towards the Millennium Development Goals.

This has prompted a number of calls for change - such as those outlined in the Kampala Declaration and Agenda for Global Action of the first HRH Global Forum. Over the past two years, WHO has responded by developing evidence-based recommendations on how to attract, recruit and retain health workers in rural and remote areas. Countries are now beginning to implement these recommendations. Building on experiences of rural health workers who have spent many years serving in these areas, this session will further explore the key elements for the long-term success of such rural retention interventions.

- **Will the WHO Global Code stop the brain drain? What will it take to succeed?**

Health worker migration has increased dramatically over the past decades. The biggest rise has been from lower income countries - further weakening already fragile health systems.

The WHO Global Code of Practice on the International Recruitment of Health Personnel, adopted by the World Health Assembly in May 2010, aims to provide an ethical framework to guide Member States in the international recruitment of health workers. It encourages destination countries to collaborate with source countries to sustain human resources for health development and training as appropriate.

This session will review the potential impact of the Code, discuss the implications, benefits and challenges of the Code, and review strategies for its successful implementation.

- **Overcoming the health worker crisis in conflict and post-conflict situations**

In conflict and post-conflict situations, an HRH crisis easily arises. Health workers are sometimes killed and threatened; some of them are also obliged to leave the country.

Although several UN agencies and humanitarian NGOs have shown ways to cope with such HRH crises, more efforts are needed to give hope to the hopeless - both health workers and the wider populations they serve. In many conflict and post-conflict situations, support is urgently needed both from within countries and externally. However, where conflict or post-conflict situations are prolonged, a long-term vision is also critical.

This is particularly important to avoid fragmented training, and to foster an improved retention mechanism. These situations might also be true after large-scale natural disasters.

- **The UN Secretary General Global Strategy for Women's and Children's Health: what will be done about the workforce?**

In the course of 2010 the global development agenda was dominated by the discourse on MDG 4 and 5 and on health systems.

Women's and children's health were the main topic of the Women Deliver and Countdown conferences, the African Union summit of Heads of States and a key focus of the G8 meeting and UN High Level Summit on the MDGs in September 2010, where the UN Secretary General launched the Global Strategy for Women's and Children's health. The grave impact of the health workforce crisis on the health of women and children was a strong undercurrent in all of these discussions.

FAST FACTS

Global Health Workforce Crisis

Key Facts

- **Scaling up.** Over 4 million health workers are needed to address the global shortages, with 1.5 million needed for Africa alone.
- **Country crisis.** WHO estimates that the shortage of trained health workers has reached crisis levels in 57 countries - 36 of which are in sub-Saharan Africa.
- **Investment.** US\$40 billion of additional investment is needed in the health workforce through 2015 to achieve the health related MDGs in 49-low income countries.
- **Developed and developing world disparity.** Sub-Saharan Africa bears 25% of the global burden of disease – but has only 3% of the world’s health workers.¹
- **Rural/urban disparity.** Approximately one half of the global population lives in rural areas, but they are served by only 38% of the total number of nurses and less than a quarter of the total number of doctors.¹
- **Health worker crisis in the developed world.** Western countries – many of which have ageing populations - are also short of trained health workers – a gap they often seek to fill by “importing” workers from developing countries.
- **Brain drain.** Three quarters of doctors trained in Mozambique now work abroad. The majority work in Portugal (1,218) and the rest work in South Africa (61), US (20) and UK (16).¹

¹ Human Resources for Health: New data on African health professionals abroad. Michael A. Clemens & Gunilla Pettersson

Key Messages

More than a quarter of the world's countries (57) are still struggling to provide basic healthcare due to a lack of health workers. This critical shortage - mostly in remote settings - is one of the major obstacles to achieving the health-related Millennium Development Goals 4, 5, and 6 by 2015.

Over 4 million more health workers are needed globally. This is currently one of the major obstacles to improving child and maternal health and protecting people from preventable diseases such as HIV and malaria in the developing world.

A billion people worldwide face a daily struggle to access basic healthcare due to the lack of skilled health workers. Hundreds of thousands of men, women and children, mostly in the world's poorest countries, live and die without ever seeing a trained health worker.

Shortages of doctors, nurses and midwives are most acute in sub-Saharan Africa. WHO recommends a minimum of 23 health workers per 10 000 people to provide the most basic health coverage.

Second Global Forum on Human Resources for Health, Bangkok, Thailand. The need to expand and strengthen the health workforce will be the focus of international leaders and experts from 25-29 January, 2011. Participants will review progress on the scale up of health workers and accelerate implementing towards the Kampala Declaration and Agenda for Global Action, the roadmap adopted in 2008 to drive improvements in human resources for health. Participants will also call for increased investment and sustainable, collaborative action to accelerate progress by 2015.

Health worker statistics from World Health Report 2010

Including countries in Africa and Asia with most severe shortages

Country	No. of doctors per 10,000 people	No. of nurses and midwives per 10,000 people	% of births attended by skilled birth attendant
Niger	<0.5	1	18
Somalia	<0.5	1	33q
Ethiopia	<0.5	2	6
Burundi	<0.5	2	34
Sierra Leone	<0.5	2	42p
Tanzania	<0.5	2	46m
Bhutan	<0.5	2	51
Chad	<0.5	3	14
Mozambique	<0.5	3	48p
Liberia	<0.5	3	46m
Malawi	<0.5	3	54
Rwanda	<0.5	4	52p
Guinea Bissau	<0.5	6	39r
Gambia	<0.5	6	57m
Guinea	1	<0.5	38r
Mali	1	2	49q
Togo	1	3	62r
Senegal	1	4	52r
Central African Republic	1	4	54r
Papua New Guinea	1	5	39n
Ivory Coast	1	5	57
DR Congo	1	5	74
Eritrea	1	6	28p
Lesotho	1	6	55
Zambia	1	7	47

Country	No. of doctors per 10,000 people	No. of nurses and midwives per 10,000 people	% of births attended by skilled birth attendant
Burkina Faso	1	7	54
Mauritania	1	7	61m
Indonesia	1	8	73p
Benin	1	8	78m
Congo, Rep	1	8	86m
Ghana	1	10	57
Kenya	1	12	42
Uganda	1	13	42
Angola	1	13	47m
Timor Leste	1	22	
Afghanistan	2	5	14
Nepal	2	5	19
Cambodia	2	8	44
France	37	81	99
UK (2009)	23	128	99
USA	27	98	99

m Data are preliminary or provisional.

n Includes <5% of deliveries by cadres of health workers other than doctors, nurses and midwives.

p Institutional births.

q Includes deliveries by cadres of health workers other than doctors, nurses and midwives – range not available.

r Includes >15% of deliveries by cadres of health workers other than doctors, nurses and midwives.

Questions and answers

Health worker crisis

Q: What is the impact of the health worker shortages?

A: Without enough adequately trained health workers, the health MDGs, designed to reduce disease and improve child and maternal health, will never be met.

In many developing countries people have to walk for hours and even days to reach a trained health professional in a health centre. When they arrive they often wait around for hours as the health workers attend to hundreds of patients a day. Illnesses are misdiagnosed and go untreated, children are not vaccinated against life-threatening diseases and mothers die in childbirth because of these shortages and lack of adequate training.

Health workers are overworked and underpaid and sometimes not even paid at all. They have to deal with poor equipment and facilities and often do not have the basic essential drugs they need to treat their patients. This frustration leads to a lack of motivation and encourages health workers to migrate towards the cities, move to a private health facility or an international NGO or even further afield. Some decide to leave the healthcare profession altogether.

Q: Which countries are most heavily affected?

A: Sub-Saharan Africa faces the greatest challenges and proportionately, is the most heavily affected region of the world. Within Africa, Chad, Ethiopia, Liberia, Malawi, Mozambique, Niger, Sierra Leone and Tanzania face particularly acute shortages. The situation is exacerbated in southern African countries facing high levels of HIV/AIDS, TB and malaria. In Asia, Afghanistan, Cambodia, Nepal and Pakistan are particularly badly affected by health worker shortages.

Q: Why are health workers migrating?

A: Health workers migrate for the same reason all migrants do: they seek better employment opportunities and quality of life. A higher income is an important motivation for migration, but not the only one. Other reasons include better working conditions, more job satisfaction, career and training opportunities and the quality of management and governance. Political instability, war, and the threat of violence in the workplace also are strong drivers of migration in many countries.

Q: Why is migration a problem for global health?

A: When a country has a fragile health system, the loss of its workforce can bring the whole system close to collapse, with the consequences are measured in lives lost.

In financial terms, when significant numbers of doctors and nurses leave, the countries that financed their education lose a return on their investment and become unwilling donors to the wealthy countries to which their health personnel have migrated.

The United Nations Conference on Trade and Development has estimated that each migrating African professional represents a loss of \$184,000 to Africa.²

However, the movement of health workers abroad also has positive features: each year, migration generates billions of dollars in remittances (the money sent back to home countries by migrants) to low-income countries and has therefore been associated with a decline in poverty. Health workers also may return, bringing significant skills and expertise back to their home countries.

Q: Can / should health worker migration be stopped?

A: The issue is not about 'stopping' migration; rather it is about management and regulation. Freedom of movement is a fundamental right according to the 1948 Universal Declaration of Human Rights, and migration is a staple of human history. Globalisation has accelerated this trend significantly. But the grave effects of health workforce migration on developing countries call for a responsible, regulated management of migration, with a critical aim that all countries move towards self-sufficiency.

Some countries specifically train health workers for 'export'. Bilateral agreements between 'importing' and 'exporting' countries need to be encouraged to protect the rights of the health worker and offer some guarantee of employment level in the 'importing' country.

The World Health Organization and partners, including the Global Health Workforce Alliance, worked to develop a global code of practice on the international recruitment of health workers. The Code was unanimously adopted at the 63rd World Health Assembly in May 2010. The code sets out guiding principles and voluntary international standards for recruitment of health workers, to increase the consistency of national policies and discourage unethical practices, while promoting an equitable balance of interests among health workers, source countries and destination countries.

Q: What is the WHO doing to help developing countries ‘retain’ their health workers?

A: The WHO recently launched global recommendations³ which seek to advise countries on how to improve access to health workers in remote and rural areas through improved retention. The sixteen recommendations were drawn up in consultation with a group of experts, comprising researchers, policy makers, representatives of professional associations, donors and programme implementers from around the world. They include: enrolling students from rural areas; locating training schools in rural areas; ensuring compulsory service in rural areas and providing incentives such as grants for housing and paid vacations. The recommendations also offer a guide for policy makers to choose the most appropriate interventions, and to implement, monitor and evaluate their impact over time.

² Ogowe A. Brain drain: colossal loss of investment for developing countries. The Courier ACP-EU. 1996;159:59–60.

³ WHO - Increasing access to health workers in remote and rural areas through improved retention <http://www.who.int/hrh/retention/guidelines/en/index.html>

Q: Countries are now giving more responsibility to community health workers to try and address health worker shortages. How are any potential risks associated with this being managed?

A: Community health workers (CHWs) play a key role in delivering health care and helping to meet the health-related MDGs. The Alliance produced key messages to help governments develop appropriate strategies involving CHWs in the health workforce. These were produced following a global consultation on CHWs involving policy makers, programme managers and experts who reviewed the recommendations of a study commissioned to gather evidence on the wide-scale use of CHWs.

The messages give guidelines on the deployment, selection, training, remuneration, incentives and monitoring of CHWs, with the aim of enabling CHWs to fulfil effective roles in the health workforce, working closely with existing health workers.

Global Health Workforce Alliance

Q: What is the Global Health Workforce Alliance?

A: The Alliance provides international leadership on the health workforce by bringing members, partners and countries together to find solutions, advocate for their effective implementation and facilitate the sharing of knowledge and best practices on health workforce issues.

The Alliance is advocating for urgent and long-term investment and coordination from national governments and donors to address the health worker crisis.

Q: What does the Alliance believe needs to happen for the health worker crisis to be addressed?

A: The Alliance believes that the health worker crisis needs to be addressed through:

- Training – to ensure more health workers at every level of the health work force, depending on country context and needs
- Health worker retention – including efforts to ensure decent wages; adequate equipment and facilities; quality supervision and professional development
- Financing – increasing both international and domestic funding. Training the 1.5 million additional workers needed for Africa alone will cost an estimated £2.6 billion per year over ten years. Macro-economic and national constraints on increased health spending must be relaxed.
- Addressing health worker migration to manage the pressures of the international health workforce market.

- Evidence-based capacity building to ensure models of best practice are replicated and adapted within country and regional contexts.
- New technologies – that diversify health care capability, link facilities and increase the reach of trained health workers

Q: What are the concrete actions the Alliance is taking to address the health worker crisis?

A: The Alliance recognises that the health worker crisis is complex and multi-faceted and cannot be addressed without strong coordination between the various stakeholders, including government, private sector, NGOs and the international community.

The Alliance has established task forces and working groups involving the above stakeholders to address certain aspects of the health worker crisis. Six task forces have so far been commissioned on the following themes: Financing, Migration, Private Sector, Scaling up Education and Training, Tools & Guidelines and Universal Access to HIV treatment. The aim of these taskforces is to produce concrete evidence that will help countries to come up with sustainable solutions to the health worker crisis. The financing taskforce, for example, has developed a tool to help governments calculate how much money is needed to address the health worker shortages in their own countries

Q: How is the Alliance helping countries to coordinate a national response to health worker shortages?

A: The Alliance has organised regional and global meetings for governments to share experiences on coordinating an effective national health workforce plan. This is impossible without a strong coordination of all involved, including government ministries, the private sector, NGOs and the international community. The Alliance has included the most positive government experiences in a document entitled: “Human Resources for Health”: Good Practices for Coordination and Facilitation.

Second Global Forum, Bangkok

Q: What is the Second Global Forum on Human Resources for Health

A: The Alliance convened the first ever Global Forum on Human Resources for Health in Kampala in 2008. This resulted in a clear action plan to address the health worker crisis over the next decade, in the form of the Kampala Declaration and Agenda for Global Action.

The Second Global Forum in Bangkok will review progress since 2008 and provide guidance on how best to move forward through sharing knowledge and experiences of concrete actions taken and progress made so far to address the crisis.

Q: What have been the key achievements since the Kampala Forum?

A: Since the 2008 Forum, important new political and financial commitments have been made. Donor countries, such as the UK, US and Japan pledged funding to address the health worker crisis.

At the UN High Level meeting on MDGs in 2008, the UK government pledged over GBP450 million over three years to support national health plans, including training more nurses, midwives and doctors in eight of the world's poorest countries. Japan committed to train 100,000 new health workers in Africa over the next five years

The adoption, in 2010, of the WHO Global code of practice on the recruitment of international health personnel marks a major step forward in highlighting and addressing issues of migration. WHO also developed guidelines for countries to aid retention of health workers in rural areas.

At the UN Summit in September 2010, the UN Secretary General launched the Global Strategy for Women's and Children's Health⁴. Stakeholders including heads of state and governments, the private sector, foundations, international organisations, civil society and research organisations committed US \$40 billion to improving the lives of women and children and acknowledged the key role of a strong health workforce.

⁴ UN – Global strategy for Women's and Children's Health <http://www.un.org/sg/globalstrategy>

Impact of health worker crisis on the MDGs

The health worker crisis impacts on many of the MDGs, but particularly the health-related goals 4,5, and 6 – reducing HIV/AIDS, malaria and other diseases and improving maternal and child health. And these are all inter-related. For example, strengthening HIV/AIDS-related services can significantly contribute to the outcomes on child and maternal health and vice versa.

HIV/AIDS

Health workers are essential in administering treatment to HIV patients. One of the MDG targets is to achieve universal access to treatment by 2010 for all those who need it. Health workers now distribute life-saving ARVs to more than five million people - a 12-fold increase in the past six years. However, this still represents just one third of people who need HIV treatment. And for every two people who are able to start treatment, another five people are newly infected.

Malaria

Malaria kills around 850,000 people a year, 89% of whom live in Africa. The MDG target seeks to halt the disease by 2015 and begin to reverse its incidence. In order to help meet this goal, sufficient numbers of trained health workers are needed to correctly diagnose the disease and administer the use of Artemisinin-based Combination Therapy (ACT) drugs and intermittent preventive treatment (IPTp) for pregnant women.

Maternal health

Every year 358,000 women die due to complications during pregnancy or childbirth.⁵ More than half of these deaths occur in sub-Saharan Africa.

The WHO estimates that to meet the MDG goal of reducing maternal mortality by 75%, 1,334,000 more skilled birth attendants are needed.

⁵ *Trends in maternal mortality*, released by the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA) and the World Bank.

Global Health Workforce Alliance Awards

Recognising dedication and innovation

The Forum will feature an awards ceremony to recognise individual health workers who demonstrate great dedication or innovation in their profession and country case stories showcasing successful examples of recent health workforce improvements.

Shortlisted candidates will attend the Forum.

Résumés of individual health workers short-listed for award:

ID No. 42, submitted by Merlin, DRC, Collette Botchomoli (matron)

For the past 33 years, Collette has been working as a matron at the Elila health centre in Maniema, DRC. The centre serves over 5 000 people and, until recently, Collette was the only matron available for the female population, delivering babies by candlelight because of a lack of electricity and accessing remote patients by pirogue. Despite these challenges, Collette has stated that she "will never turn her back on those who need her".

At 61 years old, Collette meets around 20 pregnant women a week and is a mother of five. She has never received a wage from the government, and only recently started receiving financial incentives from Merlin to keep the centre running. In fact, the maternity ward was just renovated by Merlin, and Collette now has a clean and safe space to support deliveries.



ID No. 12, submitted by Ministry of Health, China, Dr. Wu Dengyun (doctor)

Dr. Wu believes that to be a good doctor one needs to have strong compassion for his or her patients. He applies this motto to his daily tasks and regularly demonstrates this quality in Wuquia County of Xinjiang Uygur Autonomous region where he's been serving since his graduation from medical school. Over the past 40 years, Dr. Wu has donated his blood more than 30 times, accounting for over 7 000 ml, and has once removed 13 stamp-size pieces of his own skin to transplant it on a little boy's body suffering severe burns. Dr. Wu, to this day, considers his patients' health the number one priority.



ID No. 13, submitted by Ministry of Health and USAID, Niger, Dr. Saidou Ekoye (doctor)

Doctor Ekoye's passionate and committed leadership resulted in the improvement of health worker productivity and motivation in Niger's Tahoua region. Through an innovative Quality Improvement (QI) collaborative, Dr. Ekoye wrote specific job descriptions for all staff, something unheard of prior to Dr. Ekoye's arrival. He also launched a comprehensive evaluation procedure to monitor staff progress and reward health workers demonstrating outstanding performance. Thanks to these changes, postpartum haemorrhage during pregnancy has been reduced by half, and more women in labour are using the clinic for the delivery of their babies.



ID No. 6, submitted by Ministry of Health, Thailand for Dr. Pakdee Suebnukarn (doctor)

Unlike the majority of rural hospitals in Thailand, the Damsai district hospital retains qualified health workers and has a turnover rate of only 3%. Dr. Pakdee Suebnukarn committed the past 21 years to ensure not only better healthcare for the 52 000 people living in the district, but also to improve the infrastructure and quality of care at the Damsai hospital. The progress made since his arrival in 1987 is impressive. From being the sole physician in a 30-bed hospital, its capacity has doubled to 60 beds, and includes five doctors and 100 staff. Dr. Suebnukarn's strategy was multifaceted: hiring of indigenous staff, developing a standard payment system and encouraging staff to pursue personal projects which directly benefit the community. Furthermore, for more specialized care, Dr. Suebnukarn has ensured that a pool of voluntary specialists from tertiary hospitals (both public and private) regularly visit Damsai, which avoids referrals to remote areas for the local population.



ID No. 33, submitted by The Health Workforce Advocacy Forum, Uganda, Dr. Ebele Omeke Micheal (doctor)

For the past 10 years, Dr. Ebele has worked in the remote Moroto District, located in the arid North Eastern part of Uganda-Karakmoja. He serves nomadic sections of the population through a system of mobile health services. Thanks to support from the Uganda Health Sector Programme and DANIDA, four mobile clinics were set up in Moroto and Kotido districts. He has also established community-based health initiatives and worked with community volunteers in health service delivery to provide treatment of tuberculosis, malaria and HIV/AIDS.



ID No. 32, submitted by Ministry of Health, Mali, Dr. Karamoko Nimaga (doctor)

After a seven-year career with the World Health Organization, Dr. Karamoko Nimaga decided to settle in 1997 in the large town of Markakoungo, 80 km from Bamako, and build his own clinic. His clinic consists of a medical unit, a small surgical room, a maternity ward, a hospitalization unit with 12 beds and a laboratory. It is located in a village of 5 000 but serves an area with a population of 13 000. Thanks to his specialized medical background from his medical thesis and his years at WHO, Dr. Nimaga is able to treat chronic pathologies such as epilepsy, arterial hypertension and diabetes. He is also a real pioneer in the fight against epilepsy and onchocerciasis (about 10 for every 1 000 Malians suffer from epilepsy) thanks to thorough research conducted over three years in 23 villages. He found that the fight against epilepsy and onchocerciasis were effective when using ivermectin, and this research was quickly validated by the scientific world.



To this day, he regularly participates in vaccination campaigns organized in villages in his area, sometimes as far as 25km away. He has also been elected three times as President of the Association of Rural Doctors, an association he has coordinated for eight years. More importantly, Dr. Nimaga has become a model for young doctors as he provides them with another vision of rural healthcare by confirming it's not a sacrifice, but a lifestyle.

ID No. 20, submitted by WHO and AAAH focal point, Sri Lanka, Pera Dorapage Lalitha Padmini (midwife)

For the past 13 years Mrs. Lalitha Padmini has demonstrated outstanding innovations in the remote Sri Lankan village of Medagama. Child nutrition being a major cause of concern, Mrs. Padmini took action and developed a colour coded system designed to alert mothers of their children's weight. This system has encouraged mothers to seek advice on how to improve their child's nutrition. Her clinic also won the award of best immunization coverage in 2008 thanks to her efforts in mobilizing the community to participate in immunization drives.



ID No. 19, submitted by the Ministry of Medical Services, Kenya, Leochrist Shali Mwanyumba (nurse)

Ms. Shali Mwanyumba has demonstrated great leadership and drive to improve the health of Kenya's remote populations. During her experience at the Taveta District Hospital, she was able to scale up natal care, family planning and immunization. She liaised with donors to distribute treated mosquito nets to pregnant women and children under five years of age, worked closely with community midwives to improve deliveries and regularly organizes support groups for HIV-positive mothers. Thanks to Ms. Mwanyumba's activities, community health in Taveta district has greatly improved in an effort to attain the Millennium Development Goals.



ID No. 7, submitted by Ministry of Health, Thailand for Mr. Therawat Daengkrapao (primary care)

At the Bansiyaksuanpa health centre Mr. Theawat Daengkrapao, a primary care worker, has been dedicated to serving the health needs of rural populations for the past 20 years. He firmly believes that community health is the determinant of a country's health system and that it belongs to the people. Thanks to his drive, he has implemented an around-the-clock service at the health centre and has also organized a community prevention network. This network directly involves local NGOs as well as the educational and agricultural sectors. Together they have implemented a complex system of Village Health Volunteers (VHV) to respond to remote community needs.



ID No. 52, submitted by AAAH Myanmar, Daw Nan Than Than Oo (midwife)

Daw Nan Than Than Oo was appointed as a midwife in 1982 and 1987 at the Htin Shu Taung sub-Rural Health Centre (RHC) in Mogok Township and at the Shwe Nyaung Pin sub-RHC respectively. In both positions, there were no maternal nor child deaths. In July 1989, she was transferred to Kyun Gyi sub-RHC, her native town, where she won a prize for best performance of immunization and nutrition services. During the cholera outbreak in 1991-1992, Ms. Than Oo actively assisted patients day and night and helped chlorinate the water and provide health education.



More recently, Ms Than Oo was transferred to Lwe-Satone sub-RHC where she's been working since 2000. The health centre is situated near the Thai border and the sub-RHC covers nine villages with a total population of 5 000 people with an additional estimated nomadic population of 3 000. She caters to 120-130 pregnant women yearly and provides immunization to over 200 children under one year of age every year. Given her exceptional work over the years, Ms. Than Oo received the "outstanding health worker" in 2002 issued by the Department of Health Planning/UNFPA.

Driven by her own motto of "no maternal mortality", she encourages the community to support her efforts through a network of village health volunteers. She also trains auxiliary midwives to improve skilled birth attendance. In 2010, she achieved 78% antenatal coverage, no maternal deaths, and contraceptive prevalence rate reached 62% in her area.

ID No. 10, submitted by health human resources development centre, Dr. Wang Tangyao (doctor)

Thanks to a balanced blend of traditional Chinese and contemporary medicine, Dr Wang Tangyao has, transformed the village clinic in Anhui province. In the past twenty years, it has developed from a small establishment consisting of only a desk, a medicine box and a visiting pack into a standard healthcare centre. Now villagers have access to more convenient and affordable health services.



ID No. 37, submitted by Ministry of Health, Vietnam, Mrs Ho Thi Thanh Hoa (community health worker)

After graduating from the Thua Thien Hue Provincial Secondary Medical School, Mrs. Hoa was assigned head of the Huong Lam Commune Health Centre in 1996. In 2001, she chose to pursue an undergraduate course in medicine to improve her knowledge and to better serve the people. Upon graduation in 2005, instead of returning to Huong Lam Commune Health Centre, Mrs. Hoa requested to be stationed in a remote area, at A Dot Commune Health Centre. Located in the Thua Thien Hue Province in central Vietnam, ethnic minorities account for 98% of the population. Despite these difficulties, Mrs. Hoa has stayed contributing greatly to the improvement of reproductive health and the reduction of maternal and infant mortality. She has also actively engaged in prevention of disease by educating the local population about malaria, maternal health and personal hygiene. Thanks to her efforts, locals have gained confidence in modern medicine. Today 70% of women go to the community health centre to give birth, 80% of the population seeks Mrs. Hoa's advice when ill and 80%-90% of households have built latrines.



Select biographies of conference speakers

Dr Mubashar Sheikh - Executive Director, Global Health Workforce Alliance

Dr Sheikh is a specialist in health system policy and planning. He has a Masters of Public Health from Yale University and is a Fellow of the College of Physicians and Surgeons in Pakistan.

He started his career with the Pakistan Institute of Medical Sciences in Islamabad, Pakistan. Between 1993 - 1998, he managed the Primary Health Care Department at the Ministry of Health in Pakistan. During this time he also designed, implemented and led a nationwide community based childcare and reproductive health network under the 'Lady Health Workers' initiative. This initiative, which involved a wide network of female community health workers operating at the grass roots level, has had an important positive impact on the health status of mothers and children in some of the remotest parts of the country.

In 1998, Dr Sheikh joined the Eastern Mediterranean Office of World Health Organization as Regional Adviser in the department of Health Systems, responsible for the promotion of Primary Health Care approach among the member states. He also developed strategies for the advocacy and implementation of Community Based Initiatives including the Basic Minimum Needs approach. In 2004 he became the WHO Country Representative in Iran, where he also served as Resident Coordinator of the UN system as well as Representative for FAO.

Dr Sheikh has served on various committees and task forces at the national, regional and international levels. He is the author of numerous policy documents, training manuals and guidelines and also writes regularly on various aspects of health systems and human development.



Dr Sigrun Møgedal

Chair, Global Health Workforce Alliance and Ambassador, HIV/AIDS and Global Health Initiatives, Norway

Sigrun Møgedal is the Chair of the Board for the Global Health Workforce Alliance and has been the Norwegian HIV/AIDS Ambassador since 2005. Dr Møgedal is a medical doctor with professional and diplomatic engagement in the global health and HIV/AIDS response, partnership development, global and national health architecture and reform and global health challenges to foreign policy. Her main areas of professional involvement are the HIV/AIDS response, with focus on policy and strategy development, coordination, global and national architecture.



She also works on issues of development policy, international health policy analysis, human resources for health, health systems development and reform.

She is currently a board member of the Global Fund to Fight against Aids, TB and Malaria (GFATM), the Global Alliance for Vaccines and Immunization (GAVI) and UNITAID. From 2000-2001 she was the State Secretary of the Ministry of Foreign Affairs for international development. She has also served as the Senior Executive Adviser, for Global Initiatives at NORAD, and as Senior Policy Adviser to the Executive Director of UNAIDS. She is a founding member of Board, Global Forum for Health Research, and a member of various committees as well as the Norwegian Research Council, During the 1970s she was Director of the Lalitpur District Community Health and Development Programme in Kathmandu, Nepal, Medical officer for primary health care at Lumbini Zonal Hospital for the Government of Nepal. From 1980-82 she was the Health Services Director of the United Mission to Nepal.

Carissa F. Etienne

Assistant Director-General - Health Systems and Services, WHO

Dr Carissa F. Etienne assumed her role as Assistant Director-General for Health Systems and Services in February 2008. Prior to that, she was the Assistant Director of the Pan American Sanitary Bureau, which is the Secretariat of the Pan American Health Organization (PAHO) and of the American Regional Office of WHO. As Assistant Director since July 2003, she directed five technical areas - health systems and services; technology and health services delivery; health surveillance and disease management; family and community health; and sustainable development and environmental health.



A national of Dominica, Dr Etienne began her career as a medical officer at the Princess Margaret Hospital in her country, where she eventually became the Chief Medical Officer. Throughout her career, she has gained extensive knowledge and experience in various aspects of health management, health systems and health-care delivery, including management of essential drugs, human resource management for primary health care and the integration of health programmes and systems.

Dr Etienne has held high-level posts such as the Coordinator of Dominica's National AIDS Programme, Disaster Coordinator for the Ministry of Health of Dominica, Chairperson for the National Advisory Council for HIV/AIDS and the Director of Primary Health Care for Dominica. She received her MBBS degree from the University of the

West Indies, Jamaica and her M.Sc. degree in community health in developing countries from the University of London.

In addition to serving in her homeland, Dr Etienne has been very active in the regional public health arena, particularly in the transformation of health systems and the introduction of a primary health care approach. She has had a long history of collaboration with PAHO/WHO, and was a founding member of the Technical Advisory Group for the Eastern Caribbean Drug Service. Dr Etienne has also conducted a significant amount of research on health services in Dominica.

Professor Michel D. Kazatchkine
Executive Director, The Global Fund to Fight AIDS, TB and Malaria

Michel D. Kazatchkine became Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria in April 2007. The Global Fund, based in Geneva, Switzerland, is the world's leading multilateral financier of programs for the three diseases and one of the major financiers of health systems strengthening.

Over the last two years, demand for Global Fund resources has more than tripled. By the end of 2008, the Global Fund had approved around US \$15 billion to support AIDS, TB and malaria programs in 140 countries.

Dr Kazatchkine has spent the past 25 years fighting AIDS as a leading physician, researcher, administrator, advocate, policy maker, and diplomat.

He attended medical school at Necker-Enfants-Malades in Paris, studied immunology at the Pasteur Institute, and has completed postdoctoral fellowships at St Mary's hospital in London and Harvard Medical School.

His involvement with HIV began in 1983, when, as a young clinical immunologist, he treated a French couple who had returned from Africa with unexplained fever and severe immune deficiency. By 1985, he had started a clinic in Paris specializing in AIDS - which now treats over 1,600 people - and later opened the first night clinic for people with HIV in Paris, enabling them to obtain confidential health care outside working hours.

Prior to joining the Global Fund, Dr Kazatchkine was Professor of Immunology at Université René Descartes and Head of the Immunology Unit of the Georges Pompidou Hospital in Paris. He has authored or co-authored of over 500 articles in peer reviewed journals, focusing on



auto-immunity, immuno-intervention and pathogenesis of HIV/AIDS.

In addition to his clinical teaching and research activities, Dr. Kazatchkine has played key roles in various organizations, serving as Director of the National Agency for Research on AIDS (ANRS) in France (1998-2005), Chair of the World Health Organization's Strategic and Technical Advisory Committee on HIV/AIDS (2004-2007), member of the WHO's Scientific and Technical Advisory Group on tuberculosis (2004-2007), and French Ambassador on HIV/AIDS and communicable diseases (2005-2007).

Dr Kazatchkine's involvement with the Global Fund to Fight AIDS, Tuberculosis and Malaria began when the organization was established in 2001. He was the first Chair of the Global Fund's Technical Review Panel (2002-2005) and has served as a Board member and Vice-Chair of the Board (2005-2006).