Forum booklet

First Global Forum on Human Resources for Health
2-7 March 2008 Kampala, Uganda
First Global Forum on Human Resources for Health
2-7 March 2008, Kampala, Uganda
# Table of contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Message from the conference organizers</td>
<td>4</td>
</tr>
<tr>
<td>Schematic Programme Overview</td>
<td>6</td>
</tr>
<tr>
<td>About the Forum</td>
<td>10</td>
</tr>
<tr>
<td>Format and activities</td>
<td>10</td>
</tr>
<tr>
<td>The Global Health Workforce Alliance (GHWA)</td>
<td>12</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>20</td>
</tr>
<tr>
<td>Registration and Forum Facilities</td>
<td>21</td>
</tr>
<tr>
<td>Conference Secretariat and registration</td>
<td>21</td>
</tr>
<tr>
<td>Forum Venue</td>
<td>21</td>
</tr>
<tr>
<td>Designated hotels for participants</td>
<td>22</td>
</tr>
<tr>
<td>Session venues</td>
<td>23</td>
</tr>
<tr>
<td>Name Tags</td>
<td>23</td>
</tr>
<tr>
<td>Internet, photocopying, fax facilities</td>
<td>23</td>
</tr>
<tr>
<td>Media</td>
<td>24</td>
</tr>
<tr>
<td>Site visits</td>
<td>24</td>
</tr>
<tr>
<td>Human Resources for Health (HRH)</td>
<td></td>
</tr>
<tr>
<td>Action Conference (4 – 5 March)</td>
<td>25</td>
</tr>
<tr>
<td>Detailed programme</td>
<td>25</td>
</tr>
<tr>
<td>Constituency Meetings</td>
<td>53</td>
</tr>
<tr>
<td>Skills-building workshops</td>
<td>59</td>
</tr>
<tr>
<td>Speakers’ corner</td>
<td>69</td>
</tr>
<tr>
<td>All week activities</td>
<td>72</td>
</tr>
<tr>
<td>Abstracts</td>
<td>73</td>
</tr>
</tbody>
</table>
Message from the conference organizers

We warmly welcome you to Kampala, Uganda for the first-ever Global Forum on Human Resources for Health, convened by the Global Health Workforce Alliance, 2-7 March 2008. We are honoured and privileged to host this Forum.

The vision of the Global Health Workforce Alliance is to ensure that every person will have access to a skilled, motivated and facilitated health worker within robust health systems.

The serious shortage of health workers is impairing provision of essential, life-saving interventions such as childhood immunization, safe pregnancy and delivery services for mothers and access to treatment for HIV/AIDS, malaria and tuberculosis.

Dr Francis Omaswa  
Executive Director  
Global Health Workforce Alliance

Dr Sigrun Møgedal  
Chair  
Forum Organizing Committee

Dr Lincoln Chen  
Chair of the Board  
Global Health Workforce Alliance
The World Health Report 2006 found that 57 countries, most of them in Africa and Asia, face the most acute crisis. More than 4 million doctors, nurses, managers and other public health workers are needed to fill the gap in these countries. Without prompt action, the shortage will intensify.

We have reached a critical juncture in this crisis where mere recognition of the situation is no longer enough. As our Forum slogan suggests: now it is time for real and urgent action!

The Global Forum on Human Resources for Health will build knowledge, build networks and build consensus for health workforce action.

Global leaders, experts and civil society leaders, Ministers of Health, Finance, Education and Public Service, together with health workers, managers and researchers will come together for the first time to strengthen their commitment to GHWA’s vision and goals, share ideas, knowledge and experiences, and keep the health workforce crisis high on the global agenda.

The Forum meshes well with current movements to revitalize primary health care on the 60th anniversary of WHO, 30 years after the Declaration of Alma Ata on Health for All and at the mid-point of the United Nations Millennium Development Goals. Kampala promises to be an exciting and critical event for re-energizing the drive for better health in the 21st century. It is a unique opportunity for our community to come together, build a solid global movement and propel each other forward.

The Forum will be the launching pad for a Global Action Plan for Human Resources for Health--the roadmap that will guide action over the coming decade. Combining previously adopted declarations and commitments from around the world, it will present the key steps needed to ensure coordinated and evidence-based action to address the crisis so that progress can be monitored and everyone held mutually accountable.

The only way forward is to work together. We are all part of the solution to this crisis and strengthened partnership is central to future action.

We look forward to coming together, sharing experience, learning from each other and working together to drive forward momentum on this critical issue. The time for action is now.
## Schematic Programme Overview

### Sunday 2 March 2008:
**Pre-conference Activities**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:00 - 13:00</td>
<td>Poster Set-up</td>
</tr>
<tr>
<td>14:00 - 18:00</td>
<td>Optional site visit</td>
</tr>
<tr>
<td></td>
<td>Constituency Meetings</td>
</tr>
<tr>
<td></td>
<td>GHWA Task Force Meetings</td>
</tr>
<tr>
<td></td>
<td>Touristic sightseeing</td>
</tr>
<tr>
<td></td>
<td>GHWA Board Meeting</td>
</tr>
<tr>
<td></td>
<td>Market Place</td>
</tr>
</tbody>
</table>

### Monday 3 March 2008:
**Pre-conference Activities**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:00 - 13:00</td>
<td>Poster Session</td>
</tr>
<tr>
<td>14:00 - 17:00</td>
<td>Registration</td>
</tr>
<tr>
<td></td>
<td>Optional Site Visit</td>
</tr>
<tr>
<td></td>
<td>GHWA Taskforce Meetings</td>
</tr>
<tr>
<td></td>
<td>Constituency Meetings</td>
</tr>
<tr>
<td></td>
<td>Touristic Sight Seeing</td>
</tr>
<tr>
<td></td>
<td>Market place</td>
</tr>
<tr>
<td></td>
<td>Press Conference</td>
</tr>
<tr>
<td></td>
<td>11:00 - 12:00</td>
</tr>
<tr>
<td>17:00 - 19:00</td>
<td>Opening Ceremony and Welcome Cocktail</td>
</tr>
</tbody>
</table>
### Tuesday 4th March 2007:

**Leadership, Education, Training and Skill Mix, Management and Ministerial Round Table**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30 - 10:00</td>
<td><strong>Theme I: Leadership</strong></td>
<td><strong>Plenary Session PI: Leadership</strong> Key note speaker and Leaders panel, leading to break-out session</td>
</tr>
<tr>
<td>10:00 - 10:30</td>
<td>Coffee</td>
<td></td>
</tr>
<tr>
<td>10:30 - 11:45</td>
<td><strong>Theme II: Education, Training and Skill Mix</strong></td>
<td><strong>Plenary Session PII: Skilling up for better health - education, training and skill mix</strong> Key note speaker and panel comments to lead into breakouts</td>
</tr>
<tr>
<td>11:45 - 13:00</td>
<td><strong>Theme III: Management</strong></td>
<td><strong>Plenary Session PIII: Management</strong> Key note speaker and panel comments to lead into breakouts</td>
</tr>
<tr>
<td>13:00 - 14:00</td>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>14:15 - 17:15</td>
<td>Ministerial Round Table and Break out Sessions on Education, Training and Skill Mix and Management</td>
<td></td>
</tr>
</tbody>
</table>

**Leadership**
- BOS 1.1
  - Closed Ministerial Round Table

**Education**
- BOS: Sub-topic 2.1
  - Task Force on Scaling up Education & Training

**Skill Mix**
- BOS: Sub-topic 2.3
  - What sorts of health workers are needed in scale up

**Management**
- BOS 3.1: Health Workforce Observatories: Better intelligence and dialogue for health workforce development
- BOS: Sub-topic 3.3
  - Creating and enabling working environment for good management

**BOS: Sub-topic 3.2**
- Innovation in education and training - getting the right skill mix
- BOS: Sub-topic 3.4
  - Developing competencies for health sector managers

**BOS: Sub-topic 2.2**
- Country action on scaling up - successes and lessons learnt

**BOS: Sub-topic 2.4**
- Human resources management systems
### Wednesday 5 March 2008:
**Migration and Retention, Financing, Partnerships, Global Action Plan**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00 - 09:15</td>
<td><strong>Theme IV: Migration and Retention</strong></td>
</tr>
<tr>
<td></td>
<td>Plenary Session PIV: Managing the competing challenges of migration and retention</td>
</tr>
<tr>
<td></td>
<td>Key note speaker and panel comments to lead into break-outs</td>
</tr>
<tr>
<td>09:15 - 10:30</td>
<td><strong>Theme V: Financing</strong></td>
</tr>
<tr>
<td></td>
<td>Plenary Session PV: Financing: A key to scaling up the health workforce and health systems</td>
</tr>
<tr>
<td></td>
<td>Keynote Speaker and panel comments to lead into break-outs</td>
</tr>
<tr>
<td>10:30 - 11:00</td>
<td><strong>Coffee</strong></td>
</tr>
<tr>
<td>11:00 - 13:00</td>
<td><strong>Breakout Sessions on Migration and retention Financing and the Private sector</strong></td>
</tr>
<tr>
<td></td>
<td>Breakout Sessions:</td>
</tr>
<tr>
<td>Migration</td>
<td>Retention</td>
</tr>
<tr>
<td>BOS: Sub-topic 4.1 Global Health Worker Migration: Trends, Impacts and Solutions</td>
<td>BOS: Sub-topic 4.2 Regional and country cases: Addressing the challenge of health worker migration</td>
</tr>
<tr>
<td>BOS: Sub-topic 4.3 Retention of health care workers: professionals point of view</td>
<td>BOS: Sub-topic 4.4 Retention of health care workers: countries’ experiences</td>
</tr>
<tr>
<td>13:00 - 14:00</td>
<td>Lunch</td>
</tr>
<tr>
<td>14:00 - 15:30</td>
<td><strong>Theme VI: Partnerships</strong></td>
</tr>
<tr>
<td></td>
<td>Plenary Session PVI: Partnerships and linking up for action</td>
</tr>
<tr>
<td></td>
<td>Panel discussion and inputs from the floor</td>
</tr>
<tr>
<td>15:30 - 16:00</td>
<td><strong>Coffee</strong></td>
</tr>
<tr>
<td>16:00 - 17:30</td>
<td>Plenary Session PVII: Presentation of Global Action Plan and Ministerial Response</td>
</tr>
<tr>
<td></td>
<td>Presentation with inputs from breakouts and comments from the floor</td>
</tr>
<tr>
<td>17:30 - 18:00</td>
<td><strong>Closing ceremony / Launch of Global Action Plan</strong></td>
</tr>
<tr>
<td>18:00 - 18:20</td>
<td>Q&amp;A with the press on Global Action Plan (panel members only)</td>
</tr>
</tbody>
</table>
### Thursday 6 March 2008:
**Skills Building Workshops and constituency meetings**

<table>
<thead>
<tr>
<th>Time</th>
<th>Skills Building Workshops</th>
<th>Skills Building Workshops</th>
<th>Skills Building Workshops</th>
<th>Optional site visit</th>
<th>Constituency Meetings</th>
<th>Touristic sight seeing</th>
<th>Market Place</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:00 - 13:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13:00 - 14:00</td>
<td></td>
<td></td>
<td></td>
<td>Optional site visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00 - 18:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Friday 7 March 2008:
**Skills Building Workshops and constituency meetings**

<table>
<thead>
<tr>
<th>Time</th>
<th>Skills Building Workshops</th>
<th>Skills Building Workshops</th>
<th>Skills Building Workshops</th>
<th>Constituency Meetings</th>
<th>Touristic sight seeing</th>
<th>Market Place</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:00 - 13:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13:00 - 14:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00 - 18:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
About the Forum

The Global Health Workforce Alliance (GHWA) is pleased to welcome you to the first-ever Global Forum on Human Resources for Health (2-7 March 2008 in Kampala, Uganda). The Forum will bring together GHWA members and potential members including global leaders in health and development, governments, civil society, UN and multilateral agencies, professional associations, private sector, academic institutions, global and regional health initiatives as well as organizations committed to health workers’ concerns.

The Forum will promote an analysis of lessons learnt within the human resources for health community on what works, what has not and why, and on how to accelerate progress. The Forum will act as a launching pad for a Global Action Plan to be implemented in partnership.

The Forum has three main objectives:

I. To build consensus on accelerating Human Resources for Health (HRH) action.
II. To build implementation capacity on HRH action at global and country level.
III. To build networks and alliances as a global movement on HRH moving from recognition to concrete action.

The key expected outcomes are:

I. Commitment to a Global Action Plan for the coming decade.
II. Better knowledge on what works, what has not, and why.
III. Enhanced and strengthened implementation capacity.
IV. Consolidated and revitalized global movement.

This programme booklet contains essential information about the week-long Forum and the different programme elements offered.

Format and activities

English is the language of the forum. There will be simultaneous translation into French at all sessions. The Forum has five major groups of activities:
I. Pre-conference activities
II. Constituency meetings
III. Human Resources for Health Action conference
IV. Skills-building workshops
V. All week activities

I. Pre-conference activities, 2-3 March
These include activities customized for various groups.
• GHWA Board meeting
• GHWA Taskforce & Working Group meetings
• Regional meetings
• Site visits

II. Constituency meetings, 2-3 and 6-7 March
Constituencies will be welcome to organize focused issue meetings.

III. Human Resources for Health (HRH) Action Conference, 4-5 March
The HRH Action Conference will comprise a series of topical keynote addresses, thematic panel discussions and related parallel break-out sessions. The themes include Leadership; Financing; Management; Migration and Retention; Education, training and skill mix; Partnerships; and the Global Action Plan.

IV. Skills building workshops, 6-7 March
These provide an opportunity to participate in a rich selection of skills-building workshops. These workshops will target country and development partner operational level staff and will cover a broad spectrum of health workforce issues.

Participants will also have the option of participating in site visits to local health facilities.

V. All week activities
There will be a number of on-going activities throughout the Forum period. These include:
• Market Place
• Poster presentation
• Photo exhibition
• Speakers’ corners
• Arts and Crafts market
The Global Health Workforce Alliance (GHWA)

The Global Health Workforce Alliance is a partnership dedicated to identifying and implementing solutions to the health workforce crisis. It brings together a variety of actors, including national agencies, academic institutions and professional associations.

The Alliance has seen the establishment of Task Forces and Working Groups to address specifically defined areas such as migration, technical cooperation, tools and guidelines and resource mobilization. More information about GHWA is available at: www.who.int/workforcealliance/

GHWA membership is open and inclusive of all interested partner institutions. The Secretariat is hosted by the World Health Organization. It is a small core group of professionals reporting directly to the Board.

Regional Networks such as the African Platform on HRH, the Asia-Pacific Action Alliance on HRH and the Pan American Health Organization Observatory on HRH are key partners of GHWA.

Task Forces and Working Groups have been established by GHWA to address specifically defined areas of work such as migration, tools and guidelines, education and training, advocacy and HRH financing.

GHWA Board

The Board of the Global Health Workforce Alliance is composed of some of the key stakeholders in human resources for health, as well as funding partners of GHWA’s activities. Board meetings occur twice a year (see our ‘events’ page).

**Chair:** Dr Lincoln Chen (China Medical Board)

➢ Eric Buch (NEPAD / African Platform)
➢ Kathy Cahill (Bill & Melinda Gates Foundation)
➢ Francisco de Campos (Government of Brazil)
➢ Mark Dybul / Estelle Quain (Government of the United States)
> Carissa Etienne / Manuel Dayrit (WHO)
> Eric Friedman (Civil society / Physicians for Human Rights)
> Louise Holt (CIDA)
> Basile Kollo (Government of Cameroon)
> LI Feng (Government of China)
> Sigrun Møgedal / Bjarne Garden (Government of Norway)
> Francis Omaswa (GHWA Executive Director)
> Judith Oulton (ICN)
> Joy Phumaphi (World Bank)
> Marie-Odile Waty (Government of France)
> Miriam Were (Civil society / AMREF)
> Suwit Wibulpolprasert (Government of Thailand / AAAH)

**GHWA Secretariat**

The GHWA Secretariat is located at WHO headquarters in Geneva. Secretariat staff members are either recruited through WHO procedures or seconded by GHWA partners.

**Executive Director:** Dr Francis Omaswa

> Fabienne Adam (Programme Manager)
> Millicent Ayata (Programme Assistant)
> Jim Campbell (Senior Health Specialist)
> P. Ben Fouquet (Communications Officer)
> Beth Magne-Watts (Advocacy & Communications Officer)
> Cornély Okwo-Bele (Secretary)
> Eric de Roodenbeke (Senior Health Specialist)
> Erica Wheeler (Knowledge Officer)

**GHWA Working Groups, Task Forces**

**Health Worker Migration Policy Initiative**

**Co-chairs**

> Hon. Mary Robinson, President, Realizing Rights
> Dr Francis Omaswa, Executive Director, GHWA
Members

> Hon. Major Courage Quarshie, Minister of Health, Ghana
> Hon. Erik Solheim, Minister of International Development, Norway
> Hon. Patricia Aragon Sto Tomas, Minister of Labor and Employment, the Philippines
> Hon. Rosie Winterton, Minister of State for Health Services, United Kingdom
> Dr Lincoln Chen, Director, Global Equities Initiative, Harvard University
> Dr Anders Nordström, Former Assistant Director-General, Health Systems and Services, WHO
> Ms Janet Hatcher Roberts, Director, Migration Health Department, IOM
> Mr Ibrahim Awad Director, International Migration Programme, ILO
> Dr Percy Mahlati, Director of Human Resources, Ministry of Health, South Africa
> Huguette Labelle, Chancellor, University of Ottawa
> Dr Titilola Banjoko, Managing Director, Africa Recruit
> Prof. Ruairi Brugha Head, Department of Epidemiology & Public Health, Ireland
> Ms Sharan Burrow, President, International Confederation of Free Trade Unions
> Ms Ann Keeling, Director, Social Transformation Programs Division, Commonwealth Secretariat
> Mr Markos Kyprianou, Director General, Health & Consumer Protection, European Commission
> Mr Peter Scherer, Directorate for Employment, Labour and Social Affairs, OECD
> Prof. Anna Maslin, Nursing Officer, International Nursing & Midwifery Health Professions Leadership Team, Department of Health, United Kingdom
> Dr Mary Pittman, President, Health Research & Education Trust, American Hospitals Association
> Dr Jean Yan, Chief Scientist for Nursing & Midwifery, WHO, chair of the Migration Technical Working Group
> Peggy Clarke (Director of the Initiative)

Task Force on Scaling up Education & Training

Co-chairs
> Lord Nigel Crisp (co-chair)
> Bience Gawanas (co-chair; African Union Commission)

Members
> Honorable Stephen Mallinga (Health Minister Uganda)
> Honorable Marjorie Ngaunje (former Health Minister Malawi)
> Honorable Urbain Olanguena Awono (former Minister of Health, Cameroon)
> Professor Srinath Reddy (Director, Public Health Foundation of India)
> Peter Loescher (President Global Human Health Merck & Co) / Jeff Sturchio (Vice President, External Affairs Merck & Co)
> Dr Joy Phumaphi (Vice President and Head, Human Development Network) / Alexander Preker (Lead Economist, Health, Nutrition and Population, World Bank)
> Judith Oulton (Chief Executive Officer, International Council of Nurses)
> Kathy Cahill (Gates Foundation)
> Dr Francisco de Campos (Director of Work and Education in Health, Ministry of Health, Brazil)
> Sarita Bhatla (CIDA, DG Governance and Social Development Directorate) / Jeea Saraswati, (CIDA, Health Specialist Africa Branch)
> Prof. Miriam Were (AMREF)
> Dr Anders Nordström, former Assistant Director-General, Health Systems and Services, WHO
> Louise Holt (CIDA)
> Michele Barzach (Independent, France)
> Imogen Sharp (Director of the Task Force)

**Working Group on Tools & Guidelines**

**Chair**
> Manuel Dayrit (WHO)

**Members**
> Mario Dal Poz (WHO)
> Gilles Dussault (IMT, Portugal)
> Tim Martineau (Liverpool, UK)
> Ferrucio Vio (Italy and Mozambique)
> Kasper Wyss (STI, Basel)
> Jennifer Nyoni (AFRO)
> Felix Rigoli (PAHO)
> Peter Hornby (Keele University, UK)
> Mary O’Neill (MSH)
> Estelle Quinn (USAID)
> Gijs Elzinga (consultant, The Nederlands)
> Jim McCaffrey (Capacity Project, USA)
> Gilbert Mliga (Tanzania), Director HRH
> Vincent Oketcho DHRH Project, (Uganda)
> Thinakorn Noree (Thailand), IHPP
Task Force on Financing Human Resources for Health

Co-Chairs
> David de Ferranti, former World Bank Vice President for Latin America
> K.Y. Amaoko, former Executive Secretary of the U.N. Economic Commission for Africa

Members
> Eyatayo Lambo (Former Minister of Health, Nigeria)
> Srinath Reddy (India; Head of the India Public Health Foundation)
> Rick Rowden (ActionAid)
> Joy Phumaphi (World Bank)
> Carissa Etienne (Assistant Director-General, Health Systems and Services, WHO)
> Sigrun Møgedal (HIV/AIDS Ambassador, Ministry of Foreign Affairs, Norway)
> Hong Wang (Yale University)
> Marty Makinen, Results for Development Institute (Director of the Task Force)

Task Force on Human Resources for Health implications of Scaling-up towards Universal Access to HIV prevention, treatment, care and support

Co-chairs
> Michel Sidibé, Deputy Executive Director, UNAIDS
> Thomas Kenyon, Principal Deputy Coordinator and Chief Medical Officer, OGAC

Members
> Hon. Brian Chituwo, Minister of Health, Zambia
> Hon. Innocent Nyaruhirira, Minister of State in charge of HIV/AIDS and other epidemics, Rwanda
> Elizabeth Mataka, Special Envoy of the Secretary-General for HIV/AIDS in Africa
> Nicola Brennan, Irish Aid
> Hon. Tewodros Adhanom, Minister of Health, Ethiopia
> Kevin De Cock, HIV Department, WHO
> Oscar Fernandes, Minister of Labor, Chair Parliamentarian Forum on AIDS
Andrew Rogerson, DFID  
Carissa Etienne, Assistant Director-General, Health Systems and Services, WHO  
Anders Nordström, Director General, SIDA, Sweden  
Sigrun Møgedal, HIV/AIDS Ambassador Ministry of Foreign Affairs, Norway  
Beatrice Were, Global Network of People Living with HIV/AIDS  
Hon. Djona Avocksoyma, Minister of Health, Chad  
Joy Phumaphi, World Bank  
Francisco de Campos, Ministry of Health, Brazil  
Jaime Sepulveda, Bill & Melinda Gates Foundation  
Takehiro Kano, JICA  
Bacha Abdelkadar, Global Alliance Services, IAA  
Bience Gawanas Commissioner for Social affairs African Union  
Edward Greener, Penn State University

**Technical Working Group on Private Sector Involvement in HRH**

**Chair**  
> Mike Merson (Duke University)

**Members**  
> Elizabeth Ashbourne (World Bank)  
> Victor Barnes (Corporate Council on Africa)  
> Maurice Bucagu (University of Rwanda)  
> Kathy Cahill (Gates Foundation)  
> Yoswa Dambisya (University of Limpopo)  
> Ernst Darkoh (BroadReach Healthcare)  
> Renuka Gadde (BD)  
> Steven Philips (Exxon Mobil)  
> Kenneth Sagoe (Ghana Health Service)

**Related initiatives**

**Health Workforce Advocacy Initiative**

**Chair**  
> Eric Friedman (Physicians for Human Rights)

**Members**  
> Abe Adediran (ACOSHED)  
> Ambrose Agweyu (University of Nairobi Medical School/Medical Students Against AIDS)
> Brook Baker (Health Gap)
> Jacqueline Bataringaya (International AIDS Society)
> Carol Bergman (GAA)
> Esme Berkhout (Oxfam)
> Linda Carrier-Walker (ICN)
> Pat Daoust (PHR)
> Mamadou Diallo (IAS)
> Sarah Hall (AMREF)
> Mireille Kingma (ICN)
> Jorge Mancillas (PSI)
> Anna Marrito (Oxfam)
> Grace Musaka (AMREF)
> Jirair Rativosian (PHR)
> Rick Rowden (Action Aid)
> Asia Russel (Health Gap)
> Judith Oulton (International Council of Nurses)
> Lola Dare (ACOSHED)
> Paul Davis (Health Gap)
> Paul Zeitz (Global AIDS Alliance)
> Piya Hanvoravongchai (AAAH)
> Rotimi Sankore/Dapo Awosokanre (CREDO-Africa/Africa Public Health Rights Alliance)

**GHWA development partners**

The Global Health Workforce Alliance wishes to express gratitude to all the governments and institutions for their allocated grants which will go a long way in achieving our shared objectives contained in our work plan. We would like to express our sincere gratitude and appreciation to the following for the support given to the Alliance and for making this Forum possible.

- Canada - Canadian International Development Agency (CIDA)
- European Commission
- France - Ministère des Affaires étrangères et européennes
- France - Agence française de Développement (AFD)
- Ireland - Irish Aid, Department of Foreign Affairs
- Norway - Ministry of Foreign Affairs
- Norway - Norwegian Agency for Development Cooperation (NORAD)
- The Bill and Melinda Gates Foundation
- United Kingdom - Department for International Development (DFID)
- USA - The Capacity Project
GHWA Forum Organizing Committee

Chair:
> Sigrun Møgedal

> Eric Buch > Eric Friedman > Joy Phumaphi
> Kathy Cahill > Bjarne Garden > Estelle Quain
> Lincoln Chen > Louise Holt > James Sekajugo
> Peggy Clark > Jantine Jacobi > Imogen Sharp
> Manuel Dayrit > Marty Makinen > Neil Squires
> Dominique Egger > Sigrun Møgedal > Miriam Were
> Carissa Etienne > Francis Omaswa > Suwit Wibulpolprasert

GHWA Forum Secretariat

> Pieter Desloovere (Communications Officer)
> Joseph Luu (Assistant)
> Marie Luy (Administrative Officer, a.i.)
> Gayatri Nandra (Coordinator)

> Milly Nsekaliye (Secretary)
> Sonali Reddy (Communications Officer)
> Kalpana Singh (Secretary)
> Jennifer Volonnino (Assistant)

GHWA Forum Programme Team

> Fabienne Adam > Bjarne Garden > Judith Oulton
> Jacqueline Bataringaya > Michael Gordy > Estelle E. Quain
> Patricia Caldwell > Jantine Jacobi > Sonali Reddy
> Jim Campbell > Mireille Kingma > Eric de Roodenbeke
> Peggy Clark > Marie Luy > Badara Samb
> Mario Dal Poz > Beth Magne-Watts > James Sekajugo
> Manuel Dayrit > Marty Makinen > Imogen Sharp
> Pieter Desloovere > Sigrun Møgedal > Neil Squires
> Carmen Dolea > Gayatri Nandra > Erica Wheeler
> Delanyo Dovlo > Agata Naphtali
> Ben Fouquet > Francis Omaswa
Local Organizing Committee

Chair: Dr Sam Zaramba

Focal Points: James Sekajugo and Juliet Bataringaya

> Esther N.K Alinda  > Godwin Kakama  > Mary L. Nannono
> Jacinto Amandua  > J H Kyabaggu  > Oteba Neville
> Nyangasi Apollo  > Naomi Kyobutungi  > Julius Nkeramihigo
> Juliet Bataringaya  > Lilliane Luwaga  > Nandudu Norah
> George Bagambisa  > Elizabeth Madraa  > Francis Ntalasi
> Pius Bigirimana  > Harriet Malinga  > Vincent Oketcho
> Tina Byaruhanga  > Nathan Kenya Mugisha  > Jude Okiria
> Margaret Chota  > Mukakarisa Hellen  > Christopher Oleke
> Isaac Ezati  > Paul Kiwanuka  > Elizabeth Ongom
> Magembe Flugencio  > Mukiibi  > Eramu Pascal
> Sugar Ray Isaac  > E. Mukooyo  > Namiti Racheal
> Charles Isabirye  > Abala Mundu  > Kaitintimba Robinah
> Lawrence Kaggwa  > M Mungherera  > Francis Runumi
> Isaac Mpoza Kagimu  > Bernard Mutabazi

Acknowledgements

Our sincere thanks go to the Government of Uganda for welcoming the Forum to Kampala and a special thanks to the World Health Organization, in particular the Uganda Country Office, who have provided invaluable guidance and assistance.

This Forum would not have been possible without the support and hard work of all those mentioned above: development partners, the Forum Organizing Committee, the Programme Team, the Local Organizing Committee and the GHWA Board and Secretariat. We thank you all sincerely.
Registration and Forum Facilities

Conference Secretariat and registration

Participants can register at the Speke Resort and Conference Centre, Munyonyo, or at many of the other designated Forum hotels, from Saturday 1 March. Designated GHWA Forum information tables will be clearly signalled at the hotel venues across the city. On registering, participants will receive a Forum bag and information pack with all the relevant details of the Forum sessions and activities.

For registration, questions and other issues, please contact the Forum Secretariat at the registration desk, located at Speke Resort and Conference Centre, Munyonyo. The following people may be contacted for assistance:

> Forum Secretariat / registration: Marie Luy
   Jennifer Volonnino

> Branding and media: Sonali Reddy

> Communications and media: Beth Magne-Watts
   Ben Fouquet

> Market Place: Pieter Desloovere

Forum Venue

Speke Resort Munyonyo
P.O Box 446, Kampala, Uganda
Tel: + (256) 031227111, Fax: + (256) 031-227110
e-mail: spekeresort@spekeresort.com
<table>
<thead>
<tr>
<th>Room name</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victoria Ball Room</td>
<td>Plenary room</td>
</tr>
<tr>
<td>Albert Hall</td>
<td>Meeting, break-out and skills-building room</td>
</tr>
<tr>
<td>Commonwealth Centre</td>
<td>Meeting, break-out and skills-building room</td>
</tr>
<tr>
<td>Kalanga Hall</td>
<td>Meeting, break-out and skills-building room</td>
</tr>
<tr>
<td>Majestic Hall</td>
<td>Meeting, break-out and skills-building room</td>
</tr>
<tr>
<td>Meera Hall</td>
<td>Meeting, break-out and skills-building room</td>
</tr>
<tr>
<td>Regal Hall</td>
<td>Meeting, break-out and skills-building room</td>
</tr>
<tr>
<td>Sheena Hall</td>
<td>Meeting, break-out and skills-building room</td>
</tr>
<tr>
<td>Sanga Hall</td>
<td>Meeting, break-out and skills-building room</td>
</tr>
<tr>
<td>Royal Hall</td>
<td>Media Centre, press conference room</td>
</tr>
<tr>
<td>Sapphire Hall</td>
<td>Production Room</td>
</tr>
<tr>
<td>Emerald Hall</td>
<td>Secretariat Centre</td>
</tr>
<tr>
<td>Amethyst Hall</td>
<td>Document Centre</td>
</tr>
</tbody>
</table>

**Designated hotels for participants**

- Speke Resort Munyonyo (conference venue)
- Grand Imperial
- Equatoria
- Africana
- Kampala Serena
- Green Valley Hotel
- Buziga Country Resort
- Victoria Travel Hotel
- Tourist Hotel ***
- The Royal Imperial Hotel
- Kabira Country Club
- Speke Hotel (not the conference venue, a separate hotel)
- The Emin Pasha Hotel
- Mamba Point Ristorante and Guest House
- Golf course Hotel
- Metropole Hotel

**Session venues**

All plenary sessions will take place in the Victoria Ball Room. Venues for break-out sessions, constituency meetings and skills-building workshops are available on the GHWA web site and in a detailed programme that will be distributed upon registration. Venues will be clearly indicated at the Speke Resort and usher services will be available to guide participants to venues.

**Name Tags**

Your personal name tag must be worn at all times during the Forum. It will allow you to access all sessions, lunches and receptions.

**Name Tags Colour key**

- **Green** Participants
- **Gold** VIP
- **Red** Media
- **Blue** GHWA Secretariat
- **Violet** Local Organizing Committee
- **Orange** GHWA Board Members, Task Forces and Working Groups

**Internet, photocopying, fax facilities**

Internet, photocopying and fax facilities are available in the Speke Resort Business Centre. There is also internet access in the hotel rooms.

**Telephone / Emergency**

The phone number of the Speke Resort Munyonyo (Forum venue) is +256 031 227 111. In case of an emergency, the Forum Secretariat can be reached through the Speke Resort reception.
Media

Media should register at the media registration desk at Speke Resort. Once registered, media will have access to attend any of the open plenary, break-out and skills building sessions.

- A press conference is organized for 11:00 on Monday 3 March, to be held in the Media Centre (“Royal”).

- Following the launch of the Global Action Plan, a short 20-minute Q&A session will be held - room to be confirmed.

To set up one-to-one media interviews, please visit the media centre and/or contact Sonali Reddy, Beth Magne-Watts and/or Ben Fouquet from the GHWA Secretariat.

Site visits

A number of interesting site visits have been organized during the Forum. The field visits will include:

- Mulago National Referral Hospital, which also hosts the Makerere University Medical school - Uganda’s leading medical school and teaching hospital.

- International Hospital Kampala (this is a purely private hospital for comparison. It also has components of teaching of some cadres and a number of in-service training programmes.)

- TASO headquarters (the AIDS Support Organization) for AIDS activities.

- MILD May centre which is also an organization involved in care of people living with HIV.

- The Infectious Diseases Institute.

Detailed information on how to register for the field visits will be available upon registration at the Forum.
Human Resources for Health (HRH) Action Conference (4 – 5 March)

The HRH Action Conference will comprise a series of topical keynote addresses, thematic panel discussions and related parallel break-out sessions. The themes include Leadership; Financing; Management; Migration and Retention; Education training and skill mix; Partnerships; and the Global Action Plan.

Detailed Programme

All names are subject to change

Monday 3 March, 2008

17:00 - 19:00

Opening Ceremony

Keynote speaker: Lincoln Chen, Chair of the Board, GHWA

> Mantombazana Tshabalala-Msimang, Chair, African Union bureau of Health Ministers and Minister of Health of the Republic of South Africa
> Anarfi-Asamoa Baah, Deputy Director-General, Switzerland
> Ban Ki-moon, Secretary-General, UN - by video message
> General Yoweri Kaguta Museveni, President of the Republic of Uganda
Tuesday, 4 March 2008
Theme I – Leadership
Plenary session – 8:30 – 10:00

Objectives

• To set the scene for the whole conference – highlighting the need for and showing how strong and assertive leadership at country, regional and global level can make a difference.

• To link the HRH agenda to current major global health initiatives and taking full advantage of the interest and momentum that has been generated by these initiatives in a cohesive and collaborative manner.

• To get commitment from leaders of key organizations to respond more effectively to country defined needs (particularly focusing on increasing effective use of resources mobilized for HIV/AIDS, TB and Malaria and other initiatives)

Key messages / themes

• The case for investing in HRH has been made. Leadership is about taking the facts and turning them into action.

• The time for action is now – we have passed the MDG mid-point.

• Leadership is needed at the country, regional and global level

• Leadership is about identifying winning strategies and backing them to the full, with long term commitments.

• Leadership is about taking forward globally defined and agreed objectives.

Leaders panel

• The leadership session will be a series of short statements from leaders at country, regional and global level including civil society leaders, answering questions about strengthening leadership on the health workforce crisis at all levels in order to ensure critical action and MDG progress at the country level.
Coordinators
> Neil Squires, Francis Omaswa, Bjarne Garden

Keynote speaker
> Honorable Meles Zenawi, Prime Minister of Ethiopia

Panellists
> Mantombazana Tshabalala Msimang, Minister of Health, South Africa
> Paul Davis, Director US governmental affairs, Health Gap, USA
> Yoshihisa Ueda, Vice president of JICA, Japan
> Julian Schweitzer, Health Nutrition Population Director, World Bank, USA
> Mongkol Na Songkhla, Minister of Health, Thailand

Plenary session moderator
> Suwit Wibulpolprasert, GHWA Board

Break out session (14:15 - 17:15)

Session 1.1 - Ministerial Round Table Discussion (closed session)

The Ministerial Round Table will use the framework of the Global Action Plan as a tool to bore down into some of the key leadership challenges, especially for achieving cross-government commitment and financing for HRH development – making the case at the country level.

Chair
> Stephen Mallinga, Minister of Health, Uganda

Moderators
> Suwit Wibulpolprasert, GHWA
> Francisco Songane, Executive Director, Partnership for Maternal Newborn & Child Health
Tuesday 4 March 2008
Theme II – Education, Training and Skill Mix
Plenary session 10:30 – 11:45

Overall objectives

- To gain global support for massive scale-up in the production of health workers through education and training, by countries and development partners, with commitment to do so as part of a wider international ‘movement’ supported by donors
- To encourage a broad understanding of the issues and challenges in scaling up the health workforce through education and training, and promote strategic discussions
- To gain support, among education policy makers and leaders, to implement change in education and training, towards a health outcomes model
- To raise awareness of the GHWA Task Force proposals, and encourage implementation, by key influencers and implementers among countries and development partners
- To build capacity on education and training of health workers
- To promote discussion on appropriate skill mix, and how to make change happen

Key messages / themes:

- The shortage of health workers is a global issue, and affects countries across the world. There is need for a massive and immediate effort, by countries and international partners, to scale up the production of health workers though education and training.
- We know what needs to be done: there is evidence from countries and governments who have scaled up, and innovation in education and training. There is a need now to apply the knowledge, and continue learning.
- Political leadership, at country and international level, is needed.
- Policy choices, including the types of health worker, need to be appropriate for country health priorities: many countries are focusing on community and mid-level workers to meet MDGs.
- There is a need for sustained investment from Finance Ministers, international development partners and donors, NGOs and ‘vertical’ programs.
• Global partnerships, such as the Global Campaign for the Health MDGs, including the International Health Partnership, need to invest in countries with a critical shortage of health workers who want to scale-up their health workforce, and use a quality improvement process, with shared learning between countries.

Coordinator
> Task Force for on Education & Training (Imogen Sharp, Director and Amy Gardiner)

Chairs
> Lord Nigel Crisp, Former NHS Permanent Secretary, UK and Task Force co-chair
> Bience Gawanas, Commissionner for Social Affairs, African Union and Task Force co-chair

Keynote speakers
> Dr. José Gomes Temporão, Minister of Health, Brazil

Panellists
> Dr Paulo Ivo Garrido, Minister of Health, Mozambique
> Dr. Tedros Adhanom Ghebreyesus, Minister of Health, Ethiopia
> Geraldine Bitamazire, Minister of Education and Sport, Uganda
> Judith Oulton, Chief Executive Officer, International Council of Nurses

Moderator
> Miriam Were, Chair of AMREF, Kenya
Tuesday 4 March 2008
Theme II – Education, Training and Skill Mix
Break-out sessions – 14:15 – 17:15

Session 2.1: Task Force on Scaling up Education & Training (14:15 - 15:35)

Objectives

- To set out Task Force proposals and recommendations on scaling up through education and training
- To consider critical success factors for successful scale up in countries, from case studies, and types of health worker
- To consider guiding principles, effective strategies and innovation in education and training of health workers
- To consider implications for national and international action.

Expected outcome

- Task Force proposals and recommendations to be presented and discussed.
- Lessons from country case studies, and from innovations and examples in education and training, to be highlighted and discussed for wider understanding
- Discussion of implications for action at national, institutional and international level.

Key messages

- There is an urgent need for scaling up in countries.
- It can be done: there are examples of countries who have successfully scaled up, and of innovation in education and training.

Co-Chairs

> Bience Gawanas, Commissionner for Social Affairs, African Union and Task Force co-chair, Lord Nigel Crisp, Former NHS Permanent Secretary, UK and Task Force co-chair
Panellists
> Miriam Were, Chair of AMREF, Kenya
> Peter Walker, University of Ottawa, Canada
> Imogen Sharp, Director, Task Force on Education & Training UK

Session 2.2: Country action on scaling up - successes and lessons learnt (15:45 - 17:15)

Objectives
- To discuss country experiences in scaling up, and draw out key lessons from country examples
- To consider broader political factors, such as sustained political will and financial support, and how countries have handled this
- To discuss how countries chose type of health worker to scale up, to meet health needs
- To consider lessons learnt and critical success factors

Expected outcome
- Country success stories highlighted – and key success factors
- Lessons learnt drawn out for wider understanding, and implications for country action on scaling up.

Key messages
- There is an urgent need for scaling up in countries.
- It can be done: there are examples of countries who have successfully scaled up, and lessons to be learned.

Co-Chairs
> Ernst Messiah, Commonwealth Secretariat, and Imogen Sharp, Director, Task Force on Education & Training

Panellists
> Marjorie Ngaunje, former Minister of Health, Malawi
> Francisco de Campos, Ministry of Health, Brazil
> A. C. Bowa, Chairman, College of Health Sciences, Zambia
> Angus O’Shea, Touch Foundation, Tanzania/USA
> Keiichi Takemoto, Health Human Development, JICA Japan
Session 2.3: What sorts of health workers are needed in scale up (14:15 - 15:45)

Objectives

- To discuss what skill mix and competencies are needed to support health goals. To discuss how training should reflect these needs, and be tailored accordingly, to achieve an ideal health workforce with complementary skills, and maximize efficiency.
- To consider how countries have decided what skill mix is needed.
- To consider the issues of skill-mix, task-shifting and training needs, in the context of scaling up community and mid-level health workers.

Expected outcome

- Understanding of the types of health workers and skill-mix needed for the future, to address health priorities and an essential health package.
- Understanding of the evidence on the effectiveness of community and mid-level health workers.
- Understanding of the competencies and skills of community and mid-level health workers, and the roles and tasks that they can undertake.

Key messages

- The importance of considering the skill-mix of health workers needed to address country health needs, in planning the health workforce.

Co-Chairs

> Kathy Cahill, Gates Foundation, USA and Peter Ngatia, AMREF, Kenya

Panellists

> Simon Lewin, Lecturer LSHTM, and MRC South Africa
> K.M. Shyamprasad, Chancellor, Martin Luther University, India
> Seble Frehywot, Professor, George Washington University, USA
> Francis Kamwendo, College of Medicine, University of Malawi
> Yann Bourgueil, Research Director, IRDES, France
> Basille Kollo, Director HRH, Ministry of Health, Cameroon
> Badara Samb, Advisor, Health Systems and Services, World Health Organization, Switzerland
Session 2.4: Innovation in education and training - getting the right skill mix (15:45 - 17:15)

Objectives

- To discuss the role of education and training – with examples - to achieve teams of health workers with an appropriate skill-mix
- To discuss innovations in the curriculum, including community-based education and training, and developing international and regional partnerships, which hold potential for accelerated scale-up.

Expected outcome

- Discussion of the skill mix and types of health workers to meet country health needs, and how innovations in education and training can contribute.
- Outline of educational and training models and processes that hold potential for accelerated scaling up for appropriate skill-mix.

Key message

Importance of education and training to focus on appropriate skill-mix of health workers to meet health needs, importance and examples of innovation in scaling up.

Co-Chairs
> Peter Walker, TWG Coordinator, University of Ottawa, Canada and Nelson Sewankabo, Dean of Makerere faculty of Medicine, Uganda

Panellists
> Peter Ndumbe, Dean of Buea Faculty of Medicine, Cameroon
> Laetitia King, Professor, Agha Khan University, Kenya
> Yves Talbot, Professor, University of Toronto, Canada
> Elseikh Badr, Vice Chancellor, Academy of Health, Sudan
> Albert Benhamou, Director, Francophone Virtual University, France
> Susan Nkinyangi, Senior Education Adviser, UNESCO Nairobi, Kenya
Tuesday 4 March 2008
Theme III – Management
Plenary session 11:45 – 13:00

Objectives

- To highlight the importance of both good HR management and an enabling environment for health managers when scaling up health services delivery to reach the MDGs.

- To provide participants with a better understanding of the scope of HR management and with examples of good practice and useful tools.

- To provide insight into the notion of an “enabling working environment” for health managers – its importance and what practically can be done to improve it.

- To identify individuals and organizations particularly interested, and active, in the above in order to galvanize networks and global movement.

- To ensure that the above reflect the perspectives of all key stakeholders involved in managing HRH and services: Government: central MOH and regional/district; private sector: faith-based and for-profit; key agencies/organizations: e.g. Duke University, Management Sciences for Health.

Key messages / themes

- For good leadership and management, there has to be a balance between four dimensions

  - Ensuring adequate numbers and deployment of managers throughout the health system.

  - Ensuring managers have appropriate competences (knowledge, skills, attitudes and behaviors)

  - The existence of functional critical support systems (to manage money, staff, information, supplies, etc.)

  - Creating an enabling working environment (roles and responsibilities, organizational context and rules, supervision and incentives, relationships with other actors).
• These four conditions are closely inter-related. Strengthening one without the others is not likely to work.

• “Human resource management” should be a strategic and coherent approach to the management of an organization’s most valued assets – its staff, who are vital to the achievement of health sector goals.

  - Effective support systems and tools are essential for managing HR coherently (and hence for delivering effective health services).

  - A good HR Information System is essential at the operational and policy levels - and is achievable.

  - Building HR management structures and capacity is feasible even in low income countries.

• Managers need to work in an enabling environment which makes it clear what they are expected to do and which encourages and rewards them appropriately.

  - Different parts of an organization are often responsible for different aspects of an “enabling working environment”. It often requires leadership to identify and deal with aspects of the working environment which are struggling with change.

  - Managers need to be clear on their roles and responsibilities and to have relevant incentives and rewards.

  - Managers need skills to deal with a broad (and changing) range of stakeholders.

Coordinator
> Manuel Dayrit, Director, Director HRH Department, and Carmen Dolea, HRH Department, WHO, Switzerland

Keynote speaker
> Rajat Gupta, Chair of the Board, Global Fund to fight AIDS, Tuberculosis and Malaria

Panellists
> Anders Nordström, Director General, SIDA, Sweden
> Brian Chituwo, Minister of Health, Zambia
> Kevin Schulman, Professor of Business Administration, The Fuqua School of Business, Duke University, USA

Moderator
> Anarfi-Asamoa Baah, Deputy Director-General, WHO, Switzerland
Tuesday 4 March 2008
Theme III - Management
Break-out sessions 14:15 – 17:15

Session 3.1 - Health Workforce Observatories: Better intelligence and dialogue for health workforce development (14:15-15:45)

In exploring mechanisms to improve HRH policy-making, planning and monitoring, health workforce observatories have evolved as one of the mechanisms to improve information and knowledge and to facilitate the dialogue for policy development and monitoring. The implementation of health workforce observatories in some regions and in a quite a number of countries has shown that they have been effective in (i) ensuring a forum to bring together the stakeholders and facilitating the policy dialogue; (ii) improving evidence and information for policy dialogue and decision-making; (iii) monitoring the health workforce trends and information. This session will help to share the experience with the health workforce observatories and guide the further improvements:

- To promote generation, dissemination, and use of evidence for health workforce policy-making;
- to share the experiences with health workforce observatories;
- to highlight the contribution of health workforce observatories in governance, monitoring and evaluation of health workforce;
- to explore how health workforce observatories can be expanded and how their impact can be improved.

Co-Chairs
> Mario Dal Poz, Coordinator, WHO/HQ, Helen Lugina, Coordinator HR Development and Capacity Building, ECSA, Kayode Odusote, Director, Division of HR Development, WAHO

Panellists
> Elsheik Badr, Focal Point National HRH Observatory & Deputy DG/HRH, Federal Ministry of Health, Sudan
> Maria Christina Fekete, Director of Special Programs, Ministry of Health, Brazil
> Jan Van den Broeck, Senior Lecturer, University of West Indies, Jamaica
> Adam Ahmat, Technical Officer, WHO/AFRO, Congo
Session 3.2 - Human resources management systems (15:45 - 17:15)

“Human resource management” should be a strategic and coherent approach to the management of an organization’s most valued assets – its staff, who are vital to the achievement of health sector goals. This session will:

- Discuss the constituent parts (or “mechanisms”) of effective HR management and its effects on service delivery; review and discuss how effective HR management is achieved at both strategic and operational levels. What are the conditions for success?
- review tools, guides and other resources which can contribute to effective HR management;
- learn key lessons from experiences and agree on essential principles for successful HR management.

Chair
> Jane Thomason, CEO, JTA International, Brisbane, Australia

Panellists
> Anthony Ofosu, District Director of Health Services, Sene District Health Directorate, Ghana Health Service
> Ummuro Adano, Senior HR Management Systems Advisor, The Capacity Project (MSH), USA
> Lawrence Kagwa, Director planning and development, Ministry of Health, Uganda

Session 3.3 - Creating an enabling working environment for good management (14:15 - 15:45)

Everyone can understand that health workers need a good (“enabling”) working environment if they are to stay in their jobs and to be effective. But it is much harder to describe the salient features of this “enabling working environment” and to identify practical strategies for improving it. In countries engaged in some form of decentralization or undergoing a public service reform, roles and relationships between the centre and other levels are shifting. Many managers have to deal with a wide variety of stakeholders – this should be recognized as an important part of their job. This break out session will focus on the enabling working environment for managers (HRH managers and managers of health services), rather than on the enabling environment for the entire health workforce. Main topics for discussion will include:
• New roles and responsibilities of managers at all level of the health system and best ways of helping health workers fulfill their changing managerial functions;

• support needs of managers and good practice examples;

• experiences in using financial and non financial incentives to encourage managers to perform well;

• accountability of managers to line ministries, local governments and/or the public for the results achieved by their organization.

Chair
> Riitta-Liisa Kolehmainen-Aitken, Independant Consultant

Panellists
> Patricia Sto. Tomas, Chair of the Board, Development Bank of the Philippines
> James Buchan, Professor, Queen Margaret University, Edinburgh, Scotland
> Derik Brinkerhoff, Senior Fellow in International Public Management, RTI International (Research Triangle Institute), USA
> John Awoonor-Williams, Director, Nkwanta District Health Directorate/ Nkwanta Health Development Centre, Ghana Health Service

Session 3.4 - Developing competencies for health sector managers (15:45 - 17:15)

Managers need specific skills and competencies to do their job well. These competences should be acquired in a planned manner, using a variety of techniques including mentoring, action learning and classroom learning. There is significant scope to adapt and use innovative private sector approaches to management training for the public health sector management. Examples of skills transfer from private sector into the public service can be show-cased. This session will:

• Provide an overview of existing competency frameworks for managers in the health sector, both public and private;

• give better understanding of the approaches and training methods used to develop management competencies;

• explore the potential offered by business-like models of training managers in the health sector.
Chairs
> Michael Smalley, Director General, AMREF

Panellists
> Joseph Dwyer, Director Leadership, Management, Sustainability Program Management Sciences for Health, USA
> Tridjoko Adiato, School of Public Health, U of Gadjah Mada, Indonesia
> Jeff Sturchio, Executive Director, Public Affairs, Human Health, Merck & Co, USA
> Elizabeth Howze, Chief, Sustainable Management Development Program Branch, Centers for Disease Control & Prevention, USA
Wednesday 5 March 2008
Theme IV – Migration and Retention
Plenary session 8:00 – 9:15

Objectives

- The intent to showcase the most current research and country-level practice which will be presented by speakers who are directly and actively involved in practical action or new research.

- At the close of the conference participants will have:
  - A sense of the scope of health worker migration issues globally including key facts, drivers, issues faced by leading source and destination countries and workers, most up to date research findings
  - Knowledge of key facts related to health worker retention—trends, global statistics, key factors, most up to date research findings
  - Knowledge of, and first hand exposure to, leading actors in best practice related to solutions to retention challenges as well as migration challenges
  - An understanding of linkages between migration and retention issues and other Forum themes including education, management, financing, health workforce planning at national, regional and global levels
  - A sense of the possible, especially related to new policy innovations between source and destination countries and the renewed global conversation on migration solutions; and a sense of promising innovations at the national level to address the retention challenge
Key messages / themes:

- Shared responsibilities--North and South working together to solve the challenges posed by migration and retention
- A focus on solutions--innovative policy action and practice at national, regional, global levels
- Research now shows there is an enormous waste of resources through the attrition of student and qualified health professionals. The importance of workforce retention is now widely acknowledged and efforts are being made to create positive practice environments and effective incentive systems to keep health sector workers in active employment.
- There is evidence that no matter how attractive the pull factors of the major destination countries, massive migration would not occur without strong push factors in the source countries. Any attempt to curb migration will need to address these factors and introduce significant retention measures.

Coordinator
> Peggy Clark, Director, Realizing Rights and Chair of Working Group on Migration, USA

Keynote speaker:
> Marc Danzon, Regional Director, WHO-EURO
> Stephen Mallinga, Minister of Health, Uganda

Panellists
> Patricia Sto.Tomas, former Minister of Employment and Labor, Philippines
> Lola Dare, Director, CHESTRAD/ACOSHED
> Mireille Kingma, Consultant, Nursing & Health Policy, ICN
> Bjorn-Inge Larsen, Director General, Directorate of Health, Ministry of Health, Norway

Moderators
> Tim Evans, Assistant Director-General, WHO, Switzerland
Wednesday 5 March 2008
Theme IV – Migration and Retention
Break-out sessions 11:00 – 13:00

Session 4.1 - Global health workers migration: trends, impacts and solutions

Expected outcomes

• Knowledge of leading current research and data on global health worker migration trends.

• Knowledge of trends and challenges in nurse migration globally and new efforts to implement ethical codes of conduct for nurse recruitment.

• Presentation of new strategic approaches being developed by the European region to ethically address the challenges of health worker migration.

• Presentation of new ideas related to policy innovations to address health worker migration on the part of northern countries.

Key Message

This session will provide an overview of key trends, impacts, and policy strategies related to health worker migration globally. Highlights include presentation of new, expert research by the OECD on global statistics and trends in health worker migration, new data and strategies related to nurse migration, a proposal for northern country action to mitigate negative effects of health worker migration on lower income countries, information on an ILO Action Programme to address health worker migration and reflections on the United Kingdom – South Africa Memorandum of Understanding (MOU).

Chair
> Peggy Clark, Director, Realizing Rights and Chair of Working Group on Migration, USA

Panellists
> Peter Scherer: Head of health Division, OECD, Paris, France
> Pascal Zurn, Health Economist, OECD Paris - WHO, Switzerland
> Barbara Nichols, ICN, Switzerland
> Fitzhugh Mullan, Professor, George Washington University, USA
> Christine Wiskow, Health service specialist, ILO, Switzerland
> Ondrej Šimek, Development (B/3), European Commission, Belgium
> Percy Mahlati, Department of Health, South Africa
Session 4.2 - Understanding internal and external migration: Why they leave and why they stay?

Expected outcomes

• Presentation of country level data on the experience of migration of health workers from Ghana, Mali and Brazil.

• Presentation of country level research and quantitative and qualitative data collection methodologies and findings related to health worker migration.

• Presentation of examples of country level and bilateral policy response in the five featured countries to include strategies to address internal migration, internal distribution of doctors, bilateral policy agreements.

Key Message

This session will present current country level experience and policy response related to health worker migration featuring Ghana, Brazil and Mali. Highlights include insight into quantitative and qualitative research efforts with migrants to understand the causes and effects of migration, innovative policy response to address internal migration and distribution of doctors and nurses between urban and rural areas, and local data collection and policy response to nurse migration in Ghana.

Chair
> Jean Yan, Coordinator, WHO, Switzerland

Panellists
> Tomas Lievens, Health Economist, Oxford Policy Management, UK
> Romulo Macrei Filho, special adviser, Ministry of Health, Brazil
> Seydou Coulibaly, Sante Sud, Mali
> Veronica Mina Darko, CEO, Nurses and Midwives Council, Ghana
> Reiko Matsuyama, project officer, IOM Regional Office for Southern Africa
> Fely Marilyn Elegado-Lorenzo, senior researcher, National Institute of Health, Philippines

Session 4.3 – Retention of health care workers: professionals point of view

Expected outcome

• Demonstrated link between workforce retention strategies, patient safety and workers’ well-being.

• Presentation of evidence on the impact of given retention measures.

• Presentation of guidelines on the effective use of retention measures.
Key Message

While much attention has been given to the recruitment of health care workers, relatively little energy has been focused until recently on retention. Research shows there is an enormous waste of resources through the attrition of student and qualified health professionals. The importance of workforce retention is now widely acknowledged and efforts are being made to create positive practice environments and effective incentive systems to keep health sector workers in active employment.

Chair
> Yoram Blachar, President, World Medical Association

Panellists:
> Sheila Anazonwu, Development program Officer, International Hospital Federation
> Williams Holzemer, Board member, ICN
> Zola Dantile, World Confederation of Physical Therapy

4.4 - Retention of health care workers: countries’ experiences

Expected outcome

- Demonstrated link between workplace incentives, workers’ well-being and workforce retention.
- Presentation of evidence on the impact of given retention measures.

Key Message

There is evidence that no matter how attractive the pull factors of the major destination countries, massive migration would not occur without strong push factors in the source countries. Any serious attempt to curb migration will need to address these factors and introduce significant retention measures.

Chair
> Mireille Kingma, Consultant, Nursing & Health Policy, ICN

Panellists
> Fadi El-Jardali, Assistant Professor, AU of Beirut, Lebanon
> Hilary Francis Mwale, HR Specialist, ABT Associates, USA
> Thabsile Dlamini, President, Nurse Association, Swaziland
> Fadima Yaya Bocoum, Health economist, IRSS, Burkina Faso
> Pamela McQuide, Senior Adviser, IntraHealth International, USA
Wednesday 5 March 2008
Theme V – Financing
Plenary session 9:15 – 10:30

Objectives
At the close of the conference participants will have:

- The perspective of and issues faced by a former Minister of Health on the challenges of financing the scale up of the health workforce
- The perspective of and issues faced by former Ministers of Finance and a former Prime Minister on the constraints and tradeoffs faced in responding to requests from line Ministries (such as Health) for the scale up of their workforces
- The perspective of key international assistance organizations and initiatives concerning resources and policies for workforce scale up
- Knowledge generated by economic analyses of health workforce scale up challenges, including the effect of wages on migration decisions, cost estimates of scale up and increasing training capacity to meet the need for scale up
- Awareness of the complements to training and retaining more health workers that could change (decrease or increase) costs, including development and use of better human resource management methods and tools, methods to increase productivity, changes in skill mix, greater involvement of the private sector, and methods to improve the distribution and equitable access to health services.

Key messages / themes

- The general approach to the financing theme sessions on the health workforce challenge is to understand how the issues around financing are seen and acted upon by governments in developing countries—from the line (Ministry of Health), core (Ministry of Finance), and overall perspectives—and by key international assistance organizations and initiatives.
- In addition, quite a bit of analytical work already has been performed on the economic aspects of workforce issues, so one of the breakout sessions will focus on the results of the analytical work, so that participants will be aware of what already has been learned and how the analytical results could inform decision making of the type discussed in the plenary.
• Another theme related to the plenary discussion that will be taken up in the breakouts is that financing is not just about raising funds, but also about how the funds are used—to increase efficiency, effectiveness, and equity.
• Finally, the theme of advocacy for resources from developing country budgets and for resources and facilitating policies from external development partners will be covered.

Coordinator
> Marty Makinen, Director, Task Force on HRH Financing

Keynote speakers
> Eyitayo Lambo, former Minister of Health, Nigeria
> Yaw Osafo-Maafo, former Minister of Finance and Economic Planning, Ghana
> Agnes Soucat, lead economist, AFTHD, World Bank, USA

Discussant
> Rick Rowden, Action Aid, USA

Moderator
> Ezra Suruma, Minister of Finance, Planning and Economic Development, Uganda
Wednesday 5 March 2008
Theme U – Financing
Break-out sessions 11:00 – 13:00

Session 5.1 - Advocacy for financing for health workforce scale up

Objectives

- Discuss key issues related to health workforce financing raised in the plenary session from an advocacy perspective
- Discuss the global aid architecture and how well or badly it responds to the challenge of health workforce scale up
- Provide suggestions on how to address policy makers at the World Bank, IMF, Global Fund, PEPFAR, GAVI, the International Health Partnership plus, and national governments of developing countries

Expected outcomes

Participants will learn about issues and practices of: (1) the international development agencies and initiatives and (2) national governments of developing countries that can hinder sufficient financing for health workforce scale. They also will learn about how the agencies, initiatives, and governments can be addressed effectively to change the situation. Finally, participants will have the opportunity to react to the presentation and provide their own input on the issues.

Key Messages

- International development agencies and initiatives and national governments make declarations that seem to indicate that they would like to provide the resources and policy environment necessary to achieve health workforce scale up. However, these entities often do not follow through.
- There are specific policies and practices that should be addressed by advocacy to allow the achievement of global, regional, and national health workforce goals and objectives.
- There are specific methods that advocates can use to be effective in changing policies and practices of the agencies, initiatives, and governments.

Chair
> Hong Wang, Yale University

Panellists
> Brook Baker, Health Workforce Advocacy Initiative
Session 5.2 - Technical aspects of health workforce economics and financing

Objectives

- Discuss key issues related to health workforce financing raised in the plenary session on a more technical level (e.g. present research results, country examples)
- Discuss which issues are most relevant for policy makers at the country level, at the global level
- Provide suggested topics the Task Force may take up as part of its work program

Expected outcomes

Participants will learn about analytic work that addresses key health workforce financing issues, hear expert opinion about the issues the financing task force should address, and have the opportunity to react and provide their own input on the issues.

Key Messages

The financing gap for scaling up the health workforce is large, larger than many countries are likely to be able to afford on their own, and maybe large relative to what external donors would be willing to support.

The costs of pre-service training might be more of a challenge than meeting the wage bill to expand the health workforce.

There are methods to improve health workforce performance within the existing resource envelope.

The issue of much to pay health workers is complex and has implications for retention, equitable deployment, and the cost of scaling up.

Chair

> Marko Vujicic, labor economist, World Bank
Panellists
> David Evans, Director HSF, WHO, Switzerland
> Gorik Ooms, Médecins Sans Frontières, Belgium
> Agnes Soucat, lead economist, AFTHD, World Bank
> Claude Sekabarage, Ministry of Health, Rwanda
> Alex Preker, Lead Economist, AFTH2, World Bank

Session 5:3 - Innovative Private Sector Responses to the Health Workforce Crisis

Objectives
- Understand the role key actors in the private sector can play in providing health services
- Present examples of health sector involvement in the human resources for health crisis
- Identify barriers and enablers that affect replication and scaling of private sector pilots and initiatives

Key Messages
Describe how the private sector is involved and evolving in response to the HRH shortage.
Effective management strategies used to direct these initiatives towards positive outcomes.

Chair
> Kathy Cahill, Bill & Melinda Gates Foundation

Panellists
> Marie Charles, International Centre for Equal Healthcare Access
> Renuka Gadde, Becton-Dickinson
> Papa Gaye, Intrahealth International
> Mark Bura, ECSA, Tanzania
Wednesday 5 March 2008
Theme VI – Partnerships and linking up for action
Plenary session – 14:00 – 15:15

Objectives
The partnership session aims to:

• Establish why partnerships matter in resolving human resource constraints for better health outcomes and sustainable results in countries
• Demonstrate the need to translate global partnerships and initiatives into country-level effectiveness in line with national priorities
• Clarify how partnerships on human resources can contribute to bringing the AIDS, disease and health systems agendas closer together

Key messages / themes

• National leadership is best communicated through its convening power, being able to bring diverse partners together around a shared agenda
• Inclusive country ownership is critical in ensuring that partnerships take into account the views and concerns of those most in need;
• Partnerships need to pass the test of mutual accountability to accelerate overall progress and build a basis for shared knowledge and learning based on evidence and transparency.

Partnership session

• The session will be guided by the key note address and a country response
• The moderated panel session will enable partners to provide brief testimonies of partnerships, highlighting its critical elements.
• The panel interventions will be followed by an interactive discussion, involving the key note speaker, respondent and panel members.
Coordinator
> UNAIDS

Keynote speaker
> Peter Piot, Executive Director, UNAIDS

Respondent
> David Mwakysa, Minister of Health, Tanzania

Panellists
> Fransisco Songane, Executive Director, Global Partnership on Maternal, Newborn and Child Health
> Hedia Belhadj, Deputy Director, Technical Support Division, UNFPA
> Simon Mphuka, Director, Churches Health Association, Zambia

Moderator
> Sigrun Møgedal, GHWA Board Member, Ambassador, HIV/AIDS and Global Health Initiatives, Norway
Wednesday 5 March 2008
Presentation of Global Action Plan and Ministerial Response
Plenary session – 15:30 – 17:15

Coordinator
> Global Health Workforce Alliance

One of the anchors of the Global Forum will be the presentation and consideration of a Global Action Plan. While there have been a number of important commitments made around the world to find a resolution to the crisis in the health workforce, these have not yet been translated sufficiently into action. Because the Forum is action-oriented, a set of recommendations for implementing these commitments must be one of its central outputs. That is the function of the Plan.

The draft of the Plan that will be presented will be a working document, originally forged by members and allies of the Global Health Workforce Alliance. It is meant to be a weighty opening round in a series of discussions that will involve all the stakeholders at the meeting. In its final form it will represent the best thinking of all those taking part in those discussions and will distil the insights and counsel gained into a focused and practical plan of action. It will gather together the political impetus expressed in prior commitments, intensifying it and aiming it at a set of fundamental targets. Global in scope, it will nonetheless count on individual countries and regions to shape specific policies in light of local circumstances, while nonetheless profiting from the opportunities afforded by collective, international initiatives.

17:30 - 18:00  Closing Ceremony / Launch of the Global Action Plan

Introduction
> Francis Omaswa, Executive Director, GHWA

Keynote Speaker
> Mary Robinson, former President of Ireland,
  President, Realizing Rights, USA

Closing messagers
> Beatrice Were, Coordinator, ActionAid Uganda
> Peter Piot, Executive Director, UNAIDS
> General Yoweri Kaguta Museveni, President of the Republic of Uganda

(Followed by Q&A with press - panel members only)
Constituency Meetings

A **constituency meeting** includes members who have shared agendas, common goals and expectations.

Venues for constituency meetings are available on the GHWA web site and in a detailed programme that will be distributed upon registration. Venues will be clearly indicated at the Speke Resort and usher services will be available to guide participants to venues.

Times are subject to change

---

**Sunday, 2 March 2008**

**Planning Meeting of Global and Regional WHO HRH staff**  
(09:00–18:00)  
**Organizer:** Department of Human Resources for Health, WHO  
**Contact:** Mario Dal Poz | dalpozm@who.int

**Human Resources for health research - they too save lives**  
(09:00–11:00)  
**Organizers:** ISHReCA; WHO/TDR; Welcome Trust; SIDA  
**Contact:** Jane Kengeya Kayondo and Nelson Sewamkamboa

**Experiences on health resource challenges in eye care in Africa**  
(09:00–13:00)  
**Organizer:** Right to Sight International, India  
**Contact:** Keerti Bhusan Pradhan | pradhankb@gmail.com
Meeting of the Health Workforce Advocacy Initiative (HWAI)
(09:00–13:00)
Organizer: HWAI
Contact: Eric Friedman \(\text{efriedman@phrusa.org}\)

Implementing actions in the IHP and PEPFAR ‘overlap’ countries (Ethiopia, Kenya, Mozambique and Zambia)
(13:00 - 15:00)
Organizers: DFID; PEPFAR; International Health Partnership
Contact: Joan Holloway (PEPFAR) \(\text{HollowayJP@state.gov}\)

International Council of Nurses: Meeting of Nurses
(14:00–18:00)
Organizer: International Council of Nurses
Contact: Patricia Caldwell \(\text{caldwell@icn.ch}\)

Private Sector involvement in HRH
(14:00–16:00)
Organizers: Duke University Fuqua Business School, Global Health Institute
Contact: Mike Merson \(\text{Michael.merson@duke.edu}\); Jeff Moe \(\text{jmoe@duke.edu}\)

Board meeting of the Global Health Workforce Alliance
(14:00–18:00)
Organizer: GHWA Secretariat
Contact: Millicent Ayata \(\text{ayatam@who.int}\)
Monday, 3 March 2008

Positive Practice Environments
(09:00–18:00)
Contact: Patricia Caldwell | caldwell@icn.ch and Linda Carrier-Walker

Health and Human Resources management training/development institutions on Africa
(09:00–13:00)
Organizer: Department of Human Resources for Health, WHO
Contact: Delanyo Dovlo | dovlo@who.int and Manuel Dayrit | dayritm@who.int

Meeting of the Health Workforce Advocacy Initiative (HWAI)
(14:00–18:00)
Organizer: HWAI
Contact: Eric Friedman | efriedman@phrusa.org

African Platform on HRH
(14:00 – 18:00)
Organizer: NEPAD
Contact: Eric Buch | ebuch@med.up.ac.za

Task Force on ‘Human Resources for Health implications of Scaling Up towards Universal Access to HIV prevention, treatment, care and support
(2 hours, pm, tbc)
Organizers: UNAIDS / WHO HIV team
Contact: Jantine Jacobi | jacobij@unaids.org
Thursday, 6 March 2008

Launch of the global WHO-UNESCO-FIP tripartite action
(09:00–11:00)
Organizers: Department Human Resources for Health / WHO (Division of Higher Education); UNESCO; FIP
Contact: Tana Wuliji, Georges Haddad, Manuel Dayrit \(\text{dayritm@who.int}\) and Ton Hoek

Round table: Recruitment and retention of health workers: policy options towards global solidarity
(09:00–13:00)
Organizer: WHO / EURO
Contact: Gérard Schmets \(\text{ges@euro.who.int}\) and Galina Perfilieva \(\text{gpe@euro.who.int}\)

Human resources for maternal health: scaling up or skilling up?
(11:00–13:00)
Organizer: UNFPA; WHO; ICM
Contact: Vincent Fauveau \(\text{fauveau@unfpa.org}\)

Informal briefing on Round 8 Global Fund, including new developments on health systems strengthening
(11:00–13:00)
Contact: Andrea Godfrey

Health Workforce Migration Initiative – Towards a Global Code of Practice
(14:00–16:00)
Organizers: Realizing Rights; GHWA; WHO
Contact: Peggy Clark \(\text{peggy.clark@aspeninst.org}\), Lucy Crawford \(\text{lucy.crawford@aspeninst.org}\), and Jean Yan \(\text{yanj@who.int}\)
Health Systems Strengthening for Equity: The Power and Potential of the Mid-level Provider/ Non-Physician Clinician
(14:00-16:00)
Organizer: Health Systems Strengthening for Equity Project (HSSE) Project
Contact: Dr. Helen de Pinho

Meeting the information and learning needs of health workers in developing countries
(14:00-16:00)
Organizers: Healthcare Information for All by 2015 (HIF A2015) and Global Health Information network - UK.
Contact: Neil Pakenham-Walsh | walsh@ghi-net.org

Consultative Meeting on the ECSA Human Resources for Health Strategy
(14:30-17:30)
Organizer: East, Central and Southern African Health Community
Contact: Dr Steven Shongwe and Dr Helen Lugina

International NGOs Code of Conduct for Health System Strengthening in Developing Countries
(14:00-18:00)
Organizers: Action Aid International USA; Health Alliance International; Health GAP; Partners in Health and Physicians for Human Rights.
Contact: Wendy Johnson and Amy Hagopian

WHO-Information, Evidence and Research Cluster (closed meeting)
(14:00-18:00)
Organizers: WHO
Contact: Ramesh Shademanir | shademanir@who.int
Migration of Human resources for health in member states of the East African community
(09:00–18:00)
Organizers: International Organization for Migration; East African Community in Kenya, Uganda and Tanzania
Contact: Anita A. Davies | adavies@iom.int, Said Fatima | fsaid@iom.int and Mosca Davide
Skills-building workshops

A *skills-building workshop* is a training session linked to one of the six Forum themes (Leadership, Financing, Management, Migration and retention, Education and training, and Partnerships). It emphasizes problem-solving, hands-on training, and requires the involvement of the participants.

The skills-building sessions will take place from 6-7 March, 2008. Venues for break-out sessions, constituency meetings and skills-building sessions are available on the GHWA web site and in a detailed programme that will be distributed upon registration. Venues will be clearly indicated at the Speke Resort and usher services will be available to guide participants to venues.

Times are subject to change.

**Thursday, 6 March 2008**

**Leadership**

**WHO Leadership and Management Framework**

*(09:00–11:00)*

Organizer: WHO

Contact: Dominique Egger \(\text{eggerd@who.int}\) and Delanyo Dolvo \(\text{dolvod@who.int}\)

**Objective:** Familiarize participants with the WHO leadership and management framework. Share country experiences in using the framework for mapping current activities, assessing management development needs, designing a coherent strategy and monitoring and evaluation progress towards management strengthening. Familiarize participants with existing tools for needs assessment and strategy design. Introduce participants to the WHO electronic resource library for health leaders and managers.
Douala Action Plan Follow-up workshop  
(09:00–13:00)

Organizer: GHWA  
Contact: Eric de Roodenbeke | deroodenbekee@who.int  
Objectives: To identify priority measures to implement at country and regional level to achieve the action plan commitments.

Expected outcomes: Measure progresses made in implementing the Douala Plan of Action, share successes and lessons. Identify the nature of regional and global support that could be provided to better support Douala plan of action implementation.

Education, training and skill mix

Innovation in Curriculum Building in Health Worker Education Institutions  
(09:00–11:00)

Organizer: Task Force on Scaling Up Education and Training  
Contact: Peter Walker and Nelson Sewankambo  
Objective: Review recommendations from the Task Force on Scaling Up Education and Training for Health Workers; Discuss innovative approaches in improving health worker education and training programmes; Consider the incorporation of these approaches to curriculum strengthening in their own institutions as it reflects country-specific health system needs; Identify barriers and opportunities to the adoption and incorporation of these new approaches to curriculum strengthening within existing health worker education programmes.

Capacity Building using WHO IMAI and IMCI tools  
(09:00–13:00)

Organizer: SSH/IMAI team, Department of HIV/AIDS / WHO  
Contact: Sandy Gove goves@who.int and Akiiki Bitalabeho bitalabehoa@who.int  
Objective: To give participants a thorough introduction to the use of available WHO IMAI and IMCI tools to support capacity building for HIV prevention, care and treatment in low resource settings while strengthening primary care. Emphasis will be on health worker follow up and support after training.
Training development methods: how to ensure effective training for Human Resources for Health

(09:00–13:00)

Organizer: Agence de Médecine Préventive, Benin Office  
Contact person: Dorothy Leab\dleab@aamp.org and Khaled Bessaoud\bessaoudk@afro.who.int  
Objectives: Participants will be able to use training development method for high quality training: training needs assessment, instructional design, implementation of training and impact evaluation.  
Expected outcomes: Identify major issue in providing appropriate training system for Health personnel. Explain importance of training needs assessment studies. Demonstrate interest of instructional design in Health training. Define necessity of determining the value and effectiveness of a learning program (Formative and Summative evaluation).

Treat, Train, Retain: Task Shifting Skills-Building Workshop

(09:00–13:00)

Organizer: Department of Human Resources for Health / WHO  
Contact: Badara Samb\sammb@who.int and Carmen Dolea\doleac@who.int  
Objective: To brief on the recently launched WHO Global guidelines and recommendations on Task Shifting; to discuss possible way to operationalize the guidelines in countries; and to discuss how to identify priority areas at country level to tackle the Human Resources for Health crisis.
Migration and retention

Macroeconomic literacy training
(09:00–13:00)

Organizer: Action Aid International
Contact: Rick Rowden \(\text{rick.rowden@actionaid.org}\) and Brook Baker \(\text{b.baker@neu.edu}\)
Objective: It is now widely recognized that macroeconomic policies can limit the resources available for governments to spend on the health workforce, and that restrictive macroeconomic policies were an important factor in the decline of the health workforce in many countries in the 1980s and 1990s. This workshop will help participants understand these policies and their rationales, including low inflation and fiscal deficit targets, how they can limit health spending, and the alternatives to these policies that will allow for the more expansive health spending needed to build a strong and sustainable response to the health workforce crisis. The objectives are to lay the groundwork for participants to develop strategies in their countries to address and change restrictive macroeconomic policies, to enable participants with limited economic backgrounds to engaged in informed dialogue with ministry of finance and IMF officials, and to introduce ministry of finance officials to alternative policies.

Management

Workplace Violence in the health sector
(09:00–18:00)

Organizer: ICN
Contact: Patricia Caldwell \(\text{caldwell@icn.ch}\)
Objective: To raise awareness of the incidence and implications of workplace violence. To promote effective strategies that reduce workplace violence and mitigate its impact.

Applying the HRH Action Framework (HAF) at the country level
(09:00–13:00)

Organizer: Capacity Project
Contacts: James McCaffery \(\text{jmccaffery@capacityproject.org}\); Manuel Dayrit \(\text{dayritm@who.int}\); Estelle Quain \(\text{equain@usaid.gov}\) and Roy Pargas
Objective: Identify emerging guidance and steps to apply the HAF at the country level. Explore a comprehensive approach for Health System Assessment that is compatible with the HAF.

**Building a National Human Resources for Health Observatory Workshop: better intelligence for health workforce development (09:00–13:00)**

Organizer: Department of Human Resources for Health / WHO
Contact: Mario Dal Poz | dalpozm@who.int and Gulin Gedik | gedikg@who.int

Objective: To ensure a good understanding of the health workforce observatories and the underlying principles. To highlight the potential contribution of health workforce observatories to health workforce development. To identify the challenges in establishing and maintaining health workforce observatories. To explore ways of ensuring active involvement of partners.

**Monitoring and evaluation of human resources for health: using information and evidence to support decision making workshop (14:00–18:00)**

Organizer: Department of Human Resources for Health / WHO
Contact: Mario Dal Poz | dalpozm@who.int and Neeru Gupta | guptan@who.int

Objective: To prioritize information needs with regard to health workforce situation and trends to support evidence-based decision-making for Human Resources for Health programmes and policies, at the international and country levels. To gain consensus on a limited number of core indicators for monitoring and evaluation of Human Resources for Health. To identify the sources via which those indicators can be measured. To identify a sustainable process through which the data can be regularly updated, maintained, disseminated and used. To build capacity in analyzing and presenting the data in a way that is useful to decision makers and stakeholders.

**Change management skills workshop (16:00 – 18:00)**

Organizer: Capacity Project
Contact: James McCaffery | mccaffery@capacityproject.org

Objective: Describe the value of managing the change process in planning and development activities. Demonstrate an understanding of the use of selected tools to support the management of change. Discuss the application of change management tools and techniques to their everyday work.
Partnership

**Advocacy Training Workshop**
(14:00–18:00)

Organizer: Health Workforce Advocacy Initiative and Physicians for Human Rights
Contact: Emily Bancroft, Action Group for Health, Human Rights and HIV/AIDS (AGHA) | agha@utlonline.co.ug

Objective: Advocacy by health workers and health consumers is beginning to change the landscape of global health. Now, advocates need to ensure that countries will meet their health workforce needs. This workshop will train health workers and other interested participants in advocacy and how local partnerships can be developed. The workshop will also address successful strategies required to effectively advocate for increased health financing, better working conditions and a more equitable distribution of the health workforce. Participants will receive a new advocacy toolkit developed by the Health Workforce Advocacy Initiative.

**Developing e-learning Programmes for HRH**
(14:00–18:00)

Organizers: WHO
Contact: Yunkap Kwankam | kwankamy@who.int

Objective: Training using the internet and distance learning methods for HR officers and heads of departments or programmes in Ministries of Health.

**Strengthening the Health Worker Production Pipeline**
(14:00–18:00)

Organizer: Health Workforce Education and Production Team, Department of Human Resources for Health / WHO
Contact: Rebecca Bailey | baileyr@who.int and Hugo Mercer | mercerh@who.int

Objective: To establish a dialogue between key stakeholders in the health workforce production process, which include secondary school educators, professional and educational associations, accrediting agencies, educational institutions, student associations, regulatory bodies, trade unions, recruitment agencies and international organizations. To identify and explore internal and external barriers and enabling factors in the production process. To suggest ways to improve coordination between the different segments, or actors, of the production process, and to reduce attrition and migration.
Friday, 7 March 2008

Education, Training and skill mix

Models for improving health worker education and training in Africa using supported open and distance learning resources
(09:00-11:00)

Organizer: The Open University, Milton Keynes, United Kingdom
Contacts: Lesley-Anne Cull \ l.a.cull@open.ac.uk  and Basiro Davey \ G.C.B.Davey@open.ac.uk
Objective: To review the experience of existing Open University partnerships in Sub-Saharan Africa delivering education and training to 450,000 primary school teachers via supported open and distance learning (ODL) resources and the potential for transforming this model to the production and lifelong learning of health workers. To examine the challenges and opportunities for using new forms of communication technologies in order to develop, deliver and evaluate supported ODL resources for healthcare education and training, particularly in rural contexts. To engage with other workshop participants in planning the learning outcomes and indicative content of a defined open-learning study module, and to reflect on this direct experience. This workshop is directed at professionals involved in the design and implementation of pre-service and in-service education and training for health workers, who wish to explore the potential for developing supported open and distance learning (ODL) methods as a means of capacity building, task shifting and quality-enhancement in their health workforce.

Curriculum Renewal in Health Worker Education Institutions
(09:00-11:00)

Organizer: Task Force on Scaling Up Education and Training
Contacts: Peter Walker and Professor G. Williams
Objective: Review recommendations from the Task Force on Scaling Up Education and Training for Health Workers; Discuss new approaches to improve the quality and relevance of health worker curricula; Consider the incorporation of these approaches to curriculum reform in their own institutions as it reflects country-specific health system needs; have the opportunity to share insights in curriculum and identify barriers and opportunities to the adoption and incorporation of these new approaches to curriculum renewal within existing health worker education programmes.
Implementing community health worker programmes in sub-Saharan Africa  
(14:00 – 16:00)

Organizers: Millennium Villages project  
Contact: Dr Joseph Nkurunziza  josenziza@yahoo.fr  
Objective: To share lessons learned on designing, implementing and managing community health worker programmes in Rwanda, Uganda and Kenya. Workshop participants will hear from health coordinators of the Millennium Villages Project in Rwanda, Uganda and Kenya and learn how these programmes have designed community health worker programmes to serve populations in sites of approximately 50,000 people each. Topics covered will include costing, training, supervisory structures and remuneration. Workshop participants will learn about the different models chosen and lessons from implementation and can apply those lessons to their own programmes.

Community / lay health worker programmes in low and middle income countries: linking policy, practice and research  
(14:00–18:00)

Organizers: SINTEF, Norway; National Knowledge Centre for the Health Services, Norway; Medical Research Council of South Africa; London School of Hygiene and Tropical Medicine, UK.  
Contact: Simon Levin  
Objective: To share and discuss knowledge and experience regarding community health worker programmes in low and middle income countries. To explore strategies for the successful and sustainable delivery for community health worker programmes in low and middle income countries.

Migration and retention

A closer look at Rural Retention Schemes: Experiences from Côte d’Ivoire, Rwanda, Uganda and Zambia  
(09:00–13:00)

Organizers: ABT Associates in collaboration with other USG partners  
Contacts: Estelle Quain  equain@usaid.gov; Gilbert Kombe  Gilbert_Kombe@abtassoc.com; Amy Holdaway  Amy_Holdaway@abtassoc.com
Objective: ABT Associates in collaboration with other USG partners will present a satellite session on how to design and implement rural retention schemes based on their field experiences in following countries: Zambia, Rwanda, Uganda, Ghana, South Africa and China. Examples of challenges and opportunities of recent incentive scheme activities will be highlighted throughout the session in order to illustrate techniques and lessons learned.

Management

Human Resources for Health Management Tools
(09:00–11:00)

Organizer: Human Resources for Health Management Groups, MSH
Contact: Estelle Quain \( \text{equain@usaid.gov} \) and Joseph Dwyer

Applying TQM-CQI-5S at Health Facility Level
(11:00–13:00)

Organizer: JICA
Contact: Prof. Yujiro Handa \( \text{handa.yujiro@jica.go.jp} \)
Objective: Quality of health service should be sought even under chronic resource shortage. At the end of workshop, the participants will obtain a skill and knowledge on 5-S Principles (Sort, Set, Shine, Standardize and Sustain), a simple management instrument useful to Work Environment Improvement, which is essential at government run hospitals and health centres. In addition to that, the participants will understand the logical framework of Total Quality management (TQM) consisted on performance excellence of the personnel, Continuous Quality Improvement (CQI, KAIZEN) and 5-S activates.

Private Sector perspectives for Human Resources for Health management
(14:00 – 16:00)

Organizer: Fuqua Business School, Global Health Institute, Duke University
Contact: Mike Merson \( \text{michael.merson@duke.edu} \) and Jeff Moe \( \text{jmoe@duke.edu} \)
Objective: Determine the business skills useful in carrying out Ministry of Health responsibilities; identify current or prospective Ministry of Health activities where increased business skills can be applied; understand how to translate Ministry of Health needed “capabilities” into business skills language; identify business schools
available to partner for Ministry of Health training; consider how to build interest and commitment to a business skills training program for Ministry of Health staff; present the experience of Kenyan Ministry of Health staff who have participated in a Strathmore Business School program.

**Partnership**

**Human Rights Training**

*(09:00 – 13:00)*

**Organizers:** Physicians for Human Rights, Action Group for Health, Human Rights and HIV/AIDS  
**Contact:** Eric Friedman | efriedman@phrusa.org  
**Objective:** Human rights need to be fully integrated into health workforce strategies if these strategies are to successfully meet the health needs of the entire population. This workshop will introduce HRH planners, health workers, advocates, and other participants to human rights, especially the right to health, and explain how human rights principles such as equity, participation, and accountability can and should inform health workforce strategies. The workshop will also highlight the importance of human rights to the success of these strategies. In addition, through discussion, the workshop will draw out practical steps and good practices in incorporating these principles into health workforce strategies.

**A strategic approach towards Human Resources for Health**

*(11:00 – 13:00)*

**Organizer:** Liverpool Associates in Tropical Health, United Kingdom  
**Contact:** Tim Martineau, Margaret Caffrey and Barbara Stilwell  
**Objective:** This workshop builds in the experience of the facilitators in promoting a more strategic approach towards Human Resources for Health in many countries over the past 15 years or so. The workshop is also informed by some of the current frameworks that support strategic thinking for Human Resources for Health. The aim is to share challenges and successes with the participants rather than to present a blueprint for developing Human Resources for Health strategic plans.
Speakers’ corner

The Speakers’ corner is the perfect mechanism for lively debate and give participants the opportunity to speak out publicly about topics that interest them and that they are passionate about.

The Market Place will feature two speakers’ corner areas, which will seat approximately 30 people. Speakers will take to the podium and engage their audience in interactive discussion.

A schedule of speakers will be available on site.

Logistical and other useful information for Speakers’ corner

The facilities in the speakers’ corner offered by the Forum will provide the possibility of:

- A fold-down screen and projector for your PowerPoint presentation
- Registration for your presentation
- Last minute alterations of your PowerPoint presentation

**Location:**
The speakers’ corners are located in the marketplace. The marketplace is situated within 3 minutes walk from the Conference Centre and will be signposted. Please also check with the information centres at the Speke resort if you have any difficulty in finding the venue.
Process:
- When you register please indicate on the form provided whether you have been asked to present at a speakers’ corner. (speaker’s name, title of presentation, theme).
- Check in at the speakers’ corner 24 hours before your presentation.
- Download your presentation on the audio-visual equipment
- Test your audio-visual presentation before your presentation
- Be at the speakers’ corner 10 minutes before your presentation to meet the moderator.
- All presentations of that session will be brought to the room and saved to the laptop by the organizers. You will be responsible for operating the computer to present your paper.

Opening hours:
Opening hours for the speakers’ corners during the Forum:

<table>
<thead>
<tr>
<th></th>
<th>Monday 3rd March</th>
<th>Tuesday 4th March</th>
<th>Wednesday 5th March</th>
<th>Thursday 6th March</th>
<th>Friday 7th March</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10.00 – 12.30 hours</td>
<td>10.00 – 10:30 hours</td>
<td>10.00 – 10:30 hours</td>
<td>08.30 – 09.00</td>
<td>08.30 – 09.00</td>
</tr>
<tr>
<td>Last minute alterations</td>
<td>14.00 – 16.00 hours</td>
<td>14.00 – 18.30 hours</td>
<td>14.00 – 18.30 hours</td>
<td>09.00 – 13.00 hours</td>
<td>09.00 – 13.00 hours</td>
</tr>
<tr>
<td>Last minute alterations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presentations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presentations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

At the time of your Presentation:

Please be certain that the length of your presentation stays within the allotted time of no longer than 20 mns. and leave time for questions from the audience. Session moderators will be instructed to terminate presentations, which exceed their time allotment.
Audio visuals per speakers’ corner:

There will be 2 speakers’ corners which will be equipped with:

- Data projector for PowerPoint presentations
- Microphone
- Small Platform
- Laser pointer
- Computer

PowerPoint:

Since good material does help to clarify your talk and poor material is more likely to distract attention, you may find the following guidelines helpful.

- Please bring a CD-ROM or USB memory stick with your presentation.
- When you use power point always use the option: ‘Font TrueType’.
- Keep the use of animations limited.
- Please note that MacIntosh presentations cannot be used

General recommendations for the preparation of presentations:

You should plan your presentation carefully and co-ordinate each phase of your lecture with your PowerPoint slides. You should select your vocabulary to address as wide an audience as possible and avoid unfamiliar abbreviations or expressions.

These three rules can assist with effective presentations:

- Introduce your topic and inform your audience what you intend to speak about.
- Deliver your talk, including the methods, results and conclusions.
- Summarize for your audience the most important points of your lecture.
All week activities

There will be a number of on-going activities throughout the Forum period. These include:

Market Place

The Market Place will give our partners an opportunity to present their work and advocacy material. A large oval-shaped marquee will shelter a number of stalls for display items, an art and craft market and two speakers corners, where authors whose abstracts are accepted but not selected for the break out sessions, will be given a chance to present their work.

Each Constituency / Task Force / Working Group will be solely responsible for setting up, manning and removal of their display(s) / area. GHWA will not be responsible for this and any damage or loss to any items.

Photo contest and exhibition

GHWA invited professional and amateur photographers worldwide to participate in a photo contest. The theme of the photo contest was “the daily life of a health worker at work”.

We were overwhelmed with over 300 entries for the three categories (colour, black & white and digital art) sent by contestants from all parts of the world. The winners for each category will be announced during the Forum. Winning entries and a selection of the best submissions will be on display in a special exhibition.

These photographs will contribute to GHWA’s efforts to raise global awareness on the importance of health workers – men and women who save lives every day, in spite of difficult conditions and inadequate resources.
ABSTRACTS

This compilation includes all oral presentations

Index by theme

Leadership 75
Education, training and skill mix 81
Management 159
Migration and retention 181
Financing 209
Partnerships and linking up for action 123
## List of abstracts
### Leadership

<table>
<thead>
<tr>
<th>Alphabetical order by first author</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>E. Necochea</strong> et al, <em>Implementation of practical workplace safety and health (WSH) guidelines in Mozambique</em></td>
<td>76</td>
</tr>
<tr>
<td><strong>M. Walusimbi</strong> et al, <em>Dynamic collaborations to strengthen health-care systems for HIV and AIDS in sub-Saharan Africa and the Caribbean</em></td>
<td>78</td>
</tr>
</tbody>
</table>
Implementation of practical workplace safety and health (WSH) guidelines in Mozambique

Authors
> Edgar Necochea (contact author), MD, MPH, director, Human and Organizational Performance, JHPIEGO, 1615 Thames Street, Baltimore, MD 21231, USA, tel. 410 537 1895, enecochea@jhpiego.net
> Americo Assan, MD, national director of medical care, Ministry of Health, Mozambique
> Antonio Mussa, MD, MPH, national director for human resources, Ministry of Health, Mozambique
> Rui Bastos, MD, clinical advisor, National HIV/AIDS Control Programme, Maputo Central Hospital, Ministry of Health, Mozambique
> Olga Novela, chief, Nursing Department, Ministry of Health, Mozambique
> Jotamo Come, MD, national coordinator of the Infection Prevention and Control Task Force, Ministry of Health, Mozambique, jotamocome@hotmail.com
> Irene Benech, MD, national coordinator of the Infection Prevention and Control Task Force, Ministry of Health, Mozambique, jotamocome@hotmail.com
> Debora Bossemeyer, BSN, team leader, Lusophone and Latin American and Caribbean Countries, JHPIEGO, dbossemeyer@jhpiego.net

Context
There is recognition of a widespread human resources for health crisis and a shortage of health-care workers, particularly in sub-Saharan Africa. Several mitigating actions have been proposed, including training more workers, shifting tasks, managing migration and improving retention and productivity. Protection of the current workforce, so it can be productive for a longer period of time, is also a key intervention.

Objective
To develop and implement practical and operational workplace safety and health (WSH) guidelines in Mozambique.

Methods
In Mozambique, JHPIEGO, with funding from the President’s Emergency Plan for AIDS Relief, through the Centers for Disease Control and Prevention, provided support to the Ministry of Health (MOH) to develop operational WSH guidelines for rapid implementation of WSH activities. HIV/AIDS post-exposure prophylaxis (PEP) guidelines were approved and published in 2007. After their initial implementation, the MOH requested JHPIEGO to develop comprehensive WSH guidelines, including
protection against TB, hepatitis B, violence in the workplace and internal disasters, which are in the final review stage for MOH approval.

Findings
The guidelines include practical, step-by-step guidance, which has greatly eased implementation. Specific requirements and procedures (staff, drugs, and references) were established for all health units categorized in three groups according to their complexity and staff availability. The MOH designated a WSH representative in each health unit, trained a core group of 15 WSH facilitators who trained staff in each province and district, and distributed reporting forms and prophylactic treatment kits to each of the 2500 facilities in the country. Initial nationwide data collection on injuries and treatment is planned for January 2008.

Conclusions
The MOH has shown substantial commitment to the implementation of WSH activities in Mozambique by approving guidelines, making drugs available and assigning responsibilities. The nature of the guidance has facilitated its acceptance and quick implementation.
Dynamic collaborations to strengthen health-care systems for HIV and AIDS in sub-Saharan Africa and the Caribbean

Authors

> Mariam Louise Walusimbi (contact author), RN, RM, MScN, assistant commissioner of nursing, Mulago Hospital, PO Box 7051, Kampala, Uganda, fax 011 256 41 532591, mobile 011 256 772 349699, bajjo@yahoo.com
> Judy Mill, RN, PhD, associate dean, Faculty of Nursing, University of Alberta, 3rd Floor, Clinical Sciences Building, Edmonton, AB T6G 2G3, Canada, tel. 780 492 7556, fax 780 492 2551, judy.mill@ualberta.ca
> Nancy Edwards, RN, PhD, professor, School of Nursing, University of Ottawa, 451 Smyth Rd, Ottawa, Ontario, Canada, K1H 8M5, tel. 613 562 5800 ext. 8395, fax 613 562 5658, nancy.edwards@uottawa.ca
> Dan Kaseje, MD, PhD, vice chancellor, Great Lakes University of Kisumu, PO Box 2224, Kisumu, Kenya, tel. 254 57 23972, fax 254 57 44117, adminkusumu@tichinafrica.org
> Eulalia Kahwa, RN, PhD, lecturer, UWI School of Nursing Mona, University of the West Indies, Kingston 7, Jamaica, tel. 876 970 3304, fax 876 927 2472, eulaliakahwa@yahoo.com
> June Webber, RN, PhD, director, Department of International Policy and Development, Canadian Nurses Association, International Policy and Development, 50 Driveway, Ottawa, ON K2P 1E2, Canada, tel. 613 237 2159 ext. 236, fax 613 237 3520, jwebber@cna-aiic.ca
> Marion Francis-Howard, RN, RM, PhD, nurse educator, Department of Nursing, Barbados Community College, Eyrie, Howells Cross Road, St Michaels, Barbados, West Indies, tel. 246 424 0819 / 425 9554, fax 246 436 6279 / 425 9554, mefolh@sunbeach.net
> Enid Mwebaza, RN, RM, MScN, principal nursing officer, Mulago Hospital, PO Box 7051, Kampala, Uganda, fax 011 256 41 532591, mobile 011 256 772 413 962
> Susan Roelofs, MA, international projects coordinator, University of Ottawa School of Nursing, 451 Smyth Road, Ottawa, ON K1H 8M5, Canada, tel. 613 562 5800 ext. 8438, fax 613 562 5658, sroelofs@uottawa.ca

Context

The global HIV/AIDS pandemic is devastating the already weakened health systems of sub-Saharan Africa and the Caribbean. Severe nursing shortages and low professional retention rates are entwined with the impact of HIV/AIDS on workload, workplace safety, health worker illness and mortality, and delivery of basic and HIV/AIDS health services. The World Health Organization (WHO) has raised particular
concerns over the minimal representation of nursing and midwifery at national, regional and international health policy forums. Nurses’ involvement in the health policy and decision-making process is constrained by lack of training, mentoring and research funds, limited experience with knowledge transfer and few opportunities to influence policy-makers. Researchers from sub-Saharan Africa (Kenya, South Africa, Uganda) and the Caribbean (Barbados, Jamaica) have joined a collaborative effort with Canadian colleagues to undertake innovative, multicountry comparative studies and capacity-building strategies to redress this gap. The “leadership hub” is a key conceptual and practical dimension within this programme.

**Purpose**
To examine how leadership hubs influence nurses’ engagement in policy development and collaborative action to address HIV and AIDS, to strengthen health-care delivery systems in five countries.

**Objectives**
To examine the mechanisms for engaging in policy and practice change used by leadership hubs, to strengthen health-care systems for patients and families living with HIV and AIDS in participating countries.
To examine the short-term impact of leadership hubs’ dynamic engagement on core areas identified to strengthen the health-care systems for patients and families living with HIV and AIDS in each country.

**Methods**
Participatory action research (PAR) approach will be used to provide a socially and culturally adaptable framework. Leadership hubs will link with stakeholders to strengthen evidence-informed public policy.

**Conclusion**
This presentation focuses on leadership hubs as an approach to engage nurses in using evidence for local decision-making on HIV/AIDS and human resources.
## List of abstracts

### Education, training and skill mix

**Alphabetical order by first author**

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>E. Badr</strong></td>
<td><em>The Academy of Health Sciences in Sudan: an opportunity for sustainable scaling up production of nurses and paramedics</em></td>
<td>84</td>
</tr>
<tr>
<td><strong>Pr. A. Benhamou</strong></td>
<td><em>UMVF, the French Cyber University for health and medicine</em></td>
<td>86</td>
</tr>
<tr>
<td><strong>S. Bergstrom</strong></td>
<td><em>The quality of emergency obstetrical surgery provided by non-physician clinicians in Malawi, Mozambique and Tanzania</em></td>
<td>89</td>
</tr>
<tr>
<td><strong>Y. Bourgueil</strong></td>
<td><em>Towards increased cooperation between health professions (delegation, transfer of tasks, new jobs): findings of a process of experimentation and consultation in the French context</em></td>
<td>91</td>
</tr>
<tr>
<td><strong>AC Bowa et al</strong></td>
<td><em>Challenges in scaling up training of health workers: the case of Zambia</em></td>
<td>93</td>
</tr>
<tr>
<td><strong>R. Brough et al</strong></td>
<td><em>The “capacity building pyramid”: a proposed systems model to enhance benefits from training</em></td>
<td>95</td>
</tr>
<tr>
<td><strong>F. de Campos et al</strong></td>
<td><em>Competences profile</em></td>
<td>97</td>
</tr>
<tr>
<td><strong>F. de Campos et al</strong></td>
<td><em>Defining the technological infrastructure for the Brazilian Telemedicine and Telehealth Project for primary care</em></td>
<td>99</td>
</tr>
<tr>
<td><strong>F. de Campos et al</strong></td>
<td><em>Pedagogical education</em></td>
<td>101</td>
</tr>
<tr>
<td><strong>F. de Campos et al</strong></td>
<td><em>Strategy for content development of the Brazilian Telemedicine and Telehealth Project for primary care</em></td>
<td>102</td>
</tr>
<tr>
<td><strong>F. de Campos et al</strong></td>
<td><em>The PROFAE experience</em></td>
<td>104</td>
</tr>
<tr>
<td><strong>F. de Campos et al</strong></td>
<td><em>The SUS technical schools and eHealth Brazil</em></td>
<td>105</td>
</tr>
</tbody>
</table>
H. de Pinho, Health systems strengthening for equity: the power and potential of the mid-level provider/non-physician clinician 106

P. Easterbrook et al, The Sewankambo Clinical Scholars Programme: a model for research capacity building in Uganda 108

M. Gautham, What’s stopping us? Needs, approaches and impediments to scaling up graduate level primary health workers’ education and training 110

Dr. S.C Ghosh et al, Option for Multi-tasking or Multi – Skilling of Health workforce in India- a multi centric study 112

D. Houéto et al, Lutte contre le paludisme de l’enfant en Afrique subsaharienne : quel rôle pour les professionnels de la santé pour une plus grande efficacité ? 115

M-G. Ingabire, Le développement des ressources humaines dans le secteur de la santé en Haïti 117

S. Lewin et al, The effectiveness of community health worker programmes: new findings from a Cochrane systematic review of trials 119

I. Lutalo, et al, HIV/AIDS Training Needs Assessment for Clinicians in ART clinics in Uganda: A study conducted by Infectious Diseases Institute (IDI) and Ministry of Health (MoH), 2006 120


M. McNamara et al, Non-physicians performing caesarean sections: a review 123

K. McAdam et al, Emerging solutions for workforce challenges facing the HIV epidemic: change agents in Uganda 125

P. McQuide et al, Strengthening the system to use current administrative data at the Uganda Nurses and Midwives Council to identify the number of trained and registered nurses and midwives 127

A. Miceli et al, Resetting the goalposts for effective post-service medical training: quality monitoring, self-study and post-classroom follow-up 129

Y.F. Mensah, Working to Reduce Maternal and Neonatal Mortality and Morbidity through Ghana Health Services Capacity Building and Setting Performance Standards 131
<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>F. Mullan, Counting public health workers: global challenges in enumerating the public health workforce (PHWF)</td>
<td>133</td>
</tr>
<tr>
<td>F. Mullan et al, What is a School of Public Health? Developing a Strategy to Inventory Public Health Training Institutions (PHTIs)</td>
<td>135</td>
</tr>
<tr>
<td>E. Necochea et al, A web-based in-service training information system in Mozambique</td>
<td>137</td>
</tr>
<tr>
<td>P. Ngatia et al, Addressing the critical shortage of nurses in Kenya through the use of e-learning</td>
<td>139</td>
</tr>
<tr>
<td>P. Ngatia et al, Scaling up health worker numbers in a post conflict setting: The example of South Sudan</td>
<td>141</td>
</tr>
<tr>
<td>P. Ngatia et al, The role of community health workers: past and present practice in Africa</td>
<td>142</td>
</tr>
<tr>
<td>B.N. Nguyen et al, The work conditions and training needs of commune medical doctors in Viet Nam</td>
<td>143</td>
</tr>
<tr>
<td>S. Panthee, Multidisciplinary Collaboration Among students: P-Squared (Physician x Pharmacist)</td>
<td>145</td>
</tr>
<tr>
<td>A. Pfitzer et al, Using a standards-based educational management and recognition approach to scale up pre-service education: building on experience in 3 Universities in Ethiopia</td>
<td>147</td>
</tr>
<tr>
<td>I. Scheel et al, Community/Lay health worker programmes for vaccine uptake in low and middle income countries: Developing a global knowledge-base</td>
<td>149</td>
</tr>
<tr>
<td>A. O’Shea, Human Resources for Health (HRH) Development and Health Systems Strengthening in Tanzania</td>
<td>151</td>
</tr>
<tr>
<td>Y. Talbot et al, Building Capacity in Primary Health Care: In-training program for interdisciplinary teams In Brazil and Chile</td>
<td>153</td>
</tr>
<tr>
<td>J.K. Tumwine et al, Hard copy publications and continuing professional development: contributing to stemming the tide of health human resource depletion in Africa</td>
<td>155</td>
</tr>
<tr>
<td>A. Wouters et al, Overview of task shifting practices in ART care projects supported by MSF</td>
<td>157</td>
</tr>
</tbody>
</table>
The Academy of Health Sciences in Sudan: an opportunity for sustainable scaling up production of nurses and paramedics

Author
> Elsheikh Badr, MBBS, DPH, MA, FCM, Vice Chancellor, Academy of Health Sciences, Federal Ministry of Health, Sudan, elsheikh941@gmail.com

Context
During the past two decades, medical schools in Sudan have proliferated enormously at the expense of other health training institutions. Currently, there are 30 medical schools as opposed to only 10 nursing schools in the country, giving a ratio of six medical students for every one nursing student. Recently, awareness and concern about this skill mix imbalance has become more topical, given its increasingly felt implications on coverage and quality of health services.

The 10-year strategic human resources for health (HRH) projections showed a need for 90 000 more nurses, medical assistants and midwives in Sudan. However, production of nurses and paramedics by universities continued at a very low rate, with the 10 nursing schools of the country graduating only 450 nurses annually.

Objectives
This paper aims at reflecting Sudan response to the HRH crisis and specifically shortage of nurses and paramedics. The study focuses on the experience and lessons learned of the recently established Academy of Health Sciences (AHS).

Methods
This is a descriptive study presenting the case of the AHS. It is supported by secondary data, including review of documents, records, registries and reports.

Findings
The AHS was established in 2005 by the Federal Ministry of Health to address the gap in nursing and paramedics. The academy adopted a decentralized system, with the main academy in Khartoum and branches in six different states. In the year 2006, the AHS enrolled 5000 students in nursing and paramedic disciplines, and 1000 practising nurses for bridging programmes (upgrading). The AHS uses the premises of the nursing and paramedic schools of the previous system, and employs a core staff in addition to a wide network of part-time staff in health facilities. The academy is backed by high-level political support and receives funds and support from the
government and professional unions, as well as from the World Health Organization (WHO) and donors. Expansion to other states, staff development and setting up distance learning remain as the main challenges facing the academy.

Conclusions
Given current and potential capacity, the AHS could contribute significantly to tackling the HRH crisis resulting from the severe shortage of nurses and paramedics in Sudan and beyond. The decentralized system proved to be instrumental in increasing the student pool, and the location of training sites within hospitals has helped in efficiency gains and staffing. The importance of consensus and political support, decentralization of training and innovative use of available resources are among the major lessons learnt from this experience. This study aims at identifying the most cost-effective methods for rapid scaling up of the health workforce, particularly for nurses and allied health workers.
UMVF, the French Cyber University for health and medicine

Author
> Pr Albert Claude Benhamou, Directeur de l’UMVF, Université Pierre et Marie Curie University, Paris 6  albert-claude.benhamou@recherche.gouv.fr, www.umvf.org

Context

The digital era: During the recent decades the development of information technology has brought about great changes in methods of university education. Internet-based telecommunication skills have been utilized as an effective means of delivering educational contents to students and facilitating feedback from them.

Numerous types of research has shown that online learners could perform as well as, or better than, their off-line counterparts. Many educators and IT specialists argue that online education will gradually replace the traditional mode of on-campus university teaching. It is now projected that one-third of university education will be conducted through the internet within 10 years, fully exploiting the possibilities inherent in advanced IT and multimedia technologies. The world is rapidly changing, and the existing educational system cannot satisfy the need of people’s endless self-development.

UMVF, Educational objectives

UMVF French Cyber University for health and medicine, is pushing the limitations of the off-line educational institutions into the new paradigm of ‘open education’ and ‘lifetime education’. Our aim is to open up the opportunity of high quality professional education to everybody through the cyber world. It is open to everyone and is accessible everywhere.

The high quality distance learning of UMVF French cyber university for health and medicine, which is based on the dual systems of ‘open education’ and ‘lifetime education,’ will enable many people who have been limited by place, age and economic disadvantage to develop their potential. The cyber education culture for health and medicine undertaken by UMVF French Cyber University will establish a new paradigm for the 21st century cyber education. The education offered at UMVF French Cyber University for health and medicine is designed to train intellectuals who combine academic excellence and creative originality, which are demanded by the current globalized society. It is designed to train citizens with outstanding leadership abilities, able to contribute to society and the nation in a spirit of devotion.
and a sense of responsibility. These graduates become true cosmopolitans able to contribute to the national prosperity and world peace.

UMVF French Cyber University for health and medicine programs also aim to strengthen needs-based learning. Learning and application occur in a context. Education is tailored to the particular situation and precise requirements of the individual. The individual can be a person or a company committed to a beneficial globalization. UMVF French Cyber University for health and medicine pursues a systematic, rational and coherent approach to education in a professional manner. In keeping with the founder’s purpose, which was to create a fair and just society, we offer this type of education to our students.

**UMVF, Educational Policy**

UMVF French Cyber University for health and medicine retains original lecture contents, which excellent faculty members and technicians at UMVF French Cyber University for health and medicine, and faculty members of thirty three medical consortium universities devised. This distinctive educational content will enable learners to experience the new educational material, which are designed to combine theory with practice. In addition, UMVF French Cyber University for health and medicine will make every effort to create an atmosphere of learner-oriented education, and make students become future-oriented professionals. UMVF for health and medicine provides the basis for students to be the leaders of the new era.

An educational revolution in the sector of the initial and continuous medical training is on line thanks to the new technologies of information and the communication and to the internet. The French-speaking Virtual Medical University (UMVF) has been recognized as a group of public interest (GIP) in August 2003. The UMVF unites today all the French faculties of medicine and will certainly include them all. (33 universities teaching medicine in France). It already offers support of work covering 95% of the teaching of the 2nd cycle of medical studies, with the preparation of the new test for residency, the national classifying tests (ECN).

**Conclusions and achievements**

It counts as an asset the systematic training of the all new national promotions of about 400 clinic chiefs per year in the pedagogy, and more specifically the techniques of e-learning for the last 5 years. The teaching is constructed within national “digital campuses” for every discipline by the national colleges of teaching. They are elaborated in common by all teachers of all faculties of medicine of France with the help of all medical programmers of all national universities. The fundamental principles are centred on the learner’s needs, and to have a system of complementary training using the classic methods of teaching, whatever the level considered appropriate in all disciplines, and for all cycles.
The digital tools go from simple software and so-called “rich media”, (allowing a link between the texts and the slides or the online videos), to visual supports of very high quality, integrating 3D animations and virtual reality associated with virtual models, as in the games videos, virtual robots and distance learning software, both synchronous and asynchronous. Some software allow simulations of situations real clinics appropriate with settings in situations of diagnosis or therapeutic interventions, to verify to require the students to perform deductive reflections, make decisions and uphold professional responsibility.

Of other digital tools: the simulators, that are comparable to those used in the domain of aeronautics, will permit very useful training in the near future for very varied disciplines, for example: ophthalmology, laparoscopic surgery, digestive endoscopy, interventional cardiology, neurosurgery, orthopaedic surgery, bacteriology, etc.

The UMVF is not a substitute university but a free educational tool, to facilitate learning and teaching for students and French-speaking teachers from all over the world. It is about facilitating the acquisition of knowledge and expertise and to have reliable systems of assessment of the performance of young students or established professionals facing problems from the simplest to the most complex.

Virtual teaching is very attractive provided that it given by true professionals providing individual tuition to learners, during the process of their training and is open to international collaboration in an interdependent and ethical manner. It offers flexibility, adapting in particular to the availability of practising professionals. Many constraints of cost, time and displacement are largely avoided, thanks to the services of very high quality of I’UMVF. The struggle against the “numeric fracture” is one of the major objectives of the information society shared by France, by the French government and more especially by the Minister of National Education and Research.
The quality of emergency obstetrical surgery provided by non-physician clinicians in Malawi, Mozambique and Tanzania

Authors
> Staffan Bergstrom (contact author), IHCAR, Karolinska Institutet, Nobels väg 9, SE-171 77 Stockholm, Sweden, tel. +46 73 573 27 41, staffan.bergstrom@ki.se
> G Mbaruku, Ministry of Health, Tanzania
> C Pereira, Karolinska Institutet, Sweden, and Ministry of Health, Mozambique
> C Nzabuhakwa, Ministry of Health, Tanzania
> C McCord, AMDD, Mailman School of Public Health, Columbia University, NY

Background
Only five countries in sub-Saharan Africa have trained and certified non-physician clinicians/mid-level providers (NPCs/MLPs) to perform major emergency obstetrical surgery. In three countries, Malawi, Mozambique and Tanzania, NPCs (variously known as assistant medical officers, clinical officers and surgical technicians) provide over 80% of the emergency obstetric care in the districts outside the major cities.

Methods
Retrospective reviews of obstetrical surgery performed during a one-year period in all of the public hospitals in Malawi and Mozambique, as well as all the hospitals in two regions (population 4.5 million) in Tanzania, have confirmed that in all three countries most caesarean sections and other obstetrical surgery is performed by NPCs. Prospective reviews to compare operations done by NPCs and by medical officers (MOs) have been carried out in one large hospital in Mozambique, in all the hospitals of two regions in Tanzania, and in all hospitals in the country in Malawi.

Findings
In all three countries there were no differences between NPCs and MOs in maternal mortality or complication rates, and case fatality rates were 2% or less. Met need for emergency obstetric care was 30% in the two rural and relatively isolated regions reviewed in Tanzania. Major deficiencies were found in almost all hospitals, notably in availability of blood for transfusion. An effective system for referral of patients from peripheral health facilities did not exist in any country.

Conclusions
If all women with complicated deliveries could have access to hospitals with a 2% case fatality rate, the maternal mortality ratio would be expected to fall by 75%. With
met need of only 30%, a fraction of this result can be expected. Better availability of blood and an effective referral system should bring case fatality well below 1% in these hospitals. Given adequate hospital facilities and referral, existing training programmes for NPCs in Malawi, Mozambique and Tanzania can provide competent staff to do the surgery.
Towards increased cooperation between health professions (delegation, transfer of tasks, new jobs): findings of a process of experimentation and consultation in the French context

Author

Yann Bourgueil, MD, MPH, MBA, Chargé de mission à l’Observatoire National de la Démographie des Professions de Santé, Directeur de recherche à l’Institut de Recherches et de Documentation en Economie de la Santé, 10 rue Vauvenargues, 75018 Paris, France, tel. 01 53 93 43 18, bourgueil@irdes.fr

Context

The number of full-time doctors in France is decreasing. Inequalities in the distribution of the health workforce are of concern. Mechanisms used to regulate the supply of medical professions appear to have been ineffective and general practice remains an unattractive career option. A new strategic plan was announced by the government in 2006. This includes opportunities for training in general practice in medical school, the development of financial incentives to encourage doctors to locate to areas of most need and particularly delegation of some clinical activities to other health professionals.

Objective

Skill mix and especially the delegation of tasks from physicians to other healthcare professionals are considered as important issues by the Ministry of Health. The objective is to improve cooperation between doctors and these professionals. Evaluations began in 2005, looking at sharing or transferring tasks from doctors, and involving 14 pilot schemes. These projects have been limited to very precise situations in a few practices, impacting a very limited number of patients and professionals. General recommendations for a widening and further generalization and development of advanced practice nurses have been elaborated under supervision of the HAS (Haute Autorité de Santé) and ONDPS. Three groups managed by leaders made recommendations on economic and organizational issues, education and training issues and regulatory change for health professions.

Findings

Evaluations of pilot projects confirm the feasibility of delegation of tasks in terms of safety and quality. General recommendations for a widening and further generalization and development of the skill mix and new jobs will be produced in early 2008. The main findings and proposals for change in the French context, derived from the
author’s experience of participation in the task shifting process driven by the World Health Organization, were presented in the Addis Ababa meeting in January 2008. The Forum provides a larger audience to whom these findings can be disseminated.
Challenges in scaling up training of health workers: the case of Zambia

Authors

> AC Bowa (contact author), acting director training, Chainama College of Health Sciences, PO Box 33991, Lusaka, Zambia, tel. +260 966 757 212 / 977 858 422 / 211 283827, acbowa@mail.com
> Hans Beks, technical advisor, Chainama College of Health Sciences, Lusaka, Zambia, muraho@iconnect.zm

Context

Chainama College of Health Sciences (CCHS) is the only institution in Zambia for training mid-level health workers. These cadres mostly provide services in rural health facilities. Zambia is facing serious human resources for health (HRH) crisis, with only 50% of public sector establishments staffed. In previous years, CCHS has been increasing student enrolments.

Objectives

Scaling up training requires more than increasing annual student numbers. This presentation describes the challenges involved with scaling up and its consequences, and explores alternative strategies.

Findings

The increase in students created unmanageable and unsustainable situations, as no simultaneous expansion of infrastructure took place.

The total number of students housed at the college in 2006–2007 exceeded the existing capacity by 80%. Only 13 classrooms accommodated 22 classes. Classrooms with a capacity of 40 accommodated groups of 60 students. The teaching staff is overstretched by the high number of students to train, supervise and assess. The college is teaching health and safety regulations, most of which are not implemented at the facility itself.

Despite the existing staff shortages and contrary to the national HRH Strategic Plan, CCHS introduced a student stop for January 2008 and will reduce future enrolments.

Conclusion

Scaling up training of health workers is an important strategy to address the HRH crisis. Increasing student numbers alone creates several problems and compromises quality.
For Zambia, alternative strategies need to be developed for increased training capacity, all of which require major investments. Possible options are expanding existing infrastructure, developing a second national College of Health Sciences, decentralizing existing training to other facilities and introducing alternative training methods (e.g. distance learning and day schooling).

Scaling up should go hand in hand with infrastructure and staff development, requiring careful planning and major investments. Without these, the HRH crisis will only become deeper, with poor-quality products coming from training institutions staffed by burned-out lecturers in dilapidated structures.
The “capacity building pyramid”: a proposed systems model to enhance benefits from training

Authors
> Richard Brough (contact author), PhD, Head of Strategic Planning and Development, Infectious Diseases Institute, Faculty of Medicine, Makerere University, Uganda, tel. +256 782 728 203, rbrough@idi.co.ug
> Lydia Mpanga Sebuyira, BMBCh, MA, MRCP, Head of Training, Infectious Diseases Institute, Faculty of Medicine, Makerere University, Uganda, tel. +256 755 702 266, lmpangasebuyira@idi.co.ug

Context
A technical assistance team supporting a large European Commission health programme in India (1998 to 2004) developed a “capacity building pyramid” (CBP) as a user-friendly guide to effective capacity building, with four interdependent tiers in a hierarchy of needs that should be met for enduring capacity to be developed.
**Concept**

The four tiers (see Figure 1) are:

1. Tools, for example equipment and drugs (performance capacity);
2. Skills (personal capacity);
3. Staff and infrastructure (workload and supervisory capacity, and facility and support service capacity);
4. Structures, roles and systems (three respective capacities).

Each tier both requires the support of lower tiers, and enables the tier above to be effective.

**Objectives**

The Infectious Diseases Institute (IDI) in Uganda (part of Makerere University) aims to build capacity in sub-Saharan Africa in relation to HIV/AIDS and related infectious diseases. IDI uses the CBP to encourage trainees to place their personal development in the context of broader organizational and systems capacity building.

**Methods**

Training builds *personal capacity* (Tier 2) in the health workforce through improvement in skills, but is of limited value without, for example:

- The tools and materials for *performance capacity* (Tier 1);
- Sufficient staff for *workload capacity*, incentives and sanctions for supervisory capacity, reliable power supply to the lab for *support service capacity* (Tier 3);
- Functional management structures and financial systems (Tier 4).

The CBP can also provide a framework to evaluate the likely enduring effectiveness of health-care workforce plans at national, regional and district levels.

**Conclusions and Recommendation**

Building personal capacity in the workforce cannot wait until underlying systems are optimized. However, we recommend that managers consider planning the training of their health-care workforce with reference to the CBP. This will potentially result in greater impact from training programmes through more effective integration with health system development.
Competences profile

Authors

> Francisco Eduardo de Campos, Secretary, Ministry of Health, Brazil, francisco.campos@saude.gov.br
> Ana Estela Haddad, Director, Ministry of Health, Brazil, ana.haddad@saude.gov.br
> Ena Galvão, Coordinator, Ministry of Health, Brazil, ena.galvao@saude.gov.br
> Claudia Marques, Advisor, Ministry of Health, Brazil, claudia.marques@saude.gov.br
> Maria Cecília Ribeiro, Advisor, Ministry of Health, Brazil, cecilia.ribeiro@saude.gov.br
> Marta Coelho, Advisor, Ministry of Health, Brazil, marta.peralba@saude.gov.br
> Maria Bonifácio, Advisor, Ministry of Health, Brazil, maria.bonifacio@saude.gov.br
> Carlos Spezia (contact author), Advisor, Ministry of Health, Brazil, carlos.spezia@saude.gov.br

Context

The Qualification Project for Nursing Area Workers (PROFAE), implemented in 1999, had as its objectives the qualification of workers in the field of nursing who were working irregularly in both the private and public sectors of the National Health System (SUS); and the continuity and sustainability of the qualification programmes at technical level.

Among the actions to strengthen institutions implemented by PROFAE, the Competence Certification System (SCC) aimed to develop strategies, methodologies and evaluation instruments to demonstrate the feasibility of a certification process linked to qualification and to qualitative evaluation.

The concept of competence adopted by the SCC is set within the context of working locations and processes, with health care developed in conjunction with concepts of service that value the professional team and the qualification process.

Two important products were essential to the SCC: (a) the professional competences profile of the nursing auxiliary; and (b) the methodology for qualitative evaluation of professional competences.

The methodology for qualitative evaluation has an educative purpose. It helps the learning process and seeks the professional improvement of all actors involved. The development of the methodology occurred in four stages: (a) objective evaluation
of the knowledge base; (b) evaluation of knowledge of how to be ethical and professional; (c) evaluation of procedures in a virtual environment; and (d) evaluation of procedures in laboratories.

Findings
The development of these actions has contributed to the extension of the competences profile to other health professional categories, publication of reports, implementation of competence profile curricula in the SUS technical schools, and qualitative evaluation and availability of learning objects for professional qualification.
Defining the technological infrastructure for the Brazilian Telemedicine and Telehealth Project for primary care

Authors
- Francisco Eduardo de Campos, Secretary, Ministry of Health, Brazil, francisco.campos@saude.gov.br
- Ana Estela Haddad, Director, Ministry of Health, Brazil, ana.haddad@saude.gov.br
- Chao Lung Wen (contact author), Advisor, Ministry of Health, Brazil, chaolung@terra.com.br, chao@usp.br
- Maria Beatriz Moreira Alkmim, Advisor, Ministry of Health, Brazil, balkmim@yahoo.com.br
- Sérgio Ivan Roschke, Advisor, Ministry of Health, Brazil, roschkes@matrix.com.br
- Carmen Verônica Mendes Abdala, Advisor, Ministry of Health, Brazil, veronica.abdala@bireme.org

Context
The Brazilian Telemedicine and Telehealth Project is an effort that encompasses all areas of the Brazilian territory, involving the combined actions of nine states. The project is coordinated by one university in each of the nine states that has experience in telemedicine and that can afford the necessary infrastructure, such as videoconferencing equipment with bandwidth dedicated to online interaction. This communication network for Internet protocol (IP) videoconferencing was made possible through a partnership between the Department of Health and the Department of Science and Technology. It aimed to create infrastructure for the Brazilian National Network of Research and Education (RNP) and develop a multipoint conference unit (MCU) to host multicentric events. This technological initiative was important because it allowed the different project implementation centres to share their experiences while incorporating the Department of Health guidelines.

Method
An Internet-based system was adopted for the implementation of telemedicine and tele-education for the family health teams. In addition to being less costly, this system imposes less bandwidth requirements, and still meets the needs of the family health teams. The necessary equipment includes a microcomputer with DVD reader, a high-definition web cam, an ink-jet printer and a digital camera with macro capability and compatibility with medical attachments for dermatoscopy, ophthalmology and...
microscopy. Each centre is responsible for establishing and implementing 100 units, and each unit is designed to serve three family health teams.

In each of the centres, an Internet-based virtual clinic (cyber clinic) was created using servers capable of supporting a tele-education environment, video streaming, web conferencing, and a virtual community, in addition to data storage for the learning objects.

To support the clinical practice, resources for distance ECG reports using ECG portable devices and servers to acquire ECG were also implemented.
Pedagogical education

Authors

> Francisco Eduardo de Campos, Secretary, Ministry of Health, Brazil, francisco.campos@saude.gov.br
> Ana Estela Haddad, Director, Ministry of Health, Brazil, ana.haddad@saude.gov.br
> Ena Galvão, Coordinator, Ministry of Health, Brazil, ena.galvao@saude.gov.br
> Valeria Goulart, Advisor, Ministry of Health, Brazil, valeria.morgana@esnsp.fiocruz.br
> Carlos Spezia (contact author), Advisor, Ministry of Health, Brazil, carlos.spezia@saude.gov.br

Context

The qualification of a great number of academicians for professional teaching at the intermediate level is a challenging goal in any area. In the case of the professionals who act in the health-care sector, this requires consideration of the limits imposed by their work conditions, the lack of time to attend conventional classes and the impossibility of commuting to educational centres.

Objectives

The pedagogic educational course was implemented with the aim of supplying the specific demands of the teachers in this area. The reality experienced by these professionals has defined remote education as an appropriate methodological strategy to overcome spatial and temporal distances without surrendering qualified and organic development processes to the educational needs of the National Health System (SUS).

Because of the lack of access to technology of the target audience of the pedagogic educational course, the pedagogical option for remote learning is supported by textbooks of three types (contextual, structural and integrated); a student’s guide in 11 modules; and a tutoring book.

In order to meet the demand to qualify 12 000 nurses/academicians, 482 tutors were initially prepared, aiming to build competences related to interdisciplinary learning skills, scientific research and relevant knowledge production.

Results

The continued education of tutors through remote pedagogic education – the Seiva Project – was performed in three classes, with the participation of 323 tutors. The result was the graduation of 13 611 specialists.
Objectives
The Brazilian Telehealth Project focuses on increasing the capacity of professionals that work in family health teams to improve the services delivered to the population, and increase the efficacy of the National Health System (SUS).

In order to achieve this goal, the qualification process is based on two foundations: (a) continuous professional development; and (b) establishment of an educational second opinion in addition to the professional competency that fits the characteristics and meets the needs of each region.

Methods
Interactive tele-education was adopted in order to expand professional development to a national level. This combines distance learning resources with virtual clinic resources, learning objects (for example Virtual Man, a tool based on 3D computer graphics that allows dynamic and realistic teaching) and units of knowledge (videos scripted to address topics relevant to the clinical practice).

Content development follows a methodology that allows training to be based on sound scientific evidence, implemented in accordance with SUS health-care characteristics, and aligned with Department of Health policies. The method involved the following steps: (a) identification of the competencies targeted for each professional group; (b) content development based on scientific evidence; (c) a review of scientific material in order to better adjust to the characteristics of clinical practice in primary care and
SUS infrastructure; (d) development of supporting iconographic materials and units of knowledge; (e) educational materials revised and modified by a team of journalists in order to refine their communicative style; (f) development of evaluation tools and competencies; and (g) submission of materials to the Department of Health.

To provide family health teams with scientific literature, a virtual library specialized in primary care was created with the support of Bireme/OPAS (www.telessaudebrasil.org.br), which is one of the references used for the educational second opinion.
The PROFAE experience

Authors
> Francisco de Campos, secretary, Ministry of Health, Brazil, francisco.campos@saude.gov.br
> Ana Estela Haddad, director, Ministry of Health, Brazil, ana.haddad@saude.gov.br
> Ena Galvão, coordinator, Ministry of Health, Brazil, ena.galvao@saude.gov.br
> Mônica Duraes, advisor, Ministry of Health, Brazil, monica.duraes@saude.gov.br
> Euzi Rodrigues, advisor, Ministry of Health, Brazil, euzi.rodrigues@saude.gov.br
> Carlos Spezia (contact author), Ministry of Health, Brazil, carlos.spezia@saude.gov.br

Context
The Qualification Project for Nursing Area Workers (PROFAE) was introduced by the Ministry of Health (MoH) in July 2000. Its main intention was to improve the quality of outpatient facilities and hospital services in Brazil, particularly in National Health System (SUS) establishments where nursing staff at medium level lacked full qualifications and were working irregularly.

According to estimates of the Ministry of Health, there were about 225 000 medium- or elementary-level workers performing nursing tasks without the qualification required by law, both in the public and private networks. The goal of PROFAE was to qualify this contingent in four years (2000–2004).

It is estimated that approximately 46 000 (24%) had not concluded elementary school, an imperative condition for professional certification as a nursing aide. PROFAE aimed to qualify these people so that they could be properly defined as nursing aides and technicians.

The project was financed by the International Development Bank (US$185 million), FAT resources (Ministry of Labour) (US$130 million), and the MoH (US$55 million).

Results
The results: 207 844 graduated nursing aides, 80 124 graduated technical nurses, 13 611 skilled academicians (professional education specialists) and 482 graduated tutors. Results concerning the technical schools: 37 modernized SUS technical schools, 11 newly established SUS technical schools (ETSUS), 9 financed architectural projects, 5 restored schools, creation of the SUS Technical School Network (RET-SUS), Publication and monthly circulation of the RET-SUS journal and 30 research projects were presented.
The SUS technical schools and eHealth Brazil

Authors
> Francisco Eduardo de Campos, Secretary, Ministry of Health, Brazil, francisco.campos@saude.gov.br
> Ana Estela Haddad, Director, Ministry of Health, Brazil, ana.haddad@saude.gov.br
> Ena Galvão, Coordinator, Ministry of Health, Brazil, ena.galvao@saude.gov.br
> Núbia Brelaz Nunes, Advisor, Ministry of Health, Brazil, nubia@saude.gov.br
> Maria de Fátima Marques, Advisor, Ministry of Health, Brazil, maria.marques@saude.gov.br
> Carlos Spezia (contact author), Ministry of Health, Brazil, carlos.spezia@saude.gov.br

Context
The National Health System technical schools (ETSUS) are mostly linked to the state secretariats for health. They were created to qualify health workers at technical level and are very important partners in the process of qualifying health professionals for the National Health System (SUS), and are now playing a crucial role in the National Pilot Project on eHealth Supporting Brazilian Primary Care.

Objectives of the ETSUS
The participation of the ETSUS increases the likelihood of reaching the general objective of the project, which is improvement of the services rendered to primary care. The qualification process of the Family Health Strategy will benefit from the use of technology to promote tele-education, encouraging dynamic solutions to the problem of providing primary care to the Brazilian population.

Conclusions
The ETSUS will facilitate development of qualification projects, digital inclusion of primary care health professionals, structuring the consultancy system and the provision of second opinion, integration between family health team professionals and SUS managers, and promotion of the integration of service and teaching.

The ETSUS will also help rank local and regional needs, participate in priority decision-making processes, construct syllabuses for the qualification courses for teachers and health workers, support the Distant Education Qualifying Project, elaborate didactical resources for eHealth, promote videoconferencing, give second opinions, carry out research through tele-education and participate in the production of knowledge resources for primary care.
Health systems strengthening for equity: the power and potential of the mid-level provider/non-physician clinician

Authors

Helen de Pinho, Averting Maternal Death and Disability Program (AMDD), Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University, 60 Haven Avenue, B3, New York, NY 10032, USA, tel. +1 212 304 5229, hd2122@columbia.edu

Staffan Bergstrom, PhD, Division of International Health (IHCAR), Karolinska Institute, Stockholm, Sweden, and AMDD Mailman School of Public Health, Columbia University, NY, USA, staffan.bergstrom@ki.se

Caetano Pereira, Licenciatura de Medicina, Especialista de Obstetricia e Ginecologia Clinician, Institute of Health Sciences, Maputo, Mozambique, pecaetano@yahoo.com.br

Garvey Chilopora, MBBS, University of Malawi, College of Medicine, Blantyre, Malawi, garveychip@yahoo.co.uk

Eilish McAuliffe, MSc, MBA, Centre for Global Health, Trinity College, Dublin, Ireland, eilish.mcauliffe@tcd.ie

Context

There is an urgent need for human resources solutions to meet the crisis in health systems, and in maternal and newborn mortality in particular. Mid-level providers (MLPs), also known as non-physician clinicians, have been delivering essential clinical and surgical services in many countries in Africa for decades, yet they are often underrepresented in health strategies.

Objectives

The proposed panel will present findings from Malawi, Mozambique and Tanzania on mid-level providers as a key ingredient in life-saving obstetric and surgical care for the reduction of maternal and neonatal mortality.

Findings

In all three countries, MLPs perform over 80% of caesarean sections at district hospitals; and a prospective assessment of MLPs in Malawi and Mozambique demonstrates that they have comparable operative outcomes to medical doctors, with case fatality rates (CFR) of 2% or less. Studies in Mozambique provide an overall picture of the emergence of técnicos de cirurgia over several decades, along with data on retention rates and cost-effectiveness of training and deployment. Additional research in Malawi reveals the main factors impacting retention and performance of MLPs: limited opportunities for career development; insufficient
financial remuneration; and inadequate or non-existent human resources management systems.

**Conclusions**

The experience of these three countries demonstrates that with appropriate training and support, MLPs are a valuable part of the comprehensive workforce needed to strengthen health systems equitably, and reduce maternal and newborn mortality. If all women with complicated deliveries could have access to hospitals with this 2% CFR, the maternal mortality ratio would be expected to fall by 75%. But achieving this will require adequate hospital facilities and referral systems, the presence of competent staff and a significant increase in met need. Utilization of MLPs has the potential to facilitate a rapid expansion of good quality, cost-effective maternal and newborn health-care services.
The Sewankambo Clinical Scholars Programme: a model for research capacity building in Uganda

Authors
> Philippa Easterbrook (contact author), professor, head of research, Infectious Diseases Institute, Makerere University, Kampala, Uganda, tel. 0773 132508, peasterbrook@idi.co.ug
> D Thomas, Infectious Diseases Institute, Makerere University, Kampala, Uganda
> P Nabunya, Infectious Diseases Institute, Makerere University, Kampala, Uganda
> K McAdam, Infectious Diseases Institute, Makerere University, Kampala, Uganda
> A Coutinho, Infectious Diseases Institute, Makerere University, Kampala, Uganda

Context
The lack of a critical mass of experienced senior researchers within many institutions across sub-Saharan Africa remains a key impediment to the development of a productive and sustainable research culture. Well-recognized barriers to recruitment and retention include lack of a defined career path, poor remuneration, lack of protected research time, lack of an effective supporting IT or administrative infrastructure and limited training opportunities in research skills.

Objective
The Infectious Diseases Institute (IDI), Makerere University, Uganda, is a regional centre of excellence for HIV/AIDS treatment, research and training in sub-Saharan Africa. In response to these concerns, in 2006 IDI established a research capacity building initiative, the Sewankambo Clinical Scholars Programme, to develop five independent investigators over five years. We describe the current status of the programme and evaluate lessons learned.

Methods
The Gilead-funded programme currently supports five scholars (two in year 1, and three in year 2). Specific features of the programme are enhanced monthly stipends above the usual remuneration rate; $20 000 per year in years 2 and 4 for research project expenses, and $3000 per year for attendance at conferences; protected time (80%) for research; excellent IT and administrative support; mentoring teams that will help develop them to international status; and biannual appraisals by an international scientific panel.
New findings and lessons learnt
The five scholars have research interests in HIV-hepatitis coinfection, HIV pharmacokinetics, HIV drug resistance, epidemiology and pathogenesis of HIV immune reconstitution syndrome, and sociobehavioural aspects of adolescent HIV infection. Overall, they have presented 14 abstracts at national and international conferences; published five papers; and supervised four local Masters theses. Key challenges encountered and solutions offered were (a) insufficient number of local senior mentors with expertise in the scholar’s areas of interest, which has been rectified by additional mentorship from international collaborators; (b) lack of an initial grounding in research methods, addressed by attendance at a 12-week module in epidemiology and biostatistics, from the ongoing Masters in Clinical Epidemiology at Makerere; (c) preference for PhD registration at European institutions to avoid bureaucratic delays at Makerere University (there is a need to incentivize students to register for local PhDs by streamlining administrative procedures); and (d) constant encroachment on protected research time from clinical duties.

Conclusions
The Sewankambo Clinical Scholars Programme will create academic leaders, who will in turn provide much-needed mentorship to another generation of young Ugandan investigators. Improvement and expansion of the programme requires additional committed senior mentors, and development of a local part-time modular Diploma in Clinical Research, with incentivization for PhD registration at Makerere rather than overseas institutions.
What’s stopping us? Needs, approaches and impediments to scaling up graduate level primary health workers’ education and training.

Authors
> Meenakshi Gautham, public health scientist, e-mail: Gautham.meenakshi@gmail.com
> K.M. Shyamprasad medical, educationist and Vice President of the National Board of Education of the Min. of Health and Family Welfare, Govt. of India, Chancellor of the Martin Luther University, Northeastern state of Meghalaya, India

Context
In many parts of the world, fully trained medical professionals are not available to the rural and disadvantaged populations that need them the most. To meet this ‘human resource crisis’, different levels and categories of mid-level cadres perform a variety of health care functions long held as the preserve of the professional cadres. In this paper we (a) argue that the predominant Western-European model of medical education has not been able to meet global human resource (HR) needs and it is time to plan alternative efforts, and (b) identify impediments to these efforts.

Findings
We identify key constraints in alternative HR production and performance. These include the following: lack of an enabling legislative climate made worse by the ‘turf protection’ mind-set of medical professionals; the profession’s selective bias for urban, privileged students; the communication challenges of reaching out and training rural youth; and ensuring continuous learning and quality standards of alternative cadres.

We present a model that we are currently developing to strengthen the existing reservoir of informal rural medical practitioners who do not have a statutory medical qualification but who are the sole providers of health care in rural India. The model rests on low cost internet technology to provide interactive distance learning material in the vernacular to village practitioners. Software that integrates patient records with diagnostic flowcharts will be piloted as a performance cum quality assurance tool. We describe some of our start up processes, challenges, and the lessons learned in developing and initiating this model.

Conclusions
Four key factors must be addressed to set up scalable models for development of
alternative HR cadres. First, archaic legal provisions that ‘outlaw’ anyone who is not a university trained medical graduate must be amended. Second, conventional classroom pedagogy must give way to innovative methods that can provide equitable access to students even in far flung villages. Third, all educational material must be available in local regional languages. Fourth, a system of continuous learning and supportive supervision must be in place for quality assurance.
Option for Multi-tasking or Multi – Skilling of Health workforce in India- a multi centric study

Author
> Dr. Subash Chandra Ghosh, Technical Officer, National AIDS Control Organisation, India
> E-mail: subash.ghosh@gmail.com 52/40, Chittaranjan Park, New Delhi-19, Tel: 91-9212584667

Context
As part of its commitment to the MDGs the government of India and the National Health Policy, 2002 has introduced the National Rural Health Mission- NRHM (2005-12). This seeks to provide effective healthcare to rural populations throughout the country, with a special focus on 18 states which have weak public health indicators and/or weak infrastructure.

Objective/Purpose
NRHM has introduced a newer concept of Health Workforce through activism called ASHA (Accredited Social Health Activist) to strengthen the service delivery at community level.

Methods
This multi-centric study was conducted in three states – Assam, Orissa and Jharkhand to understand the requirements of multi-skilling and multi-tasking the existing health workforce at the village level in order to maximize their contribution. Existing differences are as follows:

<table>
<thead>
<tr>
<th>Health Worker (Female)</th>
<th>ASHA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation Unit</td>
<td>3,000-5,000 population</td>
</tr>
<tr>
<td>Basic Qualification</td>
<td>Formally Qualified- Degree</td>
</tr>
<tr>
<td>Provision for training</td>
<td>Institutional for a period of 2 yrs</td>
</tr>
</tbody>
</table>
### Table: Training Contents, Recruitment Process, Motivational Factors

<table>
<thead>
<tr>
<th>Training Contents</th>
<th>Basic Health Care Delivery, RCH</th>
<th>Personal Hygiene, Nutrition, Counselling, Promotion of Contraception and Family Planning, RCH and STI/HIV, TB, Diarrhoeal Diseases, Child Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment Process</td>
<td>Recruitment through written test, merit, personal interview</td>
<td>Selection through village health committee</td>
</tr>
<tr>
<td>Motivational Factors</td>
<td>Official recognition, honorarium, definite accountability and reporting structure</td>
<td>Recognition is restricted to committee, no honorarium, no definite accountability and reporting. She is entitled for performance based- incentives – which is based on the number of beneficiaries mobilized and the respective departments extended their cooperation towards achieving these.</td>
</tr>
</tbody>
</table>

The study was conducted in three sub health centres (unit of health activity) of each state.

The study reviewed the available literature, interviewed health workers (female), ASHA, medical officers in concerned PHCs and collected data on work load assessment, skills and conducted a task analysis and measured expectations through a structured survey and interaction with beneficiaries during field visits.

### Findings and Conclusions

The study highlighted three critical areas. First, motivational factors like skill building on counseling and community involvement (an honorarium will help to retain the ASHAs at village level). Second, adequate availability of logistics for information (commodities will make ASHA more acceptable). Third, coordination between different players providing health care is needed to reduce duplication of services.
Conclusions and recommendations

The study recommends to invest more on skill building and introduce minimum wages as honorarium for AHSA, however the performance based incentive can be applicable for both Health Worker(Female) and ASHA. Also it is recommended that the retention of these ASHA at village level need to be strengthening through creation of village level health funds through in-kind community contributions.
Lutte contre le paludisme de l’enfant en Afrique subsaharienne : quel rôle pour les professionnels de la santé pour une plus grande efficacité ?

Auteurs
Houéto D, D’Hoore W, Ouendo EM, Charlier D, Deccache A
D. Houéto, MD, MSc, PhD. Centre de Recherche pour le Développement de la Promotion de la santé en Afrique - 07BP1411 Sainte-Rita, Cotonou, Bénin
Tél. +22995406568   Mél: dhoueto@yahoo.fr

Contexte
Le paludisme reste la principale cause de mortalité infantile en Afrique subsaharienne malgré les importants moyens mis en œuvre par plusieurs programmes. L’atteinte des Objectifs du Millénaire pour le Développement (n°4 en particulier) lui est fortement liée.

Objectif
Réduire de façon significative la mortalité infantile due au paludisme par la responsabilisation des parents et une réorientation du rôle des professionnels de la santé.

Méthodes
Recherche-action participative à base communautaire confiant à la communauté la responsabilité de l’identification des problèmes, des solutions et de la mise en œuvre des actions pour la lutte contre le paludisme de l’enfant. Les professionnels de la santé jouent un rôle de conseillers, accompagnateurs et de référents, veillant à la cohésion sociale, à la conscience critique et au capital communautaire, plutôt qu’au rôle traditionnel de dispensateurs de soins sans participation ni appropriation par la communauté. Un dispositif quasi-expérimental pré-post, pilote-témoin a été mis en place pour mesurer les effets de l’intervention.

Résultats
La communauté a initié sept activités : traitement domiciliaire précoce de la fièvre par les mères (incluant la disponibilité des antipaludiques dans le village et la formation à leur utilisation) ; utilisation de moustiquaires imprégnées, (prenant en compte l’accessibilité géographique et financière) ; mise en place d’une mutuelle de santé ; initiation de différentes activités pour l’amélioration des revenus des parents ; adoption d’un type d’habitat permettant la protection contre la piqûre des moustiques ; scolarisation systématique des enfants du village ; alphabétisation des adultes.
Conclusions

Il a été constaté un changement dans les perceptions de la fièvre de l’enfant, une modification des recours plus favorable pour des soins adéquats, une réduction des cas graves de paludisme de l’enfant et de la mortalité qui lui est due. S’en remettre aux populations pour la lutte contre le paludisme de l’enfant est en mesure de réduire de façon significative la mortalité qui lui est due tout en reconsidérant le rôle joué par les professionnels de santé.
Le développement des ressources humaines dans le secteur de la santé en Haïti

Auteur

> Marie-Gloriose Ingabire, Ph.D.
Adresse Électronique: ingabirm@paho.org

Contexte

La situation sanitaire en Haïti, comme le montrent certains indicateurs sanitaires des dernières années, est très difficile. Elle constitue un obstacle majeur pour toute stratégie cohérente de croissance, réduction de la pauvreté ou développement humain.

Les besoins en matière de ressources humaines (RH) dans le secteur de la santé sont criants. En effet, Haïti est un des pays en crise, avec moins de 25 professionnels de la santé pour 10.000 habitants.

Objectifs

Le renforcement du système de santé haïtien et l’amélioration de l’état de santé des haïtiens, requiert entre autres, le développement des ressources humaines en quantité et en qualité, avec une distribution adéquate en termes géographique et des compétences.

C’est ainsi que l’OPS, en collaboration avec le Ministère de la Santé Publique et de la Population (MSPP) et les autres intervenants, développe un projet d’expansion du marché du travail dans le secteur de la santé en Haïti.

Résultats

Le développement du projet s’appuie sur les discussions et recommandations du groupe thématique sur les ressources humaines, formé dans le cadre du Forum de Réalignement de la Réforme du Secteur Santé en Haïti. Ce Forum constitue un espace de dialogue, de conception et de suivi des planifications opérationnelles spécifiques dans le secteur de la santé.

Conclusions/recommandations

Plusieurs facteurs sous-tendent le développement du projet et la réponse à la crise des ressources humaines dans le domaine de la santé en Haïti. Entre autres, le renforcement du MSPP dans son rôle de leader dans le développement des RH, la concertation et la
The effectiveness of community health worker programmes: new findings from a Cochrane systematic review of trials

Authors

> Simon Lewin, Senior Lecturer, Medical Research Council of South Africa and London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK. Email simon.lewin@lshtm.ac.uk. Author for correspondence.
> Susan Babigumira, Researcher, Norwegian Knowledge Centre for the Health Services, Norway. Email Susan.Munabi-Babigumira@kunnskapssenteret.no
> Xavier Bosch-Capblanch, Deputy Head, Systems Performance & Monitoring Unit, Swiss Tropical Institute, Switzerland. Email x.bosch@unibas.ch
> Claire Glenton, Researcher, Norwegian Knowledge Centre for the Health Services, Norway. Email claire.glenton@kunnskapssenteret.no
> Karen Daniels, Scientist, Health Systems Research Unit, Medical Research Council of South Africa, South Africa. Email Karen.daniels@mrc.ac.za
> Brian van Wyk, Senior Lecturer, School of Public Health, University of the Western Cape, South Africa. Email bvanwyk@uwc.ac.za
> Godwin Aja, Senior Lecturer, Department of Health Sciences, Babcock University, Nigeria. Email gndaja@yahoo.co.uk
> Merrick Zwarenstein, Senior Scientist, Li Ka Shing Knowledge Institute and Associate Professor, Department of Health Policy, Management and Evaluation, University of Toronto, Canada. Email merrick.zwarenstein@utoronto.ca
> Andy Oxman, Researcher, Norwegian Knowledge Centre for the Health Services, Norway. Email oxman@online.no
> Inger Scheel, Research Director, SINTEF Health Research, Norway. Email Inger.B.Scheel@sintef.no

Context

Interest is growing in the use of community or lay health workers (CHWs) for the delivery of health services in low and middle income countries. However, robust evidence of their effectiveness is needed.

Objective

To review evidence from randomized controlled trials (RCTs) on the effects of CHW interventions in primary and community health care.

Methods

Multiple databases and reference lists of articles were searched for RCTs of CHW interventions.
HIV/AIDS Training Needs Assessment for Clinicians in ART clinics in Uganda: A study conducted by Infectious Diseases Institute (IDI) and Ministry of Health (MoH), 2006

Authors
- Ibrahim M. Lutalo, Mstat (Bio), Infectious Diseases Institute, Makerere University, Kampala
- Gisela Schneider, MD, DIFAEM, German Institute of Medical Mission, Tuebingen, Germany,
- Marcia Weaver, PhD, Department of Health Services and International Training and Education
- Centre on HIV, (I-TEC), University of Washington, Seattle
- Lydia Mpanga Sebuyira Infectious Diseases Institute, Makerere University, Kampala
- Jessica Oyugi, Infectious Diseases Institute, Makerere University, Kampala
- Richard Kaye, African Palliative Care Association, Kampala Uganda
- Frank Lule, MPH, Ministry of Health, Kampala, Uganda
- Michael Scheld, MD, Department of Internal Medicine, University of Virginia, Charlottesville, VA
- Keith McAdam, FRCP, FWACP, Department of Clinical Tropical Medicine, London School of Hygiene and Tropical Medicine, UK Pratt Medical Group, Tufts New England Medical
- Centre, Boston MA
- Merle A. Sande, MD Department of Medicine, University of Washington, Seattle, WA and Academic Alliance Foundation, Arlington, VA

Context
Several experts recommend “task shifting” among health care teams in a bid to scale-up access to anti-retroviral therapy (ART) especially in resource constrained settings. For its successful implementation, appropriate training of clinicians in relevant skills of ART is crucial. Hence, IDI together with MoH conducted a nationwide Training Needs Assessment, in 2006, targeting clinicians involved in ART provision.

Objective
To establish clinicians prescribing ART as well as determine ART training needs in the context of on-going scaling up of ART provision in Uganda.
Methods
A sample of 265 clinicians in a stratified random sample of 44 health facilities providing ART in 6 regions reported on their tasks, previous HIV training, self-assessment of knowledge and skills; and ART training needs.

Results
Ninety percent of doctors, 60% of clinical officers (COs), 14% of nurses and 24% of midwives working in accredited ART clinics reported prescribing ART (p<0.001). For initiating ART, 76%-doctors, 62%-COs, 62%-nurses and 51%-midwives were trained (p=0.457); while 73%, 46%, 50%, and 23% respectively trained in monitoring patients on ART (p=0.017). Seven percent of doctors, 42% of COs, 35% of nurses, and 77% of midwives prescribing ART assessed their knowledge and skills in ART as insufficient (p=0.001). While doctors reported a training need in HIV research (59%), Pediatric HIV care (50%), ART (44%) and ART program management (47%); priority training areas for non-doctors included Pediatric HIV care (57%), ART (47%), Training of trainers (32%), HIV research (23%) and Opportunistic Infection treatment (21%).

Conclusion
Task shifting is evident in HIV/AIDS care in Uganda. While a few non-doctors were trained in ART, high proportions of them who prescribe ART perceived their knowledge and skills as inadequate. Hence, training strategies should be developed to support task shifting for correct use of ART so as to avoid toxicity/drug resistance that may reverse current impressive accomplishments.
The role of ‘expert friends’ in HIV/AIDS counseling and social support: lessons from Kampala.

Authors
> B.M. Lutimba (Infectious Diseases Institute, IDI-KCC collaboration Project, P.O.Box 22418 Kampala, Tel: +256-772-687577, mutebib@yahoo.com), Emma Nabunnya (IDI) and Beth Naluyima (Kisenyi Health Center).

Context:
Kampala is one of the worst HIV/AIDS affected cities in the world creating an ever increasing burden on existing health services and communities. The Ugandan civil service has no cadre of counselors for people living with HIV/AIDS (PLWHAs) and hence counseling is often provided by volunteers. A collaboration project between Kampala’s Infectious Diseases Institute and the Kampala City Council (IDI-KCC project) noted that PLWHAs experienced high stigmatization and weak relationships with their health care workers and counselors.

In an attempt to break this cycle, the dynamics and discourse associated with care-worker/patient relationships were changed. PLWHAs became “our friends” instead of “patients”. “Friends” who were able to talk to other PLWHAs and promote adherence to treatment were referred to as “Expert friends”.

Methods
Active ‘expert friends’ were identified, trained and mentored in general ART and adherence counseling. They were deployed at 4 Kampala City Council Clinics to apply their skills and share their experiences with fellow ‘friends’.

Lessons
In the urban setting of Kampala a new dynamic and discourse has been created, ‘expert friends’ have been trained to play a major role in providing HIV/AIDS counseling and adherence to treatment. Over 2,100 ‘friends’ now receive social support, pre-ART counseling and adherence counseling and general counseling at the different KCC clinics. Stigma is reducing and the much needed solidarity for PLWHAs is emerging. Volunteer counselors have noted the new skills of ‘expert friends’.

Conclusions
In an urban setting like Kampala, an integrated ‘expert friend’ approach to counseling and peer education to PLWHAs can improve drug adherence and reduce levels of stigma. Counselors for PLWHAs should be included in the government’s cadre of health workers.
Non-physicians performing caesarean sections: a review

Authors
> Mariah McNamara, MD, Center for Global Health, Massachusetts General Hospital, and Harvard Medical School
> Lydia Mann-Bondat, MPH, MS, Center for Global Health, Massachusetts General Hospital
> Thomas F Burke, MD, FACEP, Center for Global Health, Massachusetts General Hospital, and Harvard Medical School

Introduction
At of the beginning of the twenty-first century 99% of maternal deaths occur in the developing world, where a woman’s lifetime risk of childbirth-related death is often 1 in 6 to 1 in 16. Approximately 70% of maternal deaths in Africa are due to obstetric complications, including postpartum haemorrhage, sepsis, hypertensive disease and obstructed labour. It is usually impossible to predict these complications in advance, which makes ready access to life-saving interventions vital. In response to the human resource crisis non-physicians are performing caesarean sections in many under-resourced environments; however, little is known about effectiveness, quality or impact.

Methods
An extensive review was conducted of peer-reviewed publications and publicly available information on the subject of non-physicians performing caesarean sections. Corroborating information was sought from key informants when peer-reviewed publications were unclear.

New findings
Thirteen African countries utilize non-physicians to perform caesarean sections. Three countries have analysed non-physicians caesarean section outcomes and one study in Mozambique assessed the economics of trained medical officers performing major obstetric surgery.

Conclusions and lessons learned
Training non-physician cadres to perform caesarean sections and other surgical procedures has been occurring in Africa for decades. Despite this, few assessment or outcome studies have been conducted. Non-physician clinicians are performing caesarean sections in a number of African countries. The costs of training and salary are less than for doctors, and non-physician clinicians are more likely to stay and practise in underserved areas. While outcomes studies are few in number it is
reported that outcomes are comparable to those of physicians. Further research is needed on outcomes and impact, models for optimal knowledge and skills transfer, and scaling and replicating.
Emerging solutions for workforce challenges facing the HIV epidemic: change agents in Uganda

Authors
> Keith McAdam (contact author) Infectious Diseases Institute, Makerere University, Kampala, Uganda  keith.mcadam@lshtm.ac.uk
> Sarah Ssali, Leah Thayer, Simon Sentesa, Caleb Twijukwe and Andrew Kambugu (Infectious Diseases Institute, Makerere University, Kampala, Uganda);
> Glenn Wagner and Gery Ryan (Rand Corporation, California)

Context
The current medical paradigm, which has been so successful at managing the HIV epidemic in affluent countries, is being stretched to the limit in Africa. It is evident that a more inclusive societal response will be required, in the context of inadequate medical staffing and facilities. In Uganda HIV prevalence has dropped from more than 18% in 1992 to less than 7% in 2005, but incidence has stabilized. The 100,000 currently taking ART in Uganda will swell to 1,000,000 by 2015, even if all transmission were to cease today. In fact 130,000 new infections are predicted in 2008; and, alarmingly, over half of stable couples with one HIV-positive member are discordant (Uganda HIV/AIDS Sero-Behavioural Survey, 2004-2005). The current trend is to open more and more clinics to manage the demand for care. An alternative approach is to prepare those who are infected with the virus, who represent an available and enthusiastic potential work force, to play a greater role in promoting prevention, disclosure, adherence and stigma reduction.

Objectives
To enable people living with HIV to serve as change agents within their social networks and communities. The hypothesis is that empowering people living with HIV, using appreciative training techniques, will enable them to influence behavior, attitudes and well being within their own social networks, and among networks of community organizations.

Methods

Design
- Randomized controlled trial: lottery selection among IDI clients living within 2km of targeted clinics
- Step-wedge design: individuals act as controls until receiving the intervention
- Network analysis: analyze changes in individual and organizational networks
Instruments

• Training program (adapted from Stepping Stones), utilizing Appreciative Inquiry
• Interview assessments every three months over 18-months to assess participants’ behaviour change
• Social network analysis to assess behaviour change among participants’ networks
• Mapping qualities of community care groups before and after intervention to assess impact on community organizations
• Economic analysis—average and marginal cost

Anticipated Results

This approach is designed to evaluate important outcomes including changes in participants’ behaviour, attitudes and well-being (measured by weight, CD4 and stigma/mental health); improved adherence and reduced risk behaviour (measured by pill counts, viral loads and condom usage); improved disclosure and advocacy; changes in behaviour of participants’ social network members; and changes in utilization of community care assets; in quality of HIV-related care they provide; and in supportive linkages between them.

Findings about how to make this model work will have important implications for health workforce programming in relation to HIV care in urban Africa.
Strengthening the system to use current administrative data at the Uganda Nurses and Midwives Council to identify the number of trained and registered nurses and midwives

Authors

> Pamela A McQuide (contact author), RN, PhD, Senior Workforce and Policy Advisor, IntraHealth International/Capacity Project, 6340 Quadrangle Drive, Suite 200, Chapel Hill, NC 27517, USA, tel. 919 313 9167, mobile 919 622 1644, pmcquide@capacityproject.org
> Rita Matte, Registrar, Uganda Nurses and Midwives Council, rita.matte@health.go.ug
> Vincent Oketcho, In-Country Coordinator, IntraHealth International/Capacity Project, voketcho@capacityproject.org
> Margaret Chota, Commissioner of Nursing Services, Uganda Ministry of Health, margaret.chota@health.go.ug

Context

Nurses, doctors and other health professionals form the backbone of a country’s health system. However, in many countries there is a lack of reliable, current and accessible health workforce information. The Capacity Project has been collaborating with the Uganda Ministry of Health and the Nurses and Midwives Council to use a participatory process to implement a human resources information system that gives current information about all nurses and midwives trained, registered, licensed and working in the country.

Objectives

- Describe a participatory process undertaken in Uganda to develop a human resources information system on the country’s trained and qualified nurses and midwives;
- Share results about the number of trained and registered nurses and midwives;
- Identify how these data can be used to improve planning and management of the health workforce.

Methods

Based on key policy questions developed by principal stakeholders, the Capacity Project installed a certification and licensing information system that tracks all nurses in Uganda from the time they enter pre-service training until they leave the
workforce. Developed by the Capacity Project, the software collects and aggregates data on a country’s health workforce. Team members analysed data using built-in report functions and geographical mapping tools.

**New findings**

Since 1970, Uganda has trained 28,064 student nurses and midwives; 21,011 of them have passed the examination and 16,739 have become registered. There is a significant gap between the number of those who are trained and those who receive licensure. These results vary according to the district in which students were trained. These data assist in targeting improvements by districts most in need and in ensuring that all health workers are registered with their regulatory authority so that only qualified health workers are hired.

**Conclusions**

These data inform policy-makers, educators and regulatory authorities about the number of trained and licensed health professionals in the country. They can be used by health system managers to ensure that only health professionals in good standing with the regulatory authorities are hired and deployed at health facilities across the country. The data can also be used for planning training and deploying health workers according to region and cadre; identifying areas that need particular attention; and tracking and planning continuing professional development.
Resetting the goalposts for effective post-service medical training: quality monitoring, self-study and post-classroom follow-up

Authors
> Ann Miceli (contact author), MA, training advisor, Lighthouse Trust, I-TECH Malawi, Malawi, a_miceli@lighthouse.org.mw
> Andreas Jahn, MD, MSc, M&E advisor, Lighthouse Trust, I-TECH Malawi, Malawi, a_jahn@lighthouse.org.mw
> Samuel Phiri, PhD, executive director, Lighthouse Trust, Malawi, samphiri@lighthouse.org.mw
> Matt Boxshall, management advisor, Lighthouse Trust, Malawi, m_boxshall@lighthouse.org.mw

Context
Post-service capacity building among health workers is critical to improving standards of care. Despite standardized national curricula, quality of training remains low. Challenges include knowledgeable but unprepared facilitators, poor planning and nonrational participant selection. During training, participants receive a daily subsistence allowance (DSA) typically exceeding three days’ salary, creating “DSA culture” – positioning training as financial reward rather than an educational end in itself.

Objectives
Lighthouse set out to improve training quality, devise new approaches and reduce the negative impact of DSA.

Methods
Quality improvement tools were developed to support planning, performance and supervision. Self-study (no DSA) became a prerequisite for classroom training (with DSA). Mentoring programmes strengthened post-training follow-up. DSA was reduced by 25%.

New findings
Quality improved but challenges remain. Many supervisors continue selecting participants according to seniority, rotation (“it’s your turn”) and favouritism. Such participants leave critical gaps at duty stations and often never work in the trained capacity or are near the end of their career.
Self-study programmes were promising: trainees saw classroom training (and DSA) as significant incentive to complete self-study.

DSA encourages prioritizing training over regular duties. This was evident from 88 scheduled mentoring sessions – only 27 (31%) of staff were found at their duty stations. High absenteeism has serious implications for service provision. There is great resistance to non-DSA educational opportunities.

Conclusions
Strong, sustained focus on quality improvement offsets DSA culture. Self-study should be an entry point to classroom training; plans should include post-classroom follow-up. The balance between salaries and DSA needs to be urgently redressed. Donors should insist on quality indicators rather than reporting numbers of people trained.
Working to Reduce Maternal and Neonatal Mortality and Morbidity through Ghana Health Services Capacity Building and Setting Performance Standards

Authors
> Yaa Frimpomaa Mensah, MBA, Jhpiego, P.M.B. 18, Legon Accra – Ghana - Email: yfmensah@jhpiego.net, Phone: 233-21-500957
> Sharon Kibwana, MPH
> Udaya Thomas, MSN, MPH
> Joyce Ablordepepey, MCmmH, PHN, SRNM
> Martha Appiagyei, B Ed, PHN, RM, SRN

Context
Ghana, like many other countries in sub-Saharan Africa, has high rates of maternal and neonatal mortality and morbidity. Despite significant strides made by the government, access to quality reproductive health services has remained poor, especially within rural Ghanaian communities. According to the GHS, the maternal mortality rate for 2005 was 197/100,000 live births.

With funding from the United States Agency for International Development (USAID), JHPIEGO, under ACCESS, in collaboration with the GHS, has been implementing a “Repositioning Safe Motherhood” project since February 2007, in an effort to address this issue.

Objective
The overall program goal is to increase demand and utilization for quality basic emergency obstetric and newborn care (BEmONC) services in selected government facilities in the Birim North District, Eastern Region of Ghana.

Using a performance quality improvement approach called Standards-Based Management and Recognition (SBM-R), JHPIEGO is orienting facilities to the use of observable performance standards and on-site demonstration and coaching to improve BEmONC competencies. SBM-R tools are also being utilized for continual assessment to help facility teams to ultimately achieve at least 85% of all performance standards. Furthermore, documentation of service statistics has been reinforced and is being monitored.

Findings and Conclusions
In comparison to the baseline data, data after six months from facility Health Management Information Systems show marked improvements in the target indicators
of active management of the third stage of labor (AMSTL), and partograph usage. The data demonstrate that these improvements were after training (in identified gaps), supportive supervision, and coaching with a locally agreed upon performance improvement tool.

It is anticipated that the combination of training, supportive supervision and supply of essential equipments for maternal and neonatal health care at the selected facilities will lead to an increase in the number of women who access such services, and ultimately decrease maternal and neonatal mortality and morbidity rates.
Counting public health workers: global challenges in enumerating the public health workforce (PHWF)

Authors
> Fitzhugh Mullan, MD, Murdock head professor of Medicine and Health Policy, Department of Health Policy, George Washington University, 2021 K St, NW, Suite 800, Washington, DC 20006, tel. 202 530 2341, fax 202 478 2772, fmullan@gwu.edu
> Seble Frehywot, MD, MHSA, assistant research professor of Health Policy and Global Health, Department of Health Policy and Department of Global Health, George Washington University, seblelf@gwu.edu
> Laura Jolley, research assistant, Department of Health Policy, George Washington University, ljolley@gwu.edu
> Irene Kuo, PhD, MPH, assistant research professor, Department of Epidemiology and Biostatistics, George Washington University, sphirk@gwumc.edu

Context
What is the size and scope of the global public health workforce? This is a key question in planning future strategic investments related to the Millennium Development Goals in health. This study seeks to develop a framework for enumerating the global public health workforce (PHWF).

Objectives
- Review definitional issues and improve clarity on who constitutes the PHWF;
- Define who is a public health worker;
- Propose methods for enumerating national, regional and global public health workforces.

Methods
- Literature review;
- Key informant interviews with global public health leaders;
- Key institution, government and nongovernmental organization reviews

New findings
- Definitions of who constitutes a public health worker are highly variable globally.
• Depending on the type and duration of training offered, the PHWF can be classified as professional and para-professional.
• Lower (how much training) and lateral (what kind of training) definitional parameters of public health workers are not yet globally set.
• Some countries are moving away from the traditional top-up model (training physicians in public health) in favour of training non-MDs at the MPH level to function as public health programme managers and policy analysts – positions that were traditionally held by physicians.

Conclusion
A global consensus needs to be reached as to who is included in the PHWF, in order to enumerate the PHWF and strategize planning at the global, national, and subnational levels for the use of the PHWF in the achievement of Millennium Development Goals.
What is a School of Public Health? Developing a Strategy to Inventory Public Health Training Institutions (PHTIs)

Authors

> Fitzhugh Mullan, MD, Murdock Head Professor of Medicine and Health Policy, The Department of Health Policy
  George Washington University fmullan@gwu.edu (Corresponding Author)
> Seble Frehywot, MD, MHSA, Assistant Research Professor of Health Policy and Global Health, The Department of Health Policy & the Department of Global Health, George Washington University seblelf@gwu.edu
> Laura Jolley, Research Assistant, the Department of Health Policy, George Washington University ljolley@gwu.edu
> Irene Kuo, PhD, MPH, Assistant Research Professor, Department of Epidemiology and Biostatistics, George Washington University, sphirk@gwumc.edu

Context

Any plans to invest in the expansion of public health education and training depend on an understanding of what types of training currently exist globally. This study intends to develop a strategy for performing an inventory of global public health training institutions (PHTI).

Objectives

1. Review the history of public health training institutions globally.
2. Review methodological issues encountered in identifying PHTIs including— institutional definitions, level of degree granted, key institutional demographics, and strategies for building on current data.
3. Review options for undertaking a global inventory of PHTI
4. Propose an option to be used as a framework for performing inventory.

Methods

- Literature review
- Key informant interviews with global public health leaders
- Key institution, government and non-governmental organization reviews
- Aggregation of extant data on PHTIs
New Findings
1. PHTI definitions are highly variable globally.
2. Most PHTI are defined by level of degree offered
3. Considerable public health training takes place in non-public health training institutions (medical schools, business schools, management programs, and training programs within ministries of health)

Conclusion
1. A common definition of what constitutes a PHTI is an important step in considering the future of public health education globally.
2. Based on a common definition, an inventory of PHTIs should be conducted and made available for general use in a web-based format.
A web-based in-service training information system in Mozambique

Authors
> Edgar Necochea (contact author), MD, MPH, director, Human and Organizational Performance, JHPIEGO, 1615 Thames Street, Baltimore, MD 21231, USA, tel. 410 537 1895, enecochea@jhpiego.net
> Martinho Dgedge, MD, MSc, PhD, associate national director for human resources and director for training, Ministry of Health, Mozambique
> Julio Pires, technical advisor in information systems, JHPIEGO, Mozambique, jpires@jhpiego.net
> Lucy Ramirez, MD, training technical advisor, Centers for Disease Control and Prevention (CDC), Global AIDS Program (GAP), Mozambique, ramirezl@mz.cdc.gov
> Cate McKinney EdD, senior training specialist, Centers for Disease Control and Prevention (CDC), Global AIDS Program (GAP), mckinneyc@mz.cdc.gov

Context
In-service training for health workers represents a very significant component of the activities of the Ministry of Health (MOH) in Mozambique. A relatively large investment is made every year in this training in the country, particularly in HIV/AIDS. However, until recently, the MOH did not have an information system to make the most appropriate decisions to track trainees and trainers, avoid duplications and make better use of qualified resources.

Objective
To develop a web-based information system that provides accurate information on in-service training, including courses provided trainers and participants.

Methods
In 2006 JHPIEGO, with funding from the President’s Emergency Plan for AIDS Relief (PEPFAR), through the Centers for Disease Control and Prevention (CDC), developed a web-based in-service training information system (SIFo in Portuguese) that provides real-time information on training activities, trainees and trainers. The model was successfully piloted in 2007 in three provinces of the country. Input of data is made from the province to a single, centralized database and the information can be accessed via the Internet from any location in the country. The system is compatible with other databases in the MOH.
Findings
The pilot showed that the web-based system works and is used regularly in spite of some inconsistencies in internet access. MOH and nongovernmental organization managers are increasingly using it for programmatic decision-making (e.g. planning of new courses and identification of trainers). The web-based and a previous Access-based version (implemented in 2005) of the system have so far provided information on 357 courses, 7749 trainees and 961 trainers. Nearly 50% of these activities were AIDS-related.

Conclusions
Based on the results of the pilot and the nationwide expansion of internet access, the MOH decided to expand SIFo nationally. The web-based training information system provides a practical method for monitoring training in Mozambique and providing data for programme planning.
Addressing the critical shortage of nurses in Kenya through the use of e-learning

Authors
> Peter Ngatia (contact author), director of capacity-building, AMREF, petern@amrefhq.org
> Sarah Hall, advocacy and research manager, AMREF UK, s.hall@amrefuk.org

Context
There is urgent need to rapidly scale up the number and competencies of health workers. Quickly and cost-effectively scaling up provision cannot be achieved simply by expanding institutions and programmes that already exist, but will require investment in innovative technology, such as electronic learning (e-learning).

In 2004 AMREF was asked by the Kenyan Ministry of Health and the Nursing Council of Kenya to upgrade the status of 20 000 nurses from “enrolled” status to “registered” status. To do this, AMREF is working with Accenture, a global management consulting and technology services and outsourcing company, to deliver an innovative e-learning programme.

Programme methodology
E-learning was chosen as the preferred method due to its interactivity for students, cost-effectiveness, ease of revision and ability to upgrade the skills of nurses quickly.

Objectives
The e-learning programme has two health workforce objectives:
- design and implement an e-learning solution to enable the rapid skills upgrade of Kenyan nurses to “registered” level;
- leverage the results from the programme to influence policy and replicate the e-learning programme in other African countries.

Conclusion
Upgrading the skills of workers to rapidly impact the health of the population needs an innovative approach. Prior to the introduction of distance education and e-learning, Kenya had the resources and classrooms to train only 100 registered nurses a year using traditional classroom methods. At this rate it would have taken over 100 years to certify Kenya’s enrolled nurses; using e-learning will enable Kenya to train and certify these nurses in just five years. The pilot and roll-out phases have generated
evidence supporting this ground-breaking model for continuing medical education in Africa, leapfrogging the need to develop extensive traditional classroom-based centres for further education and doing so on a national scale.
Scaling up health worker numbers in a post conflict setting: The example of South Sudan

Authors
> Peter Ngatia, Director of Capacity Building, AMREF petern@amrefhq.org
> Sarah Hall, Advocacy and Research Manager, AMREF UK s.hall@amrefuk.org

Context
Task shifting to lower cadres of health workers has proved a feasible way of ensuring and improving delivery of health services in weak and under-resourced health systems. Training can be delivered at a lower cost and more quickly than training new professionals. Providing appropriate supervision and support is in place, evidence suggests that there are no reductions in quality of care.

Since 1998, AMREF has been operating the National Health Training Institute (NHTI) training clinical officers in Maridi, South Sudan, the only training college for clinical officers in the country. The institute aims to ensure that the country is equipped with trained health professionals who can cope with the country’s health needs and demands, as well as training others to do so.

Objectives
It is imperative that health workforce strategies focus on matching the skills of workers to the local profile of health needs. This includes delegating work to, and effectively training and supporting, lower and mid-level cadres of formal workers to deliver health care at community level.

Conclusions
South Sudan is an example of a country where increasing the cadres of workers with basic clinical and community health competencies is vital. South Sudan has some of the worst health indicators in the world as the primary health care system has been ravaged by 20 years of conflict. The total trained health workforce in South Sudan is currently estimated at 4,600, far below the 17,300 required to deliver health care for the current population of approximately eight million people. In view of such massive need, focusing on lower and middle cadres of workers is a critical strategy.

Donors should support policies which enable task shifting in order to make essential health services more widely available, particularly in post-conflict settings such as that of South Sudan.
The role of community health workers: past and present practice in Africa

Authors
> Peter Ngatia (contact author), director of capacity-building, AMREF, petern@amrefhq.org
> Sarah Hall, advocacy and research manager, AMREF UK, s.hall@amrefuk.org

Context
In the absence of adequate numbers of formal health workers, community health workers (CHWs) are playing an important role in linking communities to health systems throughout sub-Saharan Africa.

The role of CHWs has evolved over time and in response to health-care priorities, the burden of disease and current severe shortages of human resources for health in sub-Saharan Africa. However, CHWs have some core roles that they can play as health-care providers. These comprise health promotion, disease prevention, basic curative care and referrals, monitoring of health indicators and creating linkages between community and formal health systems.

Methods and findings
A review has been undertaken that draws on existing literature and a qualitative survey carried out in 15 countries in Africa. Five countries – Ethiopia, Kenya, South Africa, Sudan (southern) and Uganda – were selected for in-depth case studies of CHWs, due to their long experience with PHC programmes and training and use of CHWs.

Available literature points to the need for concrete and clearly defined roles and functions for CHWs. Their status, including rights to payment and incentives, and their responsibilities within the health system, must be clear. The changing role of CHWs has resulted in the need for CHWs to acquire greater technical competencies. Training for CHWs must be adequate and appropriate for the work they do and must be ongoing throughout their working lives.

Conclusion
CHWs should be recognized as a distinct cadre of health professionals providing care beyond health facilities. They are critical in efforts to tackle the existing health worker crisis. However, they need support, supervision and financial and nonfinancial incentives to carry out their work effectively. As African health-care systems continue to struggle to deliver effective and equitable health care there needs to be far greater recognition of the current and potential role of CHWs.
The work conditions and training needs of commune medical doctors in Viet Nam

Authors
> Nguyen Bach Ngoc (contact author), Health Strategy and Policy Institute, Viet Nam, nguyenbachngoc@hspi.org.vn
> Doan Tuan Vu, Health Strategy and Policy Institute, Viet Nam
> Dau Thi Ha Hai, Health Strategy and Policy Institute, Viet Nam
> Vu Van Hoan, Health Strategy and Policy Institute, Viet Nam

Background
Viet Nam has 10,679 commune health centres (CHCs). They constitute the lowest level of the health-care delivery system in Viet Nam and play an important role in providing health services and primary health care for people in communes. Strengthening CHC capacity will contribute to equity and efficiency and the development of the Viet Nam health system. Many commune medical doctors have been allocated to CHCs. National and provincial policies have been promulgated to attract MDs to work in rural areas. However, only 65.1% of CHCs had an MD in 2006, while the national target is 80% by 2010. Good working conditions, continuing education opportunities and career development were qualitatively identified as the main elements of job motivation by rural MDs. A qualitative and quantitative survey was recently conducted to provide a greater evidence base for developing strategies for attracting and retaining MDs to work in CHCs.

Method
A cross-sectional study on training needs was carried out among 42 commune medical doctors and an assessment made of the working conditions in 18 CHCs in rural and remote areas of the northern (Tuyen Quang), middle (Quang Nam) and southern (Hau Giang) parts of Viet Nam between November 2006 and March 2007. Semistructured questionnaires and in-depth interview and group discussion methods were used.

Results
The results indicated that commune medical doctors are generally faced with poor working conditions: below-standard housing, old and inadequate medical instruments, shortage of medicine, difficult access to villages, a small monthly budget to run the CHC and a considerable amount of paperwork to complete every month. Re-education and training were rare: 38% of commune medical doctors had received only one training course during the previous five years, 43% had never received a re-education course, and there was a low rate of attendance at workshops and
conferences at national (2.4%), provincial (4.8%) and district (26.2%) levels. Most (83.3%) improved their knowledge through reading books. One third of commune medical doctors have to practise at home to add to their earnings. Only 22.6% were satisfied with their job. The main factors leading to job dissatisfaction were lack of opportunity for knowledge improvement or career development (80.6%), low incentives (74.2%), poor working conditions (71%) and low wages (64.5%).

Conclusions
The qualitative and quantitative results obtained constitute important evidence to be considered when developing strategies for attracting and retaining commune medical doctors to work in CHCs in order to meet the national target of 80% of commune medical doctors in CHCs by 2010 and to achieve equity, efficiency and development in the Viet Nam health system.
Multidisciplinary Collaboration Among students: P-Squared (Physician x Pharmacist)

Author
> Suresh Panthee, the P-Squared Allied Working Committee, Chairperson of Pharmacy Education 2007-08 International Pharmaceutical Students’ Federation mobile:+9779841386222/9803146287. Email: education@ipsf.org PO Box 84200, 2508 AE The Hague, The Netherlands. Website: www.ipsf.org

Introduction
It has been a growing realization that the health system involves multidisciplinary actions to provide the best health outcomes for the patient. Patients also have rated early referral to multidisciplinary teams as one of their highest priorities. Future health professionals should start to work together. In this context, a joint statement was signed by International Pharmaceutical Students’ Federation (IPSF) and the International Federation of Medical Student Associations (IFMSA) in the year 2004. Since then, two multidisciplinary conferences were successfully organized and a Memorandum of Understanding (MoU) was signed in 2006. P-squared is a collaborative project between IPSF and IFMSA which targets students majoring in pharmacy or medicine.

Objective
P- Squared, by promoting collaboration between medical and pharmacy students, aims to:
- Improve global health resulting from collaborations between future pharmacists and physicians.
- Identify current relationship between future physicians and pharmacists.
- Accelerate the cooperation between pharmaceutical and medical students.
- Promote interchange between pharmacy and medical students.
- Develop and broaden the scope of the medical and pharmaceutical professions.

Methods
An Allied Working Committee (AWC) was formed by involving three members from each organization. The proposal was presented at the World Health Care students’ symposium. A questionnaire was developed to understand the views of medical and pharmacy students about collaboration. The distribution of the questionnaire is underway.
Findings

The benefit of multi-disciplinary teamwork has been recognized internationally for the management of chronic and complex conditions. Through teamwork undertaken during pharmaceutical and medical undergraduate education, the pharmacists and medical practitioners of the future will be better equipped to respond to the challenges of an increasingly complex and rapidly evolving global health care system.
Using a standards-based educational management and recognition approach to scale up pre-service education: building on experience in 3 Universities in Ethiopia

Authors
> Anne Pfitzer, Country Director, JHPIEGO Ethiopia, apfitzer@jhpiego.net
> Tigistu Adamu, Technical Director, JHPIEGO-Ethiopia, tadamu@jhpiego.net
> Chandrakant Ruparelia, Regional Technical Advisor, JHPIEGO, Baltimore, cruparelia@jhpiego.net
> Peter Johnson, Director of Global Learning, JHPIEGO, Baltimore, pjohnson@jhpiego.net
> Amaha Haile, Medical Education Advisor, JHPIEGO-Ethiopia, ahaile@jhpiego.net
> Tegbar Yigzaw, SBEM-R Advisor, JHPIEGO Ethiopia, tyigzaw@jhpiego.net

Context
Under PEPFAR, JHPIEGO is integrating HIV/AIDS core competencies into preservice education in 3 Ethiopian universities. Along with strengthening curricular content, JHPIEGO also improves teaching methodologies. A needs assessment found “chalk and talk” the educational approach most frequently used, with some “bedside teachings” for final year medical students. Resources, text or electronic references, are limited.

JHPIEGO’s approach is to standardize faculty competency in HIV/AIDS, improve effective teaching skills, students’ assessment, and instructional design including non-internet-dependent electronic learning materials. In addition, JHPIEGO introduced a standardization approach for quality improvement, first used in health service delivery, then adapted to midwifery education in Afghanistan. This approach, called standards-based educational management and recognition (SBEM-R), establishes academic standards that are consistent with building competencies needed for the health workforce and then supports institutions to meet those standards.

Methods
In Ethiopia, the schools and national stakeholders developed and endorsed 62 educational standards in 5 areas: Classroom and practical instruction, clinical instruction and practice, assessment approaches, infrastructure and materials, and management. Teams are now applying the standards in their schools (baseline self-assessments). At the SBEM-R launch, participants endorsed SBEM-R, reiterated the urgent need to improve quality in education, and suggested improvements to the standards. Once completed, JHPIEGO can tailor additional support to address gaps.
Conclusions

The authors believe that tools/approaches (course materials, question banks, and educational standards) can be scaled up to 16 universities in Ethiopia, and private and diploma-level colleges. SBEM-R provides a platform for improvements at scale by placing onus for improving quality on the schools themselves; provides data to advocate for targeted resources or to react to increased intakes demands; and allows benchmarking of achievements and their replication across schools. Recognition of high-performing schools should motivate under-performing schools and national stakeholders to commit to educational improvement. High attrition and low morale of teaching staff remain critical challenges.
Community/Lay health worker programmes for vaccine uptake in low and middle income countries: Developing a global knowledge-base

Authors

> Inger Scheel, Research Director, SINTEF Health Research, Pb. 124 Blindern, NO-0314 Oslo, Norway. Email Inger.B.Scheel@sintef.no
Author for correspondence.
> Simon Lewin, Senior Lecturer, Medical Research Council of South Africa and London School of Hygiene and Tropical Medicine, UK. Email simon.lewin@lshtm.ac.uk.
> Claire Glenton, Researcher, Norwegian Knowledge Centre for the Health Services, Norway. Email claire.glenton@kunnskapssenteret.no

Context

More than two million people die every year of diseases prevented by widely available vaccines. A major obstacle to vaccine delivery is the shortage of health personnel in areas where they are most needed. This has caused renewed interest in community or lay health workers (CHWs) in vaccination delivery. There is a need for more knowledge on the effects and costs of such programmes, the theories and mechanisms underpinning them, and how transferrable the results are across different contexts.

Objectives

To develop a global knowledge-base on the effects of CHW interventions for vaccination uptake, with a focus on the following areas:
1. The effectiveness of CHW programmes in improving vaccination uptake in low and middle income countries (LMICs)
2. The cost-effectiveness of CHW programmes in improving vaccination uptake
3. The micro- and macro-level factors influencing the effect, or lack of effect of CHW programmes
4. Policy options for the use of CHW programmes in vaccination programmes and other priority areas across different settings.

Methods

A systematic review of controlled trials of CHW interventions in vaccination programmes to assess their effectiveness and a similar review of cost-effectiveness studies will be carried out. We will synthesize concepts and findings from qualitative studies to explore factors influencing the effects. Case studies will be conducted to
explore how the findings can be generalized across settings. Finally, we will narrate syntheses of the collected findings and develop policy recommendations.

**Outcomes**
Expected outcomes are high quality evidence for policy and practice on the effects and cost-effectiveness, and a better understanding of factors influencing the effects and sustainability of CHW programmes for vaccination uptake.

**Conclusions**
We expect the first results by February 2008.
Human Resources for Health (HRH) Development and Health Systems Strengthening in Tanzania

Author
A. O’Shea, Executive Director, Touch Foundation Inc., New York, United States of America tel. +1 (212) 446 6484, angus_oshea@mckinsey.com

Context
Despite growing investment, healthcare delivery in Tanzania – as in Africa generally – is hindered by severe health worker shortages and weak health systems. The healthcare landscape in Tanzania mirrors much of the continent with a weak health system and low life expectancy, but it has an especially acute shortage of healthcare workers.

Objective/scope
Touch Foundation Inc. works to scale up the healthcare workforce and strengthen the health system on three levels – at the grassroots with Bugando University and hospital; regionally through our Lake Zone Initiative bettering healthcare for thirteen million; and nationally through the Twiga initiative to expand health worker training.

- **Bugando:** At Bugando, we have expanded training capacity to ~700 students and have vastly improved the adjacent 850-bed teaching hospital – the second-largest in the country. However, scaling one school to capacity is not enough.

- **Lake Zone Initiative (LZI):** Expanding health worker training cannot be effective without fundamentally strengthening the health system within which trainees will work. Over the next five years, the LZI, in coordination with relevant stakeholders, will systematically identify, develop, and execute practical programs that tackle challenges in three key areas: HRH (e.g., production, retention), healthcare access and healthcare systems.

- **The Twiga Initiative:** Tanzania has pledged to improve access to basic health services through construction of over 5,000 new health facilities. Staffing these facilities requires over 100,000 new health workers – a goal the current training system cannot meet without significant intervention.

Results
Optimizing existing schools and rationalizing policy to enable maximum growth of the training system could increase training throughput by 40–60% with a $15–25
million upfront investment, and a $5–15 million increase in operating expenses. The remaining health worker gap can only be closed through ‘transformational changes’ such as virtual learning, or accelerated training of clinic-level health workers.

We have developed an HRH planning tool that links school training output to HRH availability and facility build-out, and are working with the Tanzanian health ministry to develop an implementation plan to optimize individual schools and enable systemic growth, while strengthening human resources management.

**Conclusion/lessons learnt**

Apart from developing an operational plan, Twiga also demonstrates two key learnings: system-wide and transformational changes cannot enable HRH scale up local intervention and ownership, and scaling-up training capacity requires improvements in HRM at both central and regional government levels.
Building Capacity in Primary Health Care: In-training program for interdisciplinary teams In Brazil and Chile

Authors
> Dr. Yves Talbot,
> Monica Riutort,
> Dr. Onil Battacharyya,
> Dr. Silvia Takeda

Context
The implementation of primary Health Care (PHC) has dominated the health policy agendas of many countries in the Americas. One of the pillars of health care reform is the restructuring of primary care, using a family health model. Brazil and Chile are among the countries where the development and deployment of human resources have been central to health reform.

Objective
This oral presentation describes a training program for interdisciplinary teams develop by the International Programs of the Department of Family and Community Medicine of the University of Toronto, to support the PHC strategy introduced in Brazil and Chile at the end of the 1990s. The presentation will shows how an in-service training program in primary health care for interdisciplinary teams of health care professionals in Latin America is helping Brazil and Chile to build capacity in family health.

Programme/Method
After a brief introduction of PHC reform in Brazil and Chile the five module program will be introduced explaining the participatory educational methodology which targets primary care providers from various disciplines with at least three months frontline experience. The model has a ‘train-the-trainer’ component and enables the training of a large number of professionals in a short period of time. In the initial phase of the program, the Canadian team trained 15 professionals from medicine, nursing and dentistry. This group, in turn, has facilitated the training for more than 3,000 professionals in Brazil over a period of 12 years.

Secondly, participants will learn about WHO/WONCA clock and the objectives of a modular and multi levels training (team, universities, local administration, professional associations).

Thirdly, the evaluation methodology of the training program will be discussed
followed up by a presentation of the many lessons learnt during the 12 years of the training program implementation.

Conclusion
We will conclude with an in-depth analysis about the need for a curriculum grounded in learners’ experiences in the field to respond to their needs and the needs of the communities they serve. We will also try to show the importance of a solid commitment to primary health care by governments is essential to the success of any human resources development in this area.
Hard copy publications and continuing professional development: contributing to stemming the tide of health human resource depletion in Africa

Authors
> James K Tumwine, professor of Paediatrics and Child Health, and editor-in-chief of African Health Sciences, Makerere University Medical School, tel. +256 772 494120, jtumwine@imul.com
> Bryan Pearson, publisher of MERA (Medical Education Resource Africa), and editor of Africa Health, FSG Communications Ltd, Vine House, Fair Green, Reach, Cambridge CB5 OJD, United Kingdom, tel. +44 1638 743633, fax +44 1638 743998, bryan@fsg.co.uk

Background
The tide of migration of health workers leaving Africa is increasing at an alarming rate, and the lack of in-service training and support is an important factor. Although the mobile phone is now nearly ubiquitous in most African countries, access to the Internet is still very low. With a worldwide movement to publish online, health workers in the poor and remote areas of Africa have been left with very limited reading materials for their continuing professional development. And to all health professionals, the lack of paper-based reading is leading to a widening of the gap between the outcomes of research and their reflection in policy and practice, as most practitioners do not go online for continuing professional development.

Methods
We initiated the publication and distribution of several journals and newsletters to health-care providers in African countries. Very modest support was sought from national and international agencies. Internet access was exploited in the process even though emphasis was largely on hard copy (paper).

Results
Circulation of both *African Health Sciences (AHS)* and *MERA* has reached a record 12 500 copies per issue, with an estimated 60 000 health workers reading each issue. Submission of articles for publication has increased from a handful in 2001 to almost 200 per year in 2007. Online access to *AHS* has also increased to 4000 per month, although most of these are from the developed world. Anecdotal as well as focused group discussions indicate increasing demand for both hard copy and online access.
Conclusion

It is possible to publish and sustain locally produced content in Africa and distribute it in both hard copy and online forms. The challenges are (a) how to reach the unreached; and (b) how to bridge the current disjoint between research and policy and practice.
Overview of task shifting practices in ART care projects supported by MSF

Authors
> Ann Wouters, Freya Rasschaert, Line Arnould, Mit Philips.
   Médecins Sans Frontières, Rue Dupré 94, 1090 Brussels, Belgium
   Correspondence: mit.philips@brussels.msf.org

Context
Several countries resort to task shifting to face the important ART patient load in spite of important health staff shortages.

Objectives
MSF provides ART in several countries faced with severe health worker shortages. To understand opportunities and limitations of task shifting in ART care, we reviewed task shifting experiences in MSF supported AIDS health care.

Method
19 projects received a standardized, pre-tested, self-administered question list on current task division, staff qualifications and other measures of workload management, outcomes and problems recorded. Data were analysed with EPI-Info.

New Findings
Detailed analysis is in progress at present, with full results available February 2008. Preliminary findings include:

- Outside Sub Saharan Africa almost no task shifting applied.
- Two different settings: overloaded centralized ambulant ART care and ART care decentralized into health centres.
- Task shifting to nurses, counsellors and lay workers is part of a package of measures to reduce workload and rationalize use of staff time. Other accompanying measures e.g. rationalization of patient flow and consultation frequency. Structuring patient load according to clinical needs in slow and fast tracks is critical.
- Lay workers rarely perform clinical tasks; rather do counselling, social support and treatment literacy activities- both in health structure and in community. Most lay workers perform well on dedicated tasks. Several countries reluctant to allow counselling by lay workers.
- Supervision is crucial to quality of care, requiring an important number of qualified staff hours.
Conclusion/ Lessons Learnt

Task shifting responds mainly to a country wide absolute shortage of qualified health workers, such as Southern Africa. It fits into a larger package of measures to reduce workload, improve efficiency and quality of care in such contexts. Counselling by dedicated lay workers works well in reducing workload of nurses but faces resistance from authorities. Task shifting requires important support measures and close supervision by qualified staff.
List of abstracts
Management

Alphabetical order by first author

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>W. Abubaker et al.</td>
<td>Health management workforce in selected countries of Eastern Mediterranean Region</td>
<td>160</td>
</tr>
<tr>
<td>U. Adano et al.</td>
<td>Improving morale, motivation and employee satisfaction through low-cost work climate improvement initiatives: case study of ten rural public and FBO health facilities in Kenya</td>
<td>163</td>
</tr>
<tr>
<td>B. Castelnuovo et al.</td>
<td>Improvement of the patient flow in a large urban clinic with high HIV seroprevalence (Kampala, Uganda)</td>
<td>165</td>
</tr>
<tr>
<td>D. Desplats</td>
<td>Fixer des médecins généralistes dans les zones rurales, c’est possible</td>
<td>167</td>
</tr>
<tr>
<td>G. Gedik et al.</td>
<td>Mapping health managers in selected African countries</td>
<td>169</td>
</tr>
<tr>
<td>P. McQuide et al.</td>
<td>Strengthening the system to use current administrative data at the Uganda Nurses and Midwives Council to identify the number of trained and registered nurses and midwives</td>
<td>171</td>
</tr>
<tr>
<td>C. Rosales</td>
<td>Analysis of capabilities of human resources for health units in the Region of the Americas</td>
<td>173</td>
</tr>
<tr>
<td>A. K. Rowe</td>
<td>Early results of a systematic review of the effectiveness and costs of strategies to improve health worker performance and related health outcomes in low- and middle-income countries (LMICs)</td>
<td>175</td>
</tr>
<tr>
<td>T. Hadianto et al.</td>
<td>A Clinical Performance Development and Management System in Indonesia</td>
<td>177</td>
</tr>
<tr>
<td>E. Wheeler</td>
<td>Human Resources for the Health Sector: Finding Workable Solutions</td>
<td>181</td>
</tr>
</tbody>
</table>
Health management workforce in selected countries of Eastern Mediterranean Region

Authors
> Walid Abubaker (contact author), Health Systems and Services Development, World Health Organization, Regional Office for the Eastern Mediterranean, Cairo, Egypt, abubakerw@emro.who.int
> Ghanim Alsheikh, World Health Organization, Regional Office for the Eastern Mediterranean, Cairo, Egypt, alsheikhg@emro.who.int
> Gülin Gedik, World Health Organization, Geneva, gedikg@who.int
> Mario Dal Poz, World Health Organization, Geneva, dalpozm@who.int
> Dalanyo Dovlo, World Health Organization, Geneva, dovlod@who.int

Background
Health managers play a critical role in scaling up coverage of essential services. Availability of competent managers is therefore crucial for reaching health goals, including the Millennium Development Goals (MDGs) related to health. The hypothesis is that having skilled managers who play their roles effectively in health systems will facilitate the scaling up of key health services by increasing the capacity to access and manage resources and transform them into more and better services, enhancing the motivation and effectiveness of health workers at operational levels through effective human resources management and improving performance of key interventions and demonstrating results.

The information on health service managers in the countries of the Eastern Mediterranean Region is limited. Improved intelligence on managers within health systems will provide policy-makers with an understanding of the management situation (e.g. turnover, training needs and succession planning) and enhance the response of services at operational levels.

Objectives
This study intends to provide better knowledge and data on different health managers, including human resources development (HRD) managers, in terms of numbers, competencies, gender, retention and other characteristics such as age, experience, education and professional background. The study also aims to develop and test a tool for mapping managers in HRD departments and units.

Methods
The study is a rapid descriptive review of managers as part of the health workforce. The study comprised desk reviews and key informant interviews. The study was
carried out in six countries, including Sudan and Yemen as low-income; Jordan and Lebanon as middle-income; and Bahrain and the United Arab Emirates as high-income countries.

Key informant interviews were held with a sample representing senior health sector managers at national and provincial levels and a sample of health service delivery managers at subnational and operational levels. The capacities of the human resources for health (HRH) units in the ministries of health were also explored through structured interviews.

Findings

In most mapped countries, health managers are predominately medical doctors without specific management training. Furthermore, while the percentage of managers with a medical degree in low-income countries such as Sudan is as high as 93%, it is 45% in some middle-income countries, for example Jordan, and 38% in the United Arab Emirates, as a representative of high-income countries in the region. The second major finding concerns gender. For example, male managers in Sudan, Jordan and the United Arab Emirates are 81%, 74% and 56% respectively of the total, while it is 100% in Yemen. As for health managers who have received management training, 11 of 58 respondents in Jordan have been trained in management, while in Yemen only 1 of 27 has been trained. One additional significant finding is the ranking of health managers in the ministry of health hierarchy or in civil service rating. Physician managers hold the highest-ranking management positions while nonphysician managers are at a much lower organizational ranking. Finally, the vast majority of managers are between 40 and 49 years old, and hospital managers are male with medical background.

Conclusions

One of the most significant factors revealed by the study is the absence or lack of modern management training among current health managers. It is true that many managers have been exposed to management training courses, primarily short workshops or seminars, but very few have received formal health management training. The preliminary analysis of the study also showed that health management is not being perceived as an attractive profession, particularly for non-medical personnel. Therefore, important changes have to be made in order to boost the quality of health management and remove the stigma that health managers are failed clinicians. Moreover, a great deal of awareness and advocacy is needed to make health management appear a promising and encouraging career pathway. This will require some adjustments in the ranking of health management and the laws and civil service regulations. Finally, critical areas need special focus and systematic development based on the World Health Organization management framework,
with the four elements of numeracy, competency, support systems and the work environment recognized as crucial to making health management a tool in improving health system performance and service-related outcomes.

Lessons

The most significant lesson is that training programmes need to be tailored to address the key findings and gaps in this mapping study. The Regional Office for the Eastern Mediterranean has been supporting a number of countries to either develop new health management programmes or revise existing ones. For example, countries such as Egypt (in Alexandria), Syria and Yemen are currently running special training programmes in health management and a different scale of health managers is expected to be introduced in coming years. Therefore, figures reflecting the status of health managers are changing and more skilled managers are expected to graduate.
Improving morale, motivation and employee satisfaction through low-cost work climate improvement initiatives: case study of ten rural public and FBO health facilities in Kenya

Authors
> Ummuro Adano (contact author), senior HR management systems advisor, Management Sciences for Health/Capacity Project, 6340 Quadrangle Drive, Suite 200, Chapel Hill, NC 27517, USA, tel. 919 313 9108, uadano@capacityproject.org
> Catherine Namanda, senior programme officer support functions, Intra Health International/Capacity Project, cnamanda@capacityproject.org
> Josephine Mbiyu, senior programme officer technical functions, Intra Health International/Capacity Project, jmbiyu@capacityproject.org

Context
A recent survey of health workers in Kenya identified recognition, work climate and team spirit among the nonfinancial factors affecting morale and motivation. Studies from other places also show that low motivation tends to generate poor practices that seem to contribute to low use of health facilities by vulnerable populations, and improvements in staff morale and motivation may increase use of services. The Capacity Project worked with the Kenya Ministry of Health to pilot work climate improvement interventions in 10 rural facilities over one year. Facility teams were engaged through a participatory workshop to assess their work climates, determine needs and generate simple activity plans that were used to test low-cost approaches to work climate improvements.

Objectives
Identify simple health facility and “people” factors and implement some basic interventions that will positively impact those factors.

Methods
The process consisted of establishing broad parameters (facilities, location, size of population served); administering questionnaires to clinical and shared services departments; analysing data and presenting results; conducting workshops to validate data and formulate strategies; agreeing on interventions; communicating interventions to all staff and creating action committees; implementing interventions; tracking progress on staff morale and motivation; and annual benchmarking.
New findings
Findings from the initial survey illustrated very low morale; a vast majority were also unhappy with their work climate. Results following the implementation of activity plans included departmental workplans; more frequent team meetings and sharing of information; problem solving as a team; community reach-out days; painting and refurbishing of facilities; new equipment; more equitable shifts; managing inventories to avoid stock-outs; lounges with free tea and coffee for staff; servicing vehicles; safe waste disposal measures; improved signage; organized patient flow procedures; cleaner yards, toilets and facilities; increases in service utilization (at all 10 sites); infection prevention protocols for HIV/AIDS; and setting up resource centres. A follow-up survey indicated that nearly all staff in the 10 sites expressed high satisfaction with their environments and had no intention of leaving.

Conclusions
This pilot provides evidence to help move beyond the old paradigm that most motivation and morale-related weaknesses can be solved by financial incentives or training alone. There is no tidy package of interventions that will ensure motivated workers who stay in posts for years. A complex set of factors affects morale and motivation, and how these factors play out varies from place to place. In this case, facility teams selected their own challenges and shared some of the intervention costs, enhancing ownership. The results of this programme need to be further evaluated to form the basis for a scalable approach to improving morale and retention, thereby strengthening the performance of health systems in low-resource settings on a sustainable basis.
Improvement of the patient flow in a large urban clinic with high HIV seroprevalence (Kampala, Uganda)

Authors
> Barbara Castelnuovo (contact author), study coordinator, Infectious Diseases Institute, Mulago Hill, PO Box 22418, Kampala, Uganda, tel. +256 755 360626, bcastelnuovo@idi.co.ug
> Joseph Babigumira, PhD student, School of Pharmacy, University of Washington, Seattle, Washington, USA, babijo@u.washington.edu
> Mohammed Lamorde, study doctor, Infectious Diseases Institute, Kampala, Uganda, mohalamorde@yahoo.co.uk
> Alice Muwanga, clinic administrator, Infectious Diseases Institute, Kampala, Uganda, amuwanga@idi.co.ug
> Andrew Kambugu, head of prevention, care and treatment, Infectious Diseases Institute, Kampala, Uganda, akambugu@idi.co.ug
> Robert Colebunders, professor, Institute of Tropical Medicine and University of Antwerp, Antwerp, Belgium, bcoleb@itg.be

Context
In January 2005 the authors performed a one-day survey of patient flow at the Infectious Diseases Institute clinic, Mulago Hospital, Kampala. The survey revealed prolonged waiting times and total time spent at the clinic. Organizational changes were proposed, including introduction of group (as opposed to individual) counselling sessions and training nurses to assess patients with minor complaints. Additionally, a pharmacy-only refill programme was started for patients on antiretroviral treatment (ART) for at least 12 months and CD4+ cell count ≥ 200 cells/μL.

Objectives
We repeated the survey in August 2007 to evaluate the impact of these interventions.

Methods
Using the same questionnaire (as in 2005) the waiting times at various clinic care points were recorded and compared with those of the 2005 survey.

New findings
On the study day, 400 patients visited the clinic (compared to 250 in 2005): 276 (76%) were on ART (compared to 38% in 2005), of which 87 (32%) followed up on the pharmacy refill programme.
Median time spent at the clinic decreased from 157 minutes in 2005 (range 22–426) to 124 minutes (range 15–314).

The median time from reception to triage decreased from 34 minutes (range 3–92) to 14.5 (1–155); from triage to doctor increased from 51 minutes (1–205) to 64.5 (0–23); from doctor to pharmacy decreased from 24 minutes (5–292) to 16 (0–104); waiting time at the pharmacy decreased from 30 minutes (10–175) to 5 (0–42).

For the patients in the pharmacy-only refill programme, median time spent at the clinic was 2 minutes (range 1–8).

**Conclusions**

Despite the increasing number of patients, the innovative measures introduced improved the patient flow at our clinic. A similar methodology could be used by other health services to develop efficient models of care.
Fixer des médecins généralistes dans les zones rurales, c’est possible !

Auteurs
> D. Desplats, Santé Sud, Marseille, France – Conseiller projets,
  santesud@wanadoo.fr
> S. Coulibaly, Santé Sud, Bamako, Mali – Coordinateur : santesud@afribonemali.net
> C. Razakarison, Santé Sud, Antananarivo, Madagascar – Coordinateur :
  sante-sud@moov.mg
> G. Farnarier, Santé Sud, Marseille, France – Président : guy.farnarier@mail.ap-hm.fr
> O. Doumbo, Faculté de Médecine, Bamako, Mali – Professeur : okd@mrtcbko.org
> ONG Santé Sud, 200 Bd National, Le Gyptis bat N, 13003 Marseille France
  santesud@wanadoo.fr

Contexte
Le rapport 2006 de l’OMS, intitulé “Travailler ensemble pour la santé”, a mis en
relief la crise des ressources humaines en santé. A la pénurie en personnels s’ajoutent,
en amont, de graves questions concernant la formation, la répartition, les conditions
de travail, la fuite des cerveaux. Les médecins sont particulièrement touchés par le
chômage et la fuite des cerveaux.

Dans le même temps, les Soins de Santé Primaires (SSP), conçus pour des non-
médecins, montrent leurs limites en terme de qualité et de performance (Rapport
OMS 2000).

Objectif
Depuis 1988 au Mali, et ensuite à Madagascar, Santé Sud a initié un programme
d’installation de jeunes médecins sans emploi dans les zones rurales, capables de
pratiquer conjointement la médecine clinique de famille et la santé communautaire
au niveau d’une collectivité.

Résultat
A ce jour, 166 médecins généralistes communautaires (115 au Mali, 51 à Madagascar)
soignent quotidiennement environ 1,6 millions de personnes qui n’avaient pas accès
à un médecin.

Enseignements
Au Mali, l’expérience a été facilitée par la réforme du système de santé des années
1990 : décentralisation avec création des Centres de Santé Communautaires
(CSCOM) autogérés, responsables du recrutement de leurs personnels. Ils ont pu
ainsi recruter des médecins avec un contrat de droit privé en vue d’améliorer les performances de leurs centres.

A Madagascar la volonté du gouvernement, après la crise de 2002, de promouvoir un partenariat public/privé (3P) pour développer le secteur santé a permis l’installation de médecins généralistes privés sur la base d’une convention d’association au service public intégrant chaque cabinet médical dans son district sanitaire.

**Conclusions**

L’expérience montre que les jeunes médecins sont prêts à exercer leur métier en milieu rural, mais il faut deux conditions :

1. une ouverture politique au niveau de l’Etat permettant d’associer des médecins privés au service public sur des bases contractuelles claires et équilibrées

2. accompagner le processus par la mise en place d’un “dispositif d’assurance qualité” conçu et mis en œuvre en partenariat avec les ressources locales universitaires, ordinales et associatives.

Fixer les jeunes médecins et revitaliser les SSP représentent une opportunité pour les pays qui connaissent une sous-utilisation de leurs ressources médicales
Mapping health managers in selected African countries

Authors

> Gulin Gedik (contact author), Department of Human Resources for Health, World Health Organization, Geneva, tel. +41 22 7912332, gedikg@who.int
> Jennifer Nyoni, World Health Organization, Regional Office for Africa, nyonij@afro.who.int
> Delanyo Dovlo, World Health Organization, Geneva, dovlod@who.int
> Mario Dal Poz, World Health Organization, Geneva, dalpozm@who.int
> James Antwi, jantwi23@hotmail.com
> Habtamu Argaw, World Health Organization, Regional Office for Africa, habtamua@et.afro.who.int
> Martins Ovberedjo, World Health Organization, Regional Office for Africa, ovberedjom@tz.afyro.who.int

Background

Health managers are required at both the strategic and national levels, as well as the middle and operational (province, district, hospital) levels of health systems. Senior health sector managers at central and national levels oversee the strategic direction of the sector as policy-makers, managing overall resource allocation and monitoring policy targets and outcomes. This draws attention to health managers as a critical group of the health workforce in scaling up health services towards achieving the Millennium Develop Goals (MDGs) related to health. Managers of health facilities at decentralized levels hold the responsibility to deliver services to local customers and stakeholders. They not only oversee operational units such as wards, clinics and outreach services, but also supervisors and staff to ensure that specific client tasks are effectively and efficiently carried out. Service delivery managers coordinate finances, staff, supplies, equipment and infrastructure in an effort to provide appropriate health services for the people who need them. Managers are therefore essential to scaling up coverage of essential services and availability of competent managers is crucial for reaching health goals.

However, we lack data and information regarding health service managers in low-income countries, especially in Africa. Most health workforce statistics record the various health professionals but do not necessarily provide a sense of the actual roles and functions performed by these professionals within the health system.

Objectives

This study intends to provide better knowledge and data on who are the managers of health services, how many there are, where they are located, what their main characteristics are and how well they are utilized to achieve service delivery goals.
The main objectives are:
- to help countries understand the current status of qualified managers needed for effective service delivery;
- to obtain an analysis of the true availability of professional health staff compared with management and management support professionals;
- to provide information essential for planning the training, recruitment, selection and deployment of managers in relation to other human resources for health (HRH);
- to develop and test a tool to map the health managers.

Methods
The study is a rapid descriptive review of managers as part of the health workforce. A team comprising representatives from World Health Organization (WHO) headquarters, the WHO Regional Office for Africa and country staff designed the study and country consultants carried out the following process:
- desk reviews of each country’s data and statistics (policies, strategic plans, organizational structure and systems, regulations, job descriptions and operational guides) on management in the health sector;
- key informant interviews with a sample of senior health sector managers at national and provincial levels; a sample of health service delivery managers at subnational and operational levels (health district and subdistrict leaders, hospital and facility managers); a special focus on the human resources for health department at national level.

Results
The study was undertaken in three African countries at the initial stage, namely Ethiopia, Ghana and Tanzania (mainland and Zanzibar). The results showed variations among the countries as to the definition of “manager” and the required qualifications. Thus the backgrounds of current managers showed variations, as well as their age and gender distribution. For example, 68% of managers in Tanzania (mainland) are physicians by training and 49% of managers have some kind of training in management. Male dominance among the professionals occupying managerial posts was observed (less than 10% of managers are female in Tanzania, whereas 25% are female in Ghana). The limitations observed in their working environment, such as lack of incentives and inadequate authority, need to be addressed to enable them to function better.

Conclusions
The results suggest that more clarity in attention to health managers is required in order to improve the performance of health systems. Opportunities should be provided to improve their capacity. An enabling environment should be ensured so that they can deliver their responsibilities more effectively.
Strengthening the system to use current administrative data at the Uganda Nurses and Midwives Council to identify the number of trained and registered nurses and midwives

Authors

> Pamela A McQuide (contact author), RN, PhD, Senior Workforce and Policy Advisor, IntraHealth International/Capacity Project, 6340 Quadrangle Drive, Suite 200, Chapel Hill, NC 27517, USA, tel. 919 313 9167, mobile 919 622 1644, pmcquide@capacityproject.org
> Rita Matte, Registrar, Uganda Nurses and Midwives Council, rita.matte@health.go.ug
> Vincent Oketcho, In-Country Coordinator, IntraHealth International/Capacity Project, voketcho@capacityproject.org
> Margaret Chota, Commissioner of Nursing Services, Uganda Ministry of Health, margaret.chota@health.go.ug

Context

Nurses, doctors and other health professionals form the backbone of a country’s health system. However, in many countries there is a lack of reliable, current and accessible health workforce information. The Capacity Project has been collaborating with the Uganda Ministry of Health and the Nurses and Midwives Council to use a participatory process to implement a human resources information system that gives current information about all nurses and midwives trained, registered, licensed and working in the country.

Objectives

- Describe a participatory process undertaken in Uganda to develop a human resources information system on the country’s trained and qualified nurses and midwives;
- Share results about the number of trained and registered nurses and midwives;
- Identify how these data can be used to improve planning and management of the health workforce.

Methods

Based on key policy questions developed by principal stakeholders, the Capacity Project installed a certification and licensing information system that tracks all nurses in Uganda from the time they enter pre-service training until they leave the
workforce. Developed by the Capacity Project, the software collects and aggregates data on a country’s health workforce. Team members analysed data using built-in report functions and geographical mapping tools.

**New findings**

Since 1970, Uganda has trained 28 064 student nurses and midwives; 21 011 of them have passed the examination and 16 739 have become registered. There is a significant gap between the number of those who are trained and those who receive licensure. These results vary according to the district in which students were trained. These data assist in targeting improvements by districts most in need and in ensuring that all health workers are registered with their regulatory authority so that only qualified health workers are hired.

**Conclusions**

These data inform policy-makers, educators and regulatory authorities about the number of trained and licensed health professionals in the country. They can be used by health system managers to ensure that only health professionals in good standing with the regulatory authorities are hired and deployed at health facilities across the country. The data can also be used for planning training and deploying health workers according to region and cadre; identifying areas that need particular attention; and tracking and planning continuing professional development.
**Analysis of capabilities of human resources for health units in the Region of the Americas**

**Authors**
- Carlos Rosales (contact author), regional advisor, Human Resources for Health, HSS/HR, Pan American Health Organization/WHO, Washington, DC, tel. 202 974 3805
- Juan Carlos Arroyo
- Mario Roberto Dal Poz
- Maria Helena Machado

**Background**
The Pan American Health Organization (PAHO) has succeeded in putting the human resources for health (HRH) issue on the international health agenda. One of the keys to advancing human resources development is the establishment of an institution in charge of the regulation, education and work conditions of HRH. A decennial plan has been laid out, but the national capacities that will enable its achievement are not well known. There is little information about the institutional location, functions and responsibilities of HRH, or about their need for financial and other resources to fulfil their various functions.

As HRH units have both staff and line functions, they are critical in taking HRH development actions forward.

**Objectives**
In order to obtain a better understanding of the capacities of HRH units:
- carry out a differentiated characterization of the profiles of HRH units that allows assessment of their strengths and needs;
- design a methodology for a quick diagnosis of the institutional profiles, for later use;
- characterize the different levels of development of HRH units and define areas for technical cooperation and joint effort within the countries of the region for strengthening HRH units.

**Method**
The study is a rapid descriptive review using:
- a regional survey and semistructured interviews with PAHO country offices, representatives, HRH directors and at least one key official;
- case studies (interviews in depth) directly with the national office, state office or decentralized level and centres of excellence in Brazil, Mexico
and Nicaragua; with national focal points in Canada, Costa Rica, Jamaica and Peru.

Results
The study was conducted in 17 countries of the Region of the Americas within a period of three months. It confirmed that the subject of human resources has attracted much of the attention it deserves, but this has not been reflected in the capacity of the HRH units of the ministries. The subject of human resources is gaining importance and eight countries said, promisingly, that their HRH units had become better positioned during the last 10 years.

The study has confirmed a double-sided problem: as issues related to the health workforce crisis are recognized, HRH units have not adapted as required to respond to the crisis. However, some countries, such as Brazil and Canada, are in the process of progressive restructuring, reflecting the importance of the subject and the organizational relevance of HRH units.

The consolidated results of the regional study and four case studies (Brazil, Canada, Nicaragua and Peru) were presented in a workshop held in Brasilia, Brazil, in September 2007. The analysis and the discussions at the workshop have led to further definition of areas requiring joint effort:

- strengthening of HRH units and bolstering their political influence;
- increasing the capacities of the personnel within the units consonant with the new challenges that they face;
- developing and establishing minimum parameters of provisions required by HRH units;
- strengthening the financing of HRH units, taking into account personnel and management needs.

Conclusions
The development of the methodology linked to the 10-year plans for HRH and the strategy of cooperation allowed for debate, consensus building and establishment of lines of joint effort between countries and PAHO/WHO. It is considered feasible to deepen this line of action, disseminating results to generate new projects that mobilize external financing.
Early results of a systematic review of the effectiveness and costs of strategies to improve health worker performance and related health outcomes in low- and middle-income countries (LMICs)

Authors
> Alexander K. Rowe, Medical Officer; Malaria Branch, Division of Parasitic Diseases, Centers for Disease Control and Prevention, axr9@cdc.gov
> Samantha Y. Rowe, Researcher; Data Management Activity, Division of Parasitic Diseases, Centers for Disease Control and Prevention, say9@cdc.gov
> David H. Peters, Associate Professor; Health Systems Program, Department of International Health, Johns Hopkins Bloomberg School of Public Health, dpeters@jhsph.edu
> Kathleen A. Holloway, Medical Officer; Department of Medicines Policy and Standards, World Health Organization, hollowayk@who.int
> John Chalker, Principal Program Associate; Management Sciences for Health; jchalker@msh.org
> Dennis Ross-Degnan, Associate Professor; Harvard Medical School and Harvard Pilgrim Health Care, Dennis_Ross-Degnan@hms.harvard.edu

Background
Health workers (HWs) play key roles in increasing coverage of interventions that reduce morbidity and mortality. In LMICs, however, HW performance is often inadequate. Existing reviews of strategies to improve performance are outdated or have important methodologic limitations.

Objectives
To characterize the effectiveness and costs of strategies to improve HW performance in LMICs.

Methods
We are conducting a systematic review of 15 databases and websites of 21 organizations to identify published and unpublished reports. Reports are screened, and data from relevant reports are double-abstracted and entered into a database. Effect sizes are estimated as absolute changes in performance outcomes (e.g., correct treatment increased by 20 percentage-points). Outcomes included HW practices, patient outcomes (e.g., mortality), and economic outcomes. As studies often use different outcomes, we analyzed a summary outcome, which is the median effect.
size for all primary outcomes from a study. Our analysis focused on studies with “adequate” designs (e.g., pre-post study with controls).

Results
The search strategy identified ~40,000 citations. To date, 165 reports on 124 studies have been abstracted. Early results reveal that about half of abstracted studies have adequate designs. In these studies, a wide variety of strategies were examined, and they usually had multiple components (commonly including training, supervision or feedback, or printed materials). Most strategies had small median effect sizes (<10 percentage-points), although some strategies had large effects (>25 percentage-points). This pattern was also found in separate analyses of training and of supervision/feedback. Overall, methodologic heterogeneity made comparisons across studies difficult. Few studies reported costs or cost-effectiveness.

Conclusions
Early results suggest that effectiveness varies substantially, with many strategies having small effect sizes. Standardization of outcomes and methods for estimating effect sizes, precision, and cost-effectiveness would improve future attempts to synthesize the evidence base. Additional analyses will seek to identify factors associated with increased effectiveness.
A Clinical Performance Development and Management System in Indonesia

Authors

> Tridjoko Hadianto, Lecturer, Department of Public Health, University of Indonesia tridjokohadianto@yahoo.com
> Erica Wheeler, Knowledge Officer, Global Health Workforce Alliance (HSS/HWA), WHO, Geneva wheelere@who.int

Context

Large gaps in the role function and performance management of nurses and midwives were identified during a survey of 1000 respondents, which carried out by Ministry of Health Indonesia with technical assistance from WHO in 2001. The results of the survey were used as the evidence base for the development of a Clinical Performance Development and Management System (CPDMS).

CPDMS is a system that has been developed (2001), tested (2002), and evaluated (2003, 2004) in Indonesia. The concept and model of CPDMS is built on the knowledge that following good pre-service theoretical and clinical education and further capacity building, a number of structures and processes should be in place in the health system to ensure staff is motivated to use this knowledge and continuously adapt their behavior striving towards providing high quality care.

Methods

The process of CPDMS begins in health centers and hospitals. It starts with a field assessment to identify the performance management structures and processes in place and to identify the key clinical leaders in nursing and midwifery who will participate in the first line management (FLM) training. The FLM course is followed by introducing the monitoring supervision and coaching system and encouraging sustainability mechanisms. Research has shown that the original implementation methodology is the most effective and that it is acceptable to all professions.

It was developed, implemented and evaluated with financial support from donors as well as local resources, into 9 provinces and 35 districts in Indonesia. It will be introduced into one province in 2005 and six provinces in 2006. A successful mission was made to East Timor to disseminate to the Ministry of Health.

Considerable attention has been given to sustainability following initial CPDMS implementation. All Directorates in the ministry of Health and the National Board
for the Development and Empowerment for Health Human Resources agreed to a National CPDMS Policy at the end of 2004. This policy has signed as a decree by the Minister of Health in 2005.

Lessons learnt
To sustain the CPDMS process in the decentralization era, a strategic action plan has to be developed by provincial, district and institutional organization. After CPDMS implementation the maintenance and sustainability of the inputs or the process depends on commitment to quality outcomes. This commitment must come from leadership in provincial health officers, district health offices, hospitals and health canters. Moreover, motivation and incentives of health professional are also key factors for sustainability.

Conclusion
CPDMS is now in its third phase of development and most of the provinces have conducted training but there is a degree of uncertainty about the new implementation of the system which differs from the original in terms of content and length of training. This could endanger the original training programme whose evaluation showed an improvement in performance of nursing staff. It is crucial that the system be introduced in its entirety and that the modified system be evaluated on a wider basis to ensure that quality management and an improved level of performance is achieved.
Health workforce challenges and opportunities in improving quality of HIV/AIDS ART care in Uganda: Quality Assurance Project experience

Authors
- Benson T Tumwesigye (contact author), technical coordinator, University Research Co., LLC-Health Care Improvement (HCI) Project, Uganda, btumwesigye@urc-chs.com
- Jacinto Amandua, commissioner, Clinical Services, Ministry of Health, Uganda, jamandua@yahoo.com
- Elizabeth Madraa, programme manager, Uganda AIDS Control Programme, emadraa@yahoo.com
- Stephen Kinoti, senior advisor, HCI Project, skinoti@urc-chs.com
- Anthony K Musisi, country director, HCI Project, Uganda, akyayise@urc-chs.com
- Augustin Muhwezi, national coordinator, Quality of Health Care Initiative in HIV/AIDS Care, amuhwezi@urc-chs.com
- Ibrahim Kirunda, technical quality improvement advisor, HCI Project, Uganda, ikirunda@urc-chs.com
- Edmund Pacutho, M&E advisor, HCI Project, Uganda, epacutho@urc-chs.com
- Aldo Burua, technical quality improvement advisor, HCI Project, Uganda, aburua@urc-chs.com
- Francis Ochen, laboratory quality improvement advisor, HCI Project, Uganda, fochen@urc-chs.com

Context
A skilled, competent and motivated health workforce is vital for quality HIV/AIDS antiretroviral therapy (ART) services. The Ministry of Health in Uganda, in collaboration with the Quality Assurance Project (QAP), implemented a collaborative project to improve the quality of HIV/AIDS ART services in 89 facilities in 2005. During implementation, multidisciplinary teams of service providers adopted a proper standard of care, identified quality service gaps, tested changes designed to remove gaps in services and measured their performance. The quality of care and outcomes was thus heavily dependent on the availability and performance of the health workforce.

Objective
To document and share the QAP experience on health workforce challenges and opportunities in improving the quality of HIV/AIDS ART care in Uganda.
**Methods**

We retrospectively reviewed quality of care initiative data from 89 sites. Qualitative data were sought from reports and key informants from the sites.

**Findings**

In the early stages of the initiative, understaffing, high turnover, attrition, low staff motivation and heavy workload negatively affected quality improvement team performance. Low adherence levels to antiretrovirals, declining patient follow-up and delayed ART initiation, particularly among children, were observed. Uncoordinated staff deployment with inadequate skills was also observed. The limited number of doctors in ART clinics led to poor patient management, with few sites offering paediatric ART services (26 out 57 collaborative sites). There was high turnover and attrition (43%) of staff. Poor documentation due to low staffing and inadequate skills affected data quality and utilization. To address these obstacles, multidisciplinary quality improvement teams were established, trained in improvement methods and technical skills through learning sessions and supported supervision. Service providers’ motivation, knowledge and skills improved. Changes resulted in improved outcomes, such as better adherence to antiretrovirals and survival of people living with HIV/AIDS.

**Conclusion**

Improved health workforce management, multidisciplinary trainings, coaching and support supervision have led to improved quality of ART services.
Human Resources for the Health Sector: Finding Workable Solutions

Author
> Erica Wheeler, Knowledge officer, Global health Workforce Alliance, (HSS/HWA), WHO, Geneva wheelere@who.int

Context
The Indonesian Ministry of Health oversees a public and health care system that provides services to 220 million people spread across 6000 of the country’s 17,000 islands. The Ministry of Health is responsible for developing, implementing and monitoring policies to ensure health services delivery. It collaborates with the civil service system, the Ministry of Home Affairs, provincial and district governments and a variety of educational institutions to implement workforce planning, training, administration, and personnel management.

The ‘Health Workforce 2000-2010’ policy developed by the MoH to address human resources focuses on quality (professionalism), distribution (equity), efficiency and utilization of health personnel. One of the policy recommendations was to establish a ‘National Board of Health Human Resources Development and Empowerment’ which became operational in 2002. Its challenge is to coordinate and link health training centres and to develop an integrated comprehensive strategic plan for health workforce development and a corresponding integrated health management information system.

Objectives
The realization of the health workforce policy would need to address the current problems and several suggestions are made for a way forward drawing on funding from several donors. There is also a need for cooperation is great between the Ministry of Education (which trains public health specialists, physicians and pharmacists), government-run universities, private universities, and the Ministry of Health which trains midwives, nurses, nutritionist, sanitarians, and laboratory technicians.

Lessons learnt
Several solutions are put forward to address the weaknesses of the system. The following are a few of challenges can be addressed and which will be outlined:

- Intersectoral collaboration
- Development of the skills and competencies of nurses and midwives
- Developing adequate supervision, monitoring and evaluation
- Developing provincial capacities in health workforce administration and management.
• Research and development in health workforce planning and management
• The MoH and key international donor partners should advocate lifting the civil service freeze. A standard health management information system for all regions is needed.
• Review of short term contracting of health staff.
# List of abstracts

## Migration and retention

<table>
<thead>
<tr>
<th>First author(s)</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>F. Bocoum et al</td>
<td>Financial incentives and mobility of the health workforce in Burkina Faso</td>
<td>185</td>
</tr>
<tr>
<td>V. Darko et al</td>
<td>Migration Trends of Ghanaian Nurses and Midwives: impact of a recent policy implementation</td>
<td>187</td>
</tr>
<tr>
<td>F.M. Elegado-Lorenzo et al</td>
<td>Mitigating the effects of nursing migration: development of bilateral policies between sending and destination countries</td>
<td>189</td>
</tr>
<tr>
<td>F. El-Jardali et al</td>
<td>Trends, magnitude and reasons of nurse migration out of Lebanon</td>
<td>191</td>
</tr>
<tr>
<td>R. Filho</td>
<td>Strategies for the distribution and retention of doctors in national systems of health: the Brazilian case</td>
<td>193</td>
</tr>
<tr>
<td>M. Kingma et al</td>
<td>Emerging trends, challenges and issues in regulation of migrating nurses</td>
<td>194</td>
</tr>
<tr>
<td>M. Kingma et al</td>
<td>Impact of nurse migration on health service delivery</td>
<td>195</td>
</tr>
<tr>
<td>M. Kingma et al</td>
<td>Human Rights and Migration</td>
<td>196</td>
</tr>
<tr>
<td>T. Lievens et al</td>
<td>Understanding external migration of Ghanaian nurses: results from qualitative research</td>
<td>197</td>
</tr>
<tr>
<td>R. Matsuyama</td>
<td>Facilitation of the recruitment and placement of foreign health care professionals to work in the public sector health care in South Africa: assessment</td>
<td>199</td>
</tr>
<tr>
<td>P. McQuide et al</td>
<td>Uganda health workforce study: satisfaction and intent to stay among health workers in public and private not-for-profit (PNFP) health facilities</td>
<td>201</td>
</tr>
</tbody>
</table>
F. Mullan, *A northern strategy: an action plan for mitigating HRH pull factors*  
H. Mwale et al, *Human resources retention scheme: qualitative and quantitative experience from Zambia*  
G. Thupayagale-Tshweneagae et al, *Migration of Nurses in Botswana, Brain Drain or Brain Gain?*  
C. Wiskow, *Addressing health worker migration in source countries: experiences from an ILO Action Programme*
Financial incentives and mobility of the health workforce in Burkina Faso

Authors
> Fadima Bocoum (corresponding author), health economist, researcher, Institut de Recherche en Science de la Santé, BP 7192 Ouagadougou, Burkina Faso, tel. +226 50 33 35 94, fadimabocoum@yahoo.fr
> S. Kouanda, MD, PhD in public health, researcher, Institut de Recherche en Science de la Santé, sekouanda@yahoo.fr
> R. Guissou, health economist, research assistant, Institut de Recherche en Science de la Santé
> C. Dao/Diallo, specialized nurse, research assistant, CHU Yalgado Ouédraogo
> B. Sondo, MD, tenure in public health, director of Institut de Recherche en Science de la Santé, dirss@fasonet.bf

Context
In Burkina Faso, the lack of qualified health workers and low motivation are among the causes of the poor performance of the health system. Although the financial motivations only are not enough, they have an essential role. Does this situation explain the high demand of the health workforce for the cities, where they have the opportunity of exerting a private as well as a public role?

Objectives
Our aim was (a) to analyse the perception that the health workers have of their remuneration; and (b) to determine the factors influencing mobility of the health workforce.

Method
A cross-sectional study was conducted from December 2007 to January 2008 in rural and urban areas covering 15 public, private, confessional (never heard of this before) and associative health centres. We collected quantitative data through an self administered questionnaire with different categories of health workers and qualitative data through interviews with health workers and managers.

Results
In spite of the introduction of financial incentives and pay rises, the health professionals of the public sector judge their level of remuneration to be lower than the health workforce in the private sector and associative structures. Likewise, in comparison with civil servants who work in education, finance and justice, and given
the cost of living, health workers judge that their remuneration is low. In addition, the rate of turnover of the health workforce in rural areas is high (average three years). In urban areas the mobility of personnel in the public sector is related to the level of their remuneration and a feeling of lack of recognition.

Conclusion
In Burkina Faso, the high mobility of the health workforce creates dysfunctions within the health system that have an impact on the quality of care.
Migration Trends of Ghanaian Nurses and Midwives: impact of a recent policy implementation

Authors

> Veronica Mina Darko, FWACN, MA (ed. Admin) Dip Nsh. (Admin) SRN, RM Registrar/Chief Executive NMC (Ghana) P.O. Box M44, Accra Ghana email: nmc@africaonline.com.gh
> Felix Nyante, FWACN, MA (Educ. Admin) B.Ed (Health Scs.), Dip. Nsg. SRN, Supervising Authority (Education and Research), NMC
> Prince Boni B.Sc, Deputy Director Human Resources, Ghana Health Service

Context

The migration of nurses and midwives out of Ghana has recently assumed alarming proportions and remains a concern to government and the Nurses and Midwives’ Council (the Council). Various organizations, including the WHO are setting up mechanisms for informed inquire on the issue. For this, quality data is required.

Objectives

To contribute in the provision of robust data by determining the size and trends in the migration and the impact of rule enforcement on such migration and make appropriate recommendations.

Methods

A prospective, descriptive, non-interventional desk review was performed on all nurses and midwives’ seeking verification. This was used as an indication of the intention to migrate. A questionnaire was used for data collection. The Council, assisted by the Ministry of Health adopted a “gate-keeping” role to enforce rules which govern the bond signed by all the subjects. Validation requests (outflow) were compared with the national production (supply) of nurses and midwives.

Results

In the four year study period, 3, 126 nurses and midwives sought verification; 731 in 2002, 923 in 2003, 786 in 2004 and 686 in 2005. The observed 14.8% decrease in 2004, 25.7% decrease in 2004, and 25.7% in 2005 were associated with the rule enforcement. Respondents 3 most common target destinations were the UK (71%), the USA (22%) and Canada (3.4%). When the supply was matched against the outflow of subjects, net deficits were observed: -40%, -44.3%, -18.3% in years 2002, 2003 and 2004 respectively.
Discussion
The Council is in a unique position to provide quality data on migration of Ghanaian nurses and midwives, given its track record, commitment to action research and the welfare of the profession. In this study, the data source (the Council) is reliable, and accessible. The data was well defined, accurate, measurable and comprehensive and the data collection process was cost-effective, on-going and has remained uninterrupted for decades. Two findings in the study are noteworthy: the effective performance of a gate-keepers role was associated with a downward trend in the migration of subjects; the numbers leaving were more than the numbers produced annually. About 95% of respondents were heading for the UK, USA and Canada. This was as expected from the well-documented “pull factors”.

Recommendations and Conclusions
Human resources information systems should be set up to monitor the migration of nurses and midwives. Gate-keeping roles are useful but not sufficient. Policies and strategies to enhance retention of a highly trained workforce should be comprehensive and better focused. In conclusion, it should be remembered that no matter how strong pull factors may be, migration ensues only if push factors are stronger. For Ghanaian nurses and midwives today, effective incentives include attractive salary; performance-related pay; opportunities for further training; defined career development plan and structured promotion; adequate pension: assistance with ownership of cars and houses as well as payment of children’s school fees.
Mitigating the effects of nursing migration: development of bilateral policies between sending and destination countries

Authors
> Fely Marilyn Elegado-Lorenzo (contact author), DrPH, senior researcher, Institute of Health Policy and Development Studies, National Institutes of Health, University of the Philippines, Manila, marilynlorenzo@gmail.com
> Jennifer E de la Rosa, MPH, researcher, Institute of Health Policy and Development Studies, National Institutes of Health, University of the Philippines, Manila, jfedelarosa@yahoo.com
> Julita Yabes, MPH, researcher, Institute of Health Policy and Development Studies, National Institutes of Health, University of the Philippines, Manila, jfedelarosa@yahoo.com
> Vanessa Manila, BSN, research assistant, Institute of Health Policy and Development Studies, National Institutes of Health, University of the Philippines, Manila

Context
Nurse migration has become an important feature of globalized labour markets in health care. Concern about international migration in health services has become more acute due to the widespread observation that the demand for highly skilled health workers such as nurses is largely met by developing countries.

The Philippines is recognized as one of the major source countries of nurses. This Philippine nurse migration policy and retention case study describes migration patterns from a sending country perspective and analyses current nurse migration policies and programmes towards facilitating the development and implementation of effective policies and programmes to ensure managed national nurse migration and institutional nurse retention.

Objective
This study aims to identify key policy and programmatic issues that need to be addressed in crafting effective policies and programmes to promote managed migration and nurse retention programmes and propose national and institutional policies and programmes to ensure effective nurse retention and managed migration.

This study utilized a descriptive analytic case study design. Reviews of literature and records were conducted to determine the current status of nurse migration
and describe migration practice models in different areas in the world. Based on the results of the literature review, international and national stakeholders were consulted to determine current practices of Philippine nursing migration regulation and nurse retention. This was capped with an analysis of policy and programmatic bases of Philippine nurse migration and retention practices that aimed to ensure that international exchange of nurse resources was mutually beneficial to both sending and destination countries.

Findings

Findings revolved around policy categories that need to be given attention, including recruitment and entry, re-entry to sending country, licensure and scope of practice, skill mix, welfare and human resource development and retention, protection of the rights of migrant workers, mechanisms to mitigate impact of migration on developing countries, poverty alleviation, and social and community development.

Possible core components of good-practice bilateral or multilateral cooperative agreements to manage migration were identified. Best practices were identified around the policy issues of recruitment, entry, citizenship, retention and re-entry.
Trends, magnitude and reasons of nurse migration out of Lebanon

Authors
> Fadi El-Jardali (contact author), Department of Health Management and Policy, Faculty of Health Sciences, American University of Beirut, Lebanon, fe08@aub.edu.lb
> Nuhad Dumit, School of Nursing, Faculty of Medicine, American University of Beirut, Lebanon
> Diana Jamal, Department of Health Management and Policy, Faculty of Health Sciences, American University of Beirut, Lebanon
> Gladys Mouro, American University of Beirut Medical Center, Lebanon

Context
Nursing has become a mobile profession. Nurse migration is multifactorial and is not limited to financial incentives. Lebanon is facing a problem of excessive nurse migration to countries of the Gulf, North America and Europe. No study has been conducted yet to understand the determinants and magnitude of the problem. Therefore, understanding the factors that drive the migration of Lebanese nurses is critical.

Objective
The objective of this research study is to provide an evidence base for understanding the incidence of nurse migration out of Lebanon, its magnitude and reasons.

Methods
A cross-sectional research design comprising both quantitative and qualitative methods was employed to achieve the stated objectives. This includes a survey of migrant nurses, survey of nursing schools in Lebanon, survey of nurse recruitment agencies and secondary data analysis.

Findings
An estimated one in five nurses that receive a Bachelors of Science in Nursing migrates out of Lebanon within one or two years of graduation. The majority of nurses migrate to countries of the Gulf. The main reasons for migration included: shiftwork, high patient/nurse ratios; lack of autonomy in decision-making; lack of a supportive environment; and commitment to excellent nursing care. Furthermore, nurses reported that combinations of financial and non-financial incentives can encourage them to return to practice in Lebanon. The most recurring incentives (pull
factors) to encourage nurses to return to practice in Lebanon included education support, managerial support, better working conditions, utilization of best nursing practices and autonomy.

Conclusions

Nurse migration and retention have become major health workforce issues confronting many health systems in the Eastern Mediterranean region. Our study demonstrated that nurse migration is a product of poor management and lack of effective retention strategies and sufficient knowledge about the context, needs and challenges facing nurses. Nurse migration in Lebanon underscores the importance of developing a monitoring system that would identify implications and help implement innovative retention strategies.
Strategies for the distribution and retention of doctors in national systems of health: the Brazilian case

Author
> Romulo Maciel Filho, MSc, PHD, Oswaldo Cruz Foundation, and Minister’s Special Advisor, Ministry of Health of Brazil, romulo.maciel@saude.gov.br

Context
The geographical distribution of medical services is a matter that challenges national systems of health and, in Brazil, is becoming one of the main challenges facing efforts to consolidate the Brazilian National Health System (SUS). This analysis of the determinants of this distribution is based on consideration of aspects of employment of doctors within a historical, political, economic, social, and institutional context. The objective of this study is to determine the factors that influence the distribution and retention of doctors and to identify possible intervention strategies that can be applied within the Brazilian political setting. The discussion recognizes the concern that the geographic concentration of health professionals and services obstructs realization of the guiding principles of the SUS, particularly the aim of universalization of service delivery.

Methods
The strategies of the Brazilian government to deal with this situation are highlighted, for example the Rondon Project, the PIASS and the PISUS (SUS programme for the rural areas). The analysis is complemented by a case study on the recent experience in the field of a public health programme designed to minimize the unequal distribution of doctors in the country: the PITS programme, implemented by the Ministry of Health in 2001, which aims to stimulate and increase employment in the health sector in the interior of Brazil.

Conclusion/Lessons learnt
This initiative for human resources in health has enabled identification of relevant measures to strengthen the distribution of health professionals in areas away from the major urban centres. The study concludes with an analysis of the distribution and retention of doctors based on a review of literature, discussion of related national and international experiences, and the results obtained from the case study.
Emerging trends, challenges and issues in regulation of migrating nurses

Authors
> Mireille Kingma, PhD, MA, BSc, RN, International Council of Nurses
> Barbara Nichols, DHL, MS, RN, FAAN, CGFNS International
> Judith Oulton, Med, RN, International Council of Nurses

Context
International trade agreements have existed for decades. Today’s agreements also influence the migration of workers across borders, in addition to agriculture and manufactured goods. These migrating workers account for millions of dollars in remittances to their families at home. Nations need more than migrant and seasonal workers. No group is in higher demand than nurses. The General Agreement on Trade in Services is a World Trade Organization agreement and includes 140 countries. The goal is to remove any restrictions and governmental regulations related to international trade in services. One area of service trade is individuals that supply services in another country. This “movement of natural persons” includes professionals in speciality occupations, nurses and other health-care workers.

Objective
To look at nurse migration flows in the light of trade agreements, and examine regulatory factors that encourage or inhibit nurse mobility.

The North American Trade Agreement’s primary focus is to remove barriers to trade and investment between the United States, Canada and Mexico. It allows easier migration of professionals. Those provisions are reflected in the United States Immigration Nationality Act, which governs the certification of health-care workers and affirms the United States maintenance of professional standards and licensure for protection of public health. The European Union applies its principle of free movement of persons and they also work on a system of mutual agreements. Participation in these trade agreements, which promote professional migration, may be an incentive for economically strapped nations.

Conclusions
The emphasis of this lecture/paper is to address the development of international markets in health-care service as a result of international commercial policy, such as trade agreements.
Impact of nurse migration on health service delivery

Authors
> Mireille Kingma, PhD, MA, BSc, RN, International Council of Nurses
> Barbara Nichols, DHL, MS, RN, FAAN, CGFNS International
> Judith Oulton, Med, RN, International Council of Nurses

Context
International mobility is a reality in a globalized world. Nurse supply and demand imbalances exist worldwide. In many industrialized countries there are shortages, and for some, international recruitment has been seen as a strategy to fill vacancies. Nurse migration is shaped by a constellation of social forces and determined by a multitude of stakeholders. Insufficient numbers of nurses, for whatever the cause, impacts health delivery systems in their ability to provide care and services.

Objective
To review nurse supply and demand globally, explore information about nurse migration and assess policy implications within the context of health-care delivery.

Conclusions
This paper/lecture will discuss nurse migration as it relates to health sector workforce planning and policy, building on country- and regional-level models with examples drawn from both source and destination countries. Where appropriate, examples from outside the health sector may be incorporated.
Human Rights and Migration

Authors
> Mireille Kingma, PhD, MA, BSc, RN (International Council of Nurses)
> Barbara Nichols, DHL, MS, RN, FAAN (CGFNS International)
> Judith Oulton, Med, RN (International Council of Nurses)

Context
Migration has been a fact of life from time immemorial. However, the current wave of migration is different in several ways from that which occurred in the 19th and early 20th centuries. The main characteristic difference is that current migration is no longer a mass movement of the poor, the wretched and the homeless, but primarily a movement of the elite from less prosperous countries to several of the richest countries in the world. This particular form of migration is popularly referred to as the “Brain Drain” or conversely, “Brain Gain”. It involves professionals of many disciplines, including physicians and nurses. Ethical and human rights questions are raised as nurse migratory patterns emerge.

Objective
To discuss migration in the context of human rights factors, such as diversity, cultural differences, ethical recruitment and globalization of the nursing workforce.

Conclusions
The emphasis of the lecture/paper is to examine human rights concerns as nurses migrate to work in the global village.
Understanding external migration of Ghanaian nurses: results from qualitative research

Authors

> Tomas Lievens (contact author), senior consultant, health economist, Oxford Policy Management, 6 St Aldates Courtyard, 38 St Aldates, Oxford OX1 1BN, United Kingdom, tel. +44 1865 207 325, fax +44 1865 250 580, http://www.opml.co.uk, tomas.lievens@opml.co.uk
> Sabine Garbarino, social development consultant, Oxford Policy Management, sabine.garbarino@opml.co.uk
> Peter Quartey, senior researcher, Institute of Statistical, Social and Economic Research, University of Ghana, peter.quartey@btinternet.com
> Pieter Serneels, lecturer in Economics, University of East Anglia, p.serneels@uea.ac.uk

Context

External migration has for a long time dramatically impacted the human resources for health sector in Ghana and has attracted considerable attention from researchers as well as policy-makers. External migration has often been tackled with command-and-control type policies, building on prevention and reproof. Comparatively little attention has been paid to uprooting the motivations underpinning health workers’ decisions to seek employment abroad.

Objective

This study tries to elicit the incentives and institutional framework involved in the decision to externally migrate.

Method

The data was collected through four focus group discussions with Ghanaian nurses: with nurses that have taken the decision to migrate and are about the leave the country; nurses presently working in London (United Kingdom); nurses that have retuned to Ghana after having worked abroad; and nurses who have never left nor plan to leave the country.

Findings

The presentation will provide descriptive findings and tentative explanatory hypotheses regarding the questions addressed in the focus group discussions, including:

- What are the most important drivers of migration?
• Is the prospect of external migration a factor in the decision to enter the health sector?

• What is the role of training institutions?

• What are the barriers to migration both in Ghana and in the receiving countries?

• What are job expectations of candidate nurses and what are the actual job prospects of those that have migrated?

• When and why do nurses consider coming back to Ghana?

• How do the current incentives provided within the Ghanaian health labour market impact the decision to migrate or to come back to Ghana?
Facilitation of the recruitment and placement of foreign health care professionals to work in the public sector health care in South Africa: assessment

Author
> International Organization for Migration (IOM), Regional Office for Southern Africa, in partnership with the South African Department of Health
> Reiko Matsuyama (contact), project officer, IOM, Pretoria, tel. +27 12 342 2789, fax +27 12 342 0932, mobile +27 72 238 8902, rmatsuyama@iom.int

Context
South Africa faces human resource challenges, including that of ensuring adequate staffing of the public sector health system. There are substantial differences in health worker density between the public and private sectors, and between rural and urban areas.

One response is to recruit foreign health-care professionals. However, due to limited capacities at the National Department of Health and the professions’ councils, and lack of sufficient information, foreign health-care professionals seeking opportunities in South Africa often find the application and registration processes discouraging.

Objective
The objective is to assess the feasibility and interest among stakeholders in the Netherlands, United Kingdom and United States in facilitating recruitment and placement of foreign health-care professionals to work in public sector health care in South Africa.

Methods
A mapping exercise of relevant institutions and associations, including ministries and departments, academic and professional partnerships and exchanges, as well as private initiatives (foundations, nongovernmental organizations, for-profit institutions).

Findings/conclusions
The findings led to the following recommendations to attract diaspora and foreign health-care workers:
• encourage engagement through various forms of investments and exchanges, such as training assistance and temporary, circular, or virtual returns;
• initiate long-term collaborative exchanges and twinning relationships,
such as establishing rural centres of excellence that can facilitate research, training and information sharing;

• provide web-based postings and centralized databases for recruitment, matching, and tracking;

• establish a centralized clearing house of information;

• provide placement and post-placement assistance, addressing concerns such as security, placement levels, registration and licensing, citizenship, residency and visa requirements, and assistance to families.
Uganda health workforce study: satisfaction and intent to stay among health workers in public and private not-for-profit (PNFP) health facilities

Authors

> Pamela A McQuide (contact author), RN, PhD, senior workforce and policy advisor, IntraHealth International/Capacity Project, 6340 Quadrangle Drive, Suite 200, Chapel Hill, NC 27517, USA, tel. 919 313 9167, mobile 919 622 1644, pmcquide@capacityproject.org
> Paul Kiwanuka-Mukiibi, MD, managing director/senior consultant, PS Consulting, pkj@psconsulting-ug.com
> Anneke Zuyerduin, PhD, RN, senior health consultant, anneke.zuyderduin@gmail.com
> Charles Isabiryie, medical educationist, Human Resources for Health Planning and Development, Uganda Ministry of Health, cisabiryie@netscape.net

Context

This study was done at the request of the Uganda Ministry of Health regarding its concerns about health workers’ morale, job satisfaction and motivation, as well as their intent to stay in Uganda and continue working in the health sector. There is a growing consensus that the significant health challenges facing sub-Saharan Africa cannot be addressed without strengthening health systems and providing better support for the health professionals who work in those systems.

Objectives

- Identify the level of satisfaction among current health workers in the public and PNFP sectors;
- Determine the health workers’ intent to stay in the Ugandan health sector;
- Collaborate with the Ministry of Health and other stakeholders to develop strategies to improve retention of health workers across the various sectors.

Methods

Quantitative and qualitative methods were used to collect information from 397 public and 411 PNFP health workers in nine randomly selected districts (including three hard-to-reach districts). Analysis was done using frequencies, cross-tabulations, student t-test, logistic and linear regression analyses for the quantitative questions. The qualitative program NVIVO was used to analyse the focus group interviews.
New findings
A number of factors were found to contribute to satisfaction and intent to stay. Some examples include the following: about half of the health workers planned to stay in their jobs indefinitely (54%); doctors are the cadre of health workers most likely to say they are eager to leave their jobs within two years (57%) and at risk of leaving the health sector; only 36% of respondents thought their workload was manageable; 24% percent of respondents reported they had been abused by their supervisor. These and other factors will be discussed at the session.

Conclusions
The overall job satisfaction among Ugandan health workers is not high, and working and living conditions are extremely poor. These findings may give policy-makers reasons for the overall poor performance of the health sector and suggest areas that need to be improved in order to increase access to quality health services.
A northern strategy: an action plan for mitigating HRH pull factors

Author
Fitzhugh Mullan, MD, Murdock head professor of Medicine and Health Policy, Department of Health Policy, George Washington University, 2021 K St, NW Suite 800, Washington, DC 20006, tel. 202 530 2341, fax 202 478 2772, fmullan@gwu.edu

Context
Recent research suggests that 20% of African physicians and 10% of African nurses reside in northern countries. In the United States alone there are predictions of a shortfall of 800 000 nurses and 200 000 physicians by 2020. These trends and the absence of formal policies in northern countries that promote health workforce self-sufficiency promise increasing levels of health worker migration from the South to the North.

Objectives
- To document the importance of under-training in the North as a driver of migration from the South;
- To discuss vehicles for raising public awareness in northern countries about human resources for health (HRH) inequities;
- To propose actions that could be taken by northern countries to mitigate the brain drain.

Methods
- Literature review;
- Review of research findings;
- Presentation of data in regard to migration, reverse flows and capacity development support.

New findings
In addition to codes of ethics it will be proposed that northern nations engage in:
- HRH tracking to determine the levels of southern health workers entering northern workforces on an annual basis;
• the establishment of northern goals for HRH self-sufficiency, including guidelines and targets;

• HRH capacity support targets in which northern nations would set goals for financial assistance for capacity development in southern countries;

• Reverse flow tracking in which northern nations would promote the mobilization of increased numbers of health workers to assist in health system development in the South.

Conclusion

Lack of heightened awareness in the North and more rigorous metrics related to northern immigration and southern capacity development, the best efforts of southern nations to improve the management of HRH will not offset the pull from the North. It will be proposed that a responsible HRH capacity index be developed for northern countries based on the tracking factors above.
Human resources retention scheme: qualitative and quantitative experience from Zambia

Authors
> Hilary Francis Mwale, BA, MPA, human resource technical specialist, Health Services and Systems Programme (HSSP), Abt Associates Inc., Lusaka, Zambia, tel. 260 1 254 552, hilarym@hssp.org.zm
> Simon Smith, MHA, technical coordinator, HSSP, Abt Associates Inc., Bethesda, MD, USA, tel. 301 347 5150, simon_smith@abtassoc.com

Context
The health worker shortage has adversely affected the delivery of health services to the Zambian population, exacerbated by distribution gaps of health workers between rural and urban areas. Currently, more than 50% of rural health centres have only one qualified staff member present. The Ministry of Health is implementing a pro-poor Zambia Health Workers Retention Scheme (ZHWRS). The scheme is meant to retain physicians, nurse tutors, nurses and other health cadres in key positions and critical rural locations. The ZHWRS features incentive systems including opportunities for car loans, school fees, education allowances, hardship allowances and transportation and housing allowances.

Objectives
- Describe the design and approach of the health worker retention scheme in Zambia;
- Provide quantitative data on retention scheme results and qualitative input from participants on key factors, motivations and incentive systems that lead to sustained participation in a retention programme.

Methodology/design
This presentation will provide background and an overview on the design and implementation of the ZHWRS, including results, lessons learned and challenges. In addition, a qualitative study is planned, in which participants of the ZHWRS, both active and inactive, will be interviewed to understand experiences and explore features of the scheme that are key to sustained participation in a rural retention programme.

Results
The retention scheme was initiated in 2003, with expansion based on success of the pilot programme’s 95% retention rate. The pilot has 69 physicians placed in
rural districts. Multiple donors support scale-up of the programme (165 physicians, 188 nurse tutors, 1365 other cadres including laboratory technicians, pharmacists and clinical officers). To manage a scaled-up retention programme, management and support functions are being instituted at all levels of the health system. The qualitative study will identify the most significant incentive factors in a worker’s decision to continue participation in the programme.
Migration of Nurses in Botswana, Brain Drain or Brain Gain?

Authors
> Gloria Thupayagale-Tshweneagae, MNS, RN, Lecturer - School of Nursing, Faculty of Health Sciences, University of Botswana tshweneagaeg@mopipi.ub.bw
> Geetha Feringa, MEd, RN, Executive Secretary - Nurses Association of Botswana nab@global.bw Nurses Association of Botswana, P.O. Box 126 Gaborone, Botswana, Tel:+ 267 3953840

Context
The paper was prepared at the behest of the Nurses Association of Botswana (NAB) in conjunction with Botswana Trade and Poverty programme (BTTP). The study was sponsored by the Overseas Development Institute.

Internal and external migration of nurses has been a global concern because of its impact on the quality of nursing service and the general health care system. Concerns for nurse migration are aggravated by a shortage of the nursing workforce. Migration of nurses in Botswana is not only limited to nurses in service but also to those in education and the impact has been felt on the demand and supply of nurses in Botswana.

Objective
The purpose was to look into the migration of nurses. The nurse in Botswana has been a key figure in the health care delivery system ever since the establishment of the country’s health care system. Nurses in Botswana constitute more than 60% of all the health care human resources.

Method
A literature review outlined different factors that make nurses migrate and has dubbed those the ‘pull and push’ factors, including poor working conditions, poor quality of life for nurses; low pay, unplanned transfers and slow professional progression. Such factors are also eminent in Botswana. Quantitative and qualitative methods were utilized in data collection and analysis. The sample survey covered 5% of all nurses in formal employment in Botswana.

Findings
The most revealing finding in this study was that nurses who migrate would want to come back after they have achieved some of their needs, such as the ability to
purchase a house and further their studies. HIV/AIDS was a factor in nurse migration in Botswana especially for nurses who have migrated. A need for self development superseded all other push factors.

Conclusions
A small percentage of nurses have migrated (7%), however, the intent for nurses to migrate is still very rife in Botswana, because of poor working conditions and the fact that international agencies still come to Botswana for recruitment of the nursing workforce. The study recommends that there should be temporary positive migration policy for a period of five to ten years.
Addressing health worker migration in source countries: experiences from an ILO Action Programme

Author
Christian Wiskow, health services specialist, Sectoral Activities Programme, International Labour Organization (ILO), Geneva, Switzerland, wiskow@ilo.org

Context
In March 2006 the International Labour Organization launched a two-year Action Programme on The International Migration of Health Service Workers: The Supply Side, which has been implemented in close collaboration with the World Health Organization (WHO) and the International Organization for Migration (IOM).

The overall aim of the Action Programme is to develop and disseminate strategies and good practices for the management of health worker migration from the supplying nations’ perspective. Six countries agreed to participate in this programme: Costa Rica, Kenya, Romania, Senegal, Sri Lanka and Trinidad and Tobago. Major areas of action include social dialogue and stakeholder involvement, the improvement of quality of data and specific research. The majority of the participating countries identified the need for data improvement as a priority and conducted research as a basis to inform the development of strategies and policies addressing health worker migration.

Objective
This paper will present a preliminary summary of findings of the original research undertaken in the participating countries in 2007. It will further review the process of implementing the action programme, showing the variety of approaches, activities, results and challenges. From an ILO perspective, the establishment of social dialogue and stakeholder involvement are crucial for developing consolidated strategies to address the migration of health workers in the source countries.

Conclusion
The strengths and challenges in taking this consultative and participatory approach will be critically analysed. The lessons learned are intended to inform and help other source countries in improving their strategic approaches to health worker migration.
# List of abstracts

## Financing

**Alphabetical order by first author**

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. K Baker et al</td>
<td>Gaps in sustainable financing and a critique of the emerging architecture of global health aid</td>
<td>212</td>
</tr>
<tr>
<td>P. Jensen et al</td>
<td>Building policy consensus for the reform of IMF program policies</td>
<td>214</td>
</tr>
<tr>
<td>M. Philips et al</td>
<td>Fiscal space for health expenditure in Mozambique: blocking effectiveness of international funds through budget support</td>
<td>216</td>
</tr>
<tr>
<td>A.S. Preker et al</td>
<td>Scaling up health education: opportunities and challenges for Africa</td>
<td>218</td>
</tr>
<tr>
<td>C. Sekabaraga et al</td>
<td>Block granting, performance-based incentives and the fiscal space issue: the new generation of HRH reform in Rwanda</td>
<td>220</td>
</tr>
<tr>
<td>M. Vujicic</td>
<td>Floors and ceilings: how government wage bill policies affect the scaling up of the health workforce</td>
<td>222</td>
</tr>
</tbody>
</table>
Gaps in sustainable financing and a critique of the emerging architecture of global health aid

Author
> Brook K Baker, professor, Northeastern University School of Law, GHWA/HWAI, Policy Advisory, Health GAP, b.baker@neu.edu

Context
World Health Organization (WHO) cost estimates for overcoming critical health workforce shortages have grown from $5.8–20.9 billion in 2008 to $15–40.5 billion in 2015 for Africa – other needs add billions more. The Global Fund, GAVI, World Bank and PEPFAR have acknowledged the need to address health workforce constraints, as have new initiatives from Canada, Germany, Norway and the United Kingdom. Questions remain whether these entities are promising investments sufficient to reverse the human resources for health (HRH) crisis and whether they are constructing a coherent architecture for global health aid.

Findings
Development assistance for health remains grossly insufficient, having increased from only $7 billion in 2000 to an estimated $16 billion in 2006, constituting only 3% of total health spending (15% in Africa). Almost no funding focuses on expanding HRH:

- World Bank HNP funding increased from $1.5 to $2.5 billion, FY06/07, but its effectiveness was compromised by an insistence on private sector service delivery, macroeconomic stability and loans not grants.

- PEPFAR spent only $350 million on HRH and health system strengthening (HSS) through 2006, but jumped to $640 million FY07, claiming a focus on human capacity building and systems development; the major portion of HRH funding has been for in-service training.

- The Global Fund has historically spent 22% of its funding on HRH/HSS ($363 million/$2.7 billion in Round 7), mostly for training and capacity building. However, the Global Fund too has shown ambivalence about expanding HRH and general HSS.

- Most new initiatives promise coordination but few resources.
The emerging global architecture for coordinating health-related financing is incoherent. GHWA is creating an advocacy and technical platform, but it is doing so within a confusing and confused mix of proposed coordinating and funding entities.

**Conclusion**

Donors need to devote more resources and create a more coherent architecture to meet the sustainable financing needs of a workforce able to respond to global health commitments.
Building policy consensus for the reform of IMF program policies

Authors
> Paul Jensen (contact author), global research coordinator, RESULTS Educational Fund, 750 First Street, NE, Suite 1040, Washington, DC 20002, tel. 202 783 4800 ext. 111, pjensen@results.org
> Joanne Carter, RESULTS Educational Fund, 750 First Street, NE, Suite 1040, Washington, DC 20002
> John Fawcett, RESULTS Educational Fund, 750 First Street, NE, Suite 1040, Washington, DC 20002
> Jen Maurer, RESULTS Educational Fund, 750 First Street, NE, Suite 1040, Washington, DC 20002
> Cynthia Tschampl, RESULTS Educational Fund, 750 First Street, NE, Suite 1040, Washington, DC 20002

Background
Evidence has shown that International Monetary Fund (IMF) programmes adopted by poor countries tend towards limiting the fiscal space with which to meet urgent health needs, including hiring and retaining public sector health workers. To restrict or reduce public spending, IMF programmes have relied heavily on wage bill ceilings, which have the effect of restricting the hiring and remuneration of health workers. Reforming IMF programmes to enable greater investment in health is a critical part of addressing the health worker crisis.

Objectives
To build consensus around the need for IMF policy reform through research and advocacy, ultimately intended to enable and promote the scale-up of public health workforces in poor countries.

Methods
Advocacy
- Partner with activists to conduct advocacy activities in Kenya, Tanzania and Zambia; conduct United States advocacy tours with African spokespersons;
- Leverage an international grass-roots network of activists to advocate with policymakers, IMF officials and board representation, and the media;
- Co-chair a working group of civil society allies advocating IMF reform;
- Engage high-level spokespersons to deliver messages to key audiences.
Research

- Partner with researchers in sub-Saharan Africa to conduct budget monitoring and research on the impact of IMF programmes on health spending.

New findings

Many opportunities exist to engage health experts as spokespersons; to educate policy-makers with no previous involvement in the issue; and to increase uptake among civil society groups working on health issues. Key results so far include:

- United States advocacy tour conducted by former Kenyan education ministry official;
- advocacy activities reported on by the British medical journal *The Lancet*;
- two letters delivered to IMF managing director Dominique Strauss-Kahn – one signed by 120 civil society organizations, the other by 9 members of Congress presiding over United States involvement in the IMF.

Lessons learned

While opportunities exist, there is need for broader and better-coordinated advocacy towards reforming IMF policies that serve to restrict investment in health, including the workforce.
Fiscal space for health expenditure in Mozambique: blocking effectiveness of international funds through budget support

Authors
> Mit Philips (contact author), Médecins sans Frontières, Rue Dupré 94, 1090 Brussels, Belgium, mit.philips@brussels.msf.org
> Gorik Ooms, Médecins sans Frontières, Rue Dupré 94, 1090 Brussels, Belgium

Context
The high prevalence of HIV/AIDS compounds the health workforce gap in Mozambique, with 20 nurses and 2.6 doctors per 100,000 inhabitants, one of the lowest health worker ratios per population. Mozambique receives substantial donor aid, including for health, with preference for increased budget support. General or sector-specific budget support is currently the only channel allowing international funding to improve salaries for or recruit additional Ministry of Health staff. Fiscal ceilings limit funding of these recurrent costs.

Objectives
This case study looked at caps on health spending and wage bill expenditure as an obstacle to the use of international funding for health, particularly for boosting the health workforce.

Methods
An analysis was undertaken of available data on, for example, the public health budget, wage bills and international funding. Interviews were conducted with all major stakeholders in Mozambique.

New findings
Mozambique at present applies a ceiling to its primary deficit. This ceiling reflects the estimated capacity of Mozambique to accommodate expenditures financed with aid within the domestic budget constraint in a reasonable period of time. The International Monetary Fund (IMF) and others assume foreign assistance is at best temporary, and recurrent expenditure should therefore be limited to the (future) domestic budget.

As this ceiling does not consider donor grants, it acts as a cap on international aid for recurrent expenditure (medicines, salaries). Turning down aid is sensitive, so international funding in excess of this ceiling is rather diverted to increase international
reserves or public savings. During the period 2004–2006, international reserves grew by US$315 million, equivalent to 91% of the increase in international funds over this period. In 2006, for each additional aid dollar, 50 cents were programmed to increase international reserves. Most donors are unaware of this.

All international funding through budget support will be affected by this “IMF tax”. Specific common pool funds are somewhat ring-fenced and project aid is specifically not covered by the cap, and thus could increase. Current limitations will basically have the same bottleneck effect on any budget support as explicit ceilings. This will act as an incentive to Mozambique to accept the international aid, but to divert it to international reserves or public savings.

Conclusions and lessons learnt
The IMF advises Mozambique to limit its public expenses to the domestic primary deficit, which is, in effect, current expenditure covered by donor budget support. This de facto caps budget support, while project aid is not affected. Donors should adapt their funding channels to these mechanisms in order to spend international aid effectively for health. Disease-specific project aid grant (or ring-fenced common funds) could be more effective than comprehensive budget support grant. Greater transparency on these matters is urgently needed.
Scaling up health education: opportunities and challenges for Africa

Authors
> Alexander S. Preker, World Bank, 1818 H Street NW, Washington, DC 20433, USA, apreker@worldbank.org
> Marko Vujicic, World Bank
> Yohana Duchan, World Bank
> Caroline Ly, World Bank
> Hortenzia Beciu, World Bank
> Peter Nicolas Materu, World Bank

Context
This report reviews the economics of scaling up education for health workers in the context of the Africa region. It provides an assessment of the likely resource envelope that might be available to the health and education sectors by 2015 using different assumptions about economic growth, political commitment to spending on health care and institutional development; an estimate of the number of additional staff that could be hired by countries under the different resource envelope scenarios; and an estimate of the costs of scaling up the education of health workers in terms of recurrent and capital costs. All estimates were done on a country-by-country basis. Regional estimates are based on the sum of this detailed country-level analysis. Scaling up health education has significant implications for both the health and education sectors. The cost of employing new staff falls on the health sector, while the cost of educating health workers falls mainly on the education sector.

Findings
Projecting economic trends based on the past 10 years would allow countries in the Africa region to absorb around 648,000 new staff by the year 2015. If, however, there were a skills mix shift to more highly skilled workers the absorptive capacity would be reduced to about 412,000 additional workers, while a skills mix shift to lower-skilled workers would increase the absorptive capacity to about 959,000 new workers. A wage increase of about 25% over time would partially offset this increase in staffing. Under a best-case scenario and skills mix shift towards high skills, a number of countries could reach the World Health Organization target of 2.5 health workers per 1000 population. Most countries, however, are not likely to enjoy the sustained growth, commitment to increasing public spending on the health sector or mobilization of additional resources through health insurance that are needed to achieve this target. In many countries, the binding constraint to scaling
up health education is not only the limited absorptive capacity of the health sector to hire the resulting staff but the limited resources in the education sector to train the additional staff and make the needed capital investments to increase the capacity and throughput of training institutions. In a number of countries, the cost of educating the addition health workforce would outstrip the annual higher education budgets of the ministries of education. Furthermore, many countries trying to scale up health education also need to consider parallel measures to ensure that the secondary education system is producing a sufficient supply of graduates to feed a scaling up of health education.

Although additional donor aid to both the health and education sectors is a possible solution, it is worth noting that the expenditure analysis used under the various scenarios already included current and projected levels of donor assistance. The analysis showed that increasing donor assistance by 100% improves the situation but still does not allow the region to attain the 1 million additional health workers under a projection of past trends scenario. There is considerable scope, however, for better earmarking of some overseas development aid to scale up health education, especially in the case of some of the larger international funds devoted to addressing major public health priorities.
Block granting, performance-based incentives and the fiscal space issue: the new generation of HRH reform in Rwanda

Themes: Incentives, fiscal space, decentralization

Authors
> Claude Sekabaraga, director of planning, policy and capacity building, Ministry of Health, Rwanda, claude.sekabaraga@gmail.com
> Aly Boury Sy, health economist, World Bank, asy@worldbank.org
> Agnes Soucat, lead health economist, World Bank, asoucat@worldbank.org

Context
Rwanda has made a remarkable transition from reconstruction to development since the 1994 genocide that killed about 1 million people. Outcomes have been most significant in the area of health service delivery.

Objectives
This paper reviews how Rwanda, faced with constrained fiscal conditions, has implemented innovative reforms to create fiscal space for human resources, and make human resources more responsive to needs.

Methods
The study relied mainly on an analysis of budget documents and policy and regulation changes. Key informant interviews were also conducted.

Findings
Although Rwanda has recently been able to mobilize sizeable funding for the health sector, mainly for HIV, it has faced a relative contraction of its overall wage bill. The health sector succeeded nonetheless in creating the needed fiscal space by institutionalizing an innovative model aimed at increasing the efficiency with which funds are allocated. This model uses a three-pronged approach comprising fiscal decentralization, performance-based budgeting and the use of performance-based incentives. To get a better fit between local needs and the allocation of health workers, Rwanda has implemented in a very short time a fiscal decentralization process through which health centres and hospitals fully control their human resource budgets, transferred to them as a block grant. The wage bill was delinked from civil service restrictions. Rwanda has also implemented a performance-based budgeting system through which health facilities all over the country are funded depending on their results. Finally, financial incentives are provided for hardship posts as well...
as for the delivery of a limited number of high-impact interventions related to the Millennium Development Goals.

Conclusions
This study concludes that despite the relative contraction of the overall wage bill, Rwanda has succeeded through decentralization and the introduction of performance-based financing in linking salaries to quality services in the health sector.
Floors and ceilings: how government wage bill policies affect the scaling up of the health workforce

Author
> Marko Vujicic (contact author), economist, Human Development Network, World Bank, tel. +1 202 473 6464, mvujicic@worldbank.org

Context
There have been persistent claims that wage bill ceilings in developing countries – often thought to be influenced by the International Monetary Fund (IMF) – are a key constraint to scaling up the health workforce, and therefore the principle barrier to improving health service delivery. A recent mapping by the IMF has indicated that of the 30 countries that have a Poverty Reduction and Growth Facility (PRGF)-supported programme, 14 have some form of public sector wage bill conditionality as part of the programme. This includes 11 out of 18 African countries. However, there is little empirical analysis of how aggregate wage bill policies have influenced the resource envelope (and therefore the demand) available for hiring health workers in the public sector. Has the health sector been exempt from public sector downsizing, has it been targeted, what determines the share of health spending that goes to salaries, how does this differ across countries and what are the policy implications? These questions are hotly debated yet very few empirical data have been analysed to answer them.

Objective
This study examines the relationship between overall public sector wage bill policies and wage bill and employment levels in the health sector. Information is drawn from four country cases: the Dominican Republic, Kenya, Rwanda and Zambia. In addition, date analysis is carried out on a cross-country dataset compiled from data sources at the World Health Organization (WHO), the IMF, the World Bank and the International Labour Organization (ILO).
Findings and Conclusions

The main results are that overall wage bill constraints do not influence the scaling up of the health workforce in a consistent way. Some countries deliberately budget and spend wage bill resources preferentially to the health sector, while in others the budgeted and the actual expenditures differ greatly, so that the rhetoric of prioritizing the hiring of health workers is not supported by the evidence. In addition, besides constraints on the overall resource envelope for salaries in the health sector, there is strong evidence that there are incredible inefficiencies in the management of human resources. This suggest that the global debate needs to shift towards strengthening public sector management functions before additional resources can be absorbed on a large scale.
List of abstracts
Partnerships and linking up for action

Alphabetical order by first author

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>U. Adano et al</td>
<td>Improving morale, motivation and employee satisfaction through low-cost work climate improvement initiatives: case study of ten rural public and FBO health facilities in Kenya</td>
<td>227</td>
</tr>
<tr>
<td>G. Dhaene</td>
<td>PPP initiatives and the HR crisis in the health sector</td>
<td>229</td>
</tr>
<tr>
<td>A. Hagopian et al</td>
<td>Strengthening health systems: a code of conduct for international non-government organizations</td>
<td>231</td>
</tr>
<tr>
<td>S. Islam</td>
<td>Reaching health to the unreachable: mobile medical teams and partnerships</td>
<td>233</td>
</tr>
<tr>
<td>M. Katana et al</td>
<td>People living with HIV: a key resource in the delivery of the Uganda National Minimum Health Care Package</td>
<td>235</td>
</tr>
<tr>
<td>B. Keliat</td>
<td>Capacity building for mental health nurses and doctors in the community in a post tsunami and conflict setting: the experience of Aceh Indonesia</td>
<td>237</td>
</tr>
<tr>
<td>J. Kengeya-Kayondo et al</td>
<td>Tackling the severe lack of qualified and experienced scientists in Africa: the Multilateral Initiative on Malaria</td>
<td>240</td>
</tr>
<tr>
<td>J. Lifshitz</td>
<td>Health human resources in Canada: lessons learned in building partnerships, leading and managing the health workforce 2003–2008</td>
<td>242</td>
</tr>
<tr>
<td>K. Mamadou et al</td>
<td>The challenges and opportunities in developing comprehensive human resources for health strategy in Côte D’Ivoire</td>
<td>244</td>
</tr>
<tr>
<td>W. Mthembu et al</td>
<td>Community mobilization strategy for community-based interventions: the ART literacy project experience</td>
<td>246</td>
</tr>
<tr>
<td>Authors</td>
<td>Title</td>
<td>Page</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>P. Ndegwa et al</td>
<td>Partnership and link-up for action on human resources for health</td>
<td>248</td>
</tr>
<tr>
<td>C. Richey et al</td>
<td>Elements of successful family planning programs: A worldwide knowledge-sharing initiative</td>
<td>250</td>
</tr>
<tr>
<td>H.E Robles</td>
<td>The power of partnerships: grassroots action against HIV/AIDS in South Africa</td>
<td>252</td>
</tr>
<tr>
<td>G. Tomblin Murphy et al</td>
<td>An international partnership in planning human resources for health</td>
<td>254</td>
</tr>
<tr>
<td>S. White et al</td>
<td>The benefits of public-private mix (PPM) in health care</td>
<td>256</td>
</tr>
</tbody>
</table>
Improving morale, motivation and employee satisfaction through low-cost work climate improvement initiatives: case study of ten rural public and FBO health facilities in Kenya

Authors
> Ummuro Adano (contact author), senior HR management systems advisor, Management Sciences for Health/Capacity Project, 6340 Quadrangle Drive, Suite 200, Chapel Hill, NC 27517, USA, tel. 919 313 9108, uadano@capacityproject.org
> Catherine Namanda, senior programme officer support functions, Intra Health International/Capacity Project, cnamanda@capacityproject.org
> Josephine Mbiyu, senior programme officer technical functions, Intra Health International/Capacity Project, jmbiyu@capacityproject.org

Context
A recent survey of health workers in Kenya identified recognition, work climate and team spirit among the nonfinancial factors affecting morale and motivation. Studies from other places also show that low motivation tends to generate poor practices that seem to contribute to low use of health facilities by vulnerable populations, and improvements in staff morale and motivation may increase use of services. The Capacity Project worked with the Kenya Ministry of Health to pilot work climate improvement interventions in 10 rural facilities over one year. Facility teams were engaged through a participatory workshop to assess their work climates, determine needs and generate simple activity plans that were used to test low-cost approaches to work climate improvements.

Objectives
Identify simple health facility and “people” factors and implement some basic interventions that will positively impact those factors.

Methods
The process consisted of establishing broad parameters (facilities, location, size of population served); administering questionnaires to clinical and shared services departments; analysing data and presenting results; conducting workshops to validate data and formulate strategies; agreeing on interventions; communicating interventions to all staff and creating action committees; implementing interventions; tracking progress on staff morale and motivation; and annual benchmarking.
New findings

Findings from the initial survey illustrated very low morale; a vast majority were also unhappy with their work climate. Results following the implementation of activity plans included departmental workplans; more frequent team meetings and sharing of information; problem solving as a team; community reach-out days; painting and refurbishing of facilities; new equipment; more equitable shifts; managing inventories to avoid stock-outs; lounges with free tea and coffee for staff; servicing vehicles; safe waste disposal measures; improved signage; organized patient flow procedures; cleaner yards, toilets and facilities; increases in service utilization (at all 10 sites); infection prevention protocols for HIV/AIDS; and setting up resource centres. A follow-up survey indicated that nearly all staff in the 10 sites expressed high satisfaction with their environments and had no intention of leaving.

Conclusions

This pilot provides evidence to help move beyond the old paradigm that most motivation and morale-related weaknesses can be solved by financial incentives or training alone. There is no tidy package of interventions that will ensure motivated workers who stay in posts for years. A complex set of factors affects morale and motivation, and how these factors play out varies from place to place. In this case, facility teams selected their own challenges and shared some of the intervention costs, enhancing ownership. The results of this programme need to be further evaluated to form the basis for a scalable approach to improving morale and retention, thereby strengthening the performance of health systems in low-resource settings on a sustainable basis.
PPP initiatives and the HR crisis in the health sector

Author
> Gwenaël Dhaene, Senior Adviser, French international health and social protection agency (GIP SPSI), Secretary, Health Advisory Committee, GIP SPSI, +33 1 55 30 17 06, gdhaene@gipsi.org

Context
This paper aims at providing an overall perspective as to how Public-Private Partnerships (PPP) can potentially contribute to health systems development in a wide range of countries. A narrow-focus PPP definition shall be attempted to better comprehend how a much popular concept can be broken down in a series of tools which purpose may enable a better address of health systems shortcomings. Human resources critical shortage in the health area is an issue that innovative partnerships could help overcome. Partnerships involving health sector stakeholders such as hospitals and health facilities, public and/or private funders and pharmaceuticals firms may fuel the debate and the policymaking process. This may also entail that the mix of competences from both sectors can better contribute to alleviate the HR crisis and go beyond to tackle health issues at global level.

Objectives
PPP initiatives have the potential to combine public leadership and private sector performance to strive and deliver better health services. In a given context of global shortage and acute crisis of health personnel, improving our understanding of PPP and their strengths might be a beacon in the dark.

Methods
A grey area has grown between two opposing schools of thought on the value of PPP. A desk review set out to improve understanding on how PPP can help address the needs for health sector performance improvement and in cases where public expenditure is constrained, do PPP enable to shift quality and ensure services are rendered in a more cost-effective way?
Conclusions:
Whilst the subject of PPP always raises a significant interest underpinned by ideological currents, there is sufficient consensus to learn from the application of new instruments and models in use. Key recommendations resulting from this review include:

- Strive for a more comprehensive rationale for taking on new PPP initiatives in the health sector
- Regular PPP related data collection and analysis is required.
- Closely link public and private health services providers to increase coherence and effectiveness
- Build public capacity so as to address the need of public authorities for more guidance and advisory support.
- Think outside the (public) box
- Make the best of all current and foreseen opportunities
- Make the best of the institutionalised PPP
Strengthening health systems: a code of conduct for international non-government organizations

Authors

> Amy Hagopian (contact author), PhD, Faculty, School of Public Health, and senior health workforce advisor to Health Alliance International, an NGO affiliated with the University of Washington, 4534 11th Av. NE, Seattle, Washington 98105, tel. 206 543 8382, hagopian@u.washington.edu
>
> Wendy Johnson, MD, MPH, Faculty, School of Public Health, University of Washington, and director of new initiatives for Health Alliance International, 4534 11th Av. NE, Seattle, Washington 98105, tel. 206 543 8382, wjohns@u.washington.edu
>
> Meredith Fort, PhC, PhD candidate, School of Public Health, University of Washington, and research assistant with Health Alliance International, 4534 11th Av. NE, Seattle, Washington 98105, tel. 206 543 8382, mpfort@u.washington.edu
>
> Donna Barry, NP, MPH, advocacy and policy manager, Partners In Health, 641 Huntington Avenue, Boston MA 02115, tel. 617 432 6017, www.pih.org, dbarry@pih.org
>
> Rick Rowden, senior policy analyst, ActionAid International USA, 1420 K Street, NW Suite 900, Washington, DC 20005, tel. 202 370 9918, www.actionaidusa.org, rick.rowden@actionaid.org
>
> Eric Friedman, JD, senior global health policy advisor, Physicians for Human Rights, 1156 15th Street, NW Suite 1001, Washington, DC 20005, tel. 202 728 5335 ext. 303, efriedman@phrusa.org
>
> James Pfeiffer, PhD, Faculty, School of Public Health, University of Washington, and director of Mozambique Operations with Health Alliance International, 4534 11th Av. NE, Seattle, Washington 98105, tel. 206 543 8382, jamespf@u.washington.edu
>
> Aaron Shakow, development officer, Health Alliance International, 4534 11th Av. NE, Seattle, Washington 98105, tel. 206 543 8382, ashakow@gmail.com
>
> Stephen Gloyd, MD, MPH, professor, University of Washington School of Public Health, and executive director of Health Alliance International, 4534 11th Av. NE, Seattle, Washington 98105, tel. 206 543 8382, gloyd@u.washington.edu
Context
Health systems in many countries are characterized by shortages of health workers, inadequate supplies, and limited ability to respond to a growing disease burden. Foreign assistance from government and private programs such as the United States President’s Emergency Plan for AIDS Relief (PEPFAR) have, in general, not contributed significantly to strengthening public health systems. International nongovernmental organizations (I-NGOs) have grown and multiplied dramatically, however, as many donors favour them over governments for aid packages. I-NGO growth has led to a proliferation of projects and approaches, creating a growing management burden for ministries of health.

Objectives
The authors are working to create a movement to realign the aims of international aid and I-NGO partnerships. International aid efforts should be working towards strengthening health systems in the countries where they operate, rather than creating conditions that favour the proliferation of I-NGOs themselves.

Methods
Beginning in 2007, a group of health-focused I-NGOs (working in countries with severe health worker shortages) developed an international code of conduct as a voluntary method to ensure that I-NGOs “do no harm” and, instead, collaborate with each other and the government sector to strengthen health systems. We will present our process, key elements of code content and concerns currently under discussion.

New findings
There is a growing awareness that the strongest health systems are those operated by highly functional ministries of health, with strong government oversight and adequate funding, supplemented in some areas by the private sector.

Conclusions/lessons
I-NGOs have an opportunity to support health system strengthening through sustainable practices promoted in a new code of conduct. Key topics covered in the code include hiring practices, compensation, training and support, government management burden, the role of I-NGOs in settings of conflict or very weak government, and I-NGO responsibility for advocacy.

Please note that this Code of Practice was revised in November 2007. Details can be obtained from the authors.
Reaching health to the unreachable: mobile medical teams and partnerships

Author
> Shariful Islam, programme officer, Partners in Population and Development, Partners Secretariat, B-60, Road 3, Niketan, Gulshan 1, Dhaka 1212, Bangladesh, sharif.undp@gmail.com

Background
The Chittagong Hill Tracts (CHT) is recognized as one of the most disadvantaged and isolated areas in Bangladesh, with hilly and remote terrain, a lack of communication, poor infrastructure, ethnic diversity, scattered settlement patterns and a history of internal conflict. The CHT covers 5,089 square miles and has a population of about 1.3 million people, with about two thirds of the population lacking access to basic health-care services. The United Nations Development Programme (UNDP) initiated a health pilot initiative in the CHT to improve the overall health situation of the hard-to-reach people in the region.

Objectives
The overall objective of the initiative was to improve the health and nutrition status of the people in the CHT. This includes improving maternal health, reducing child mortality and reducing the incidence of malaria, tuberculosis and other priority communicable diseases.

Methodology
UNDP initiated mobile medical teams and community health workers and built partnerships with actors in health. The initiative built its approach from the bottom up by supporting the development of a network of female village-based health workers. Outreach satellite clinics by mobile health teams and joint collaboration programmes were organized with the government, nongovernmental organizations (NGOs), the United Nations and private organizations.

Results
The project helped to increase the immunization coverage of children below 1 year from 35% to more than 68%. Maternal deaths and child deaths recorded were the lowest in a year compared to the averages of the last 10 years. The CPR increased to 85% comparing to 54% achieved in the previous year. 3780 cases of potentially fatal malaria were treated, significantly reducing malarial deaths.
Conclusions and lessons learnt
Capacity building of governments and NGOs is important to achieve desired results. Providing logistics support to government health staff helped to increase programme effectiveness. The health structures of a partner organization were utilized by another organization, thus pooling resources and maximizing utilization of resources and services.
People living with HIV: a key resource in the delivery of the Uganda National Minimum Health Care Package

Authors

> M. Katana (contact author), director, International HIV/AIDS Alliance, Uganda, tel. +256 31 2 258 100, fax +256 41 344 295, mkatana@allianceuganda.org
> S. Nampewo, M&E advisor, International HIV/AIDS Alliance, snampewo@allianceuganda.org
> E. Katamujuna, technical advisor, International HIV/AIDS Alliance, ekatamujuna@allianceuganda.org

Context

Effective delivery of the Uganda National Minimum Health Care Package is central to the health sector strategy to attain improved health and productivity of the people of Uganda. The Ministry of Health recognizes the importance of working with partners such as the International HIV/AIDS Alliance to complement the existing, inequitably distributed, health workforce, which has unacceptable health worker/patient ratios and a clinical- rather than public health-oriented workforce. Key strategic partners to achieve this are networks of people living with HIV who are able to support the delivery of health services and significantly increase access to, and utilization of health facilities and community-based services. The International HIV/AIDS Alliance is demonstrating the importance of this through a three-year USAID-funded project for expanding the role of networks of people living with HIV/AIDS in Uganda using a network model that includes a referral system to enhance HIV and AIDS service delivery and utilization, reduce HIV-related stigma and discrimination, and bring HIV and AIDS services closer to the community.

Objective

The objective of the project is: to establish, maintain and strengthen linkages for referrals; and support the delivery of health and community-based services in 28 districts in order to increase access to and utilization of HIV and AIDS comprehensive care services by households of people living with HIV and other community members. People openly living with HIV are deployed as network support agents (NSAs) to support delivery of HIV services in health facilities and communities, addressing stigma and discrimination.
Results
Between July 2006 and September 2007, 232 671 people were reached with targeted information and services in the following areas: 99 108 with education and awareness about services; 50 196 with ART literacy messages; 27 114 with ART adherence counselling; 24 492 with pre- and post-test HIV counselling; 25 403 with follow-up counselling both in health facilities and through home-based care; and 6358 referrals for health facility- and community-based services. The project has contributed to the national Health Sector Strategic Plan, the national HIV/AIDS Strategic Plan and PEPFAR targets. Documentation has been carried out of how NSAs have improved linkages and networking between health facilities and community-based organizations, improved quality and utilization of health facility-based services and reduced stigma and discrimination.

Conclusion/lessons learnt
People living with HIV are a key resource in improving linkages between communities, health facilities and community-based services and improving utilization of services by targeted communities. NSAs should be recognized as key players in the delivery of HIV and AIDS services in Uganda by complementing and supporting the roll-out and delivery of curative, preventive and health promotion services provided by health facilities. Models that are based on finding practical mechanisms to constrained health-care delivery systems, such as putting affected populations at the core of the response to HIV and AIDS, can produce dramatic results quickly and at scale. This has been recognized by increased USAID funding to scale up the Alliance network model to increase coverage. It is essential that donor agencies and ministries of health recognize the important role that people living with HIV and affected communities can play in supporting greater access to health services and efforts to train, retain and remunerate health workers, and also take into account the support required and provided by health-care providers such as NSAs.
Capacity building for mental health nurses and doctors in the community in a post tsunami and conflict setting: the experience of Aceh Indonesia

Author
> Budi Anna Keliat, Team Leader Community Mental Health Nursing, Lecturer, faculty of Nursing, University of Indonesia, Jakarta, Indonesia

Context
The advent of the tsunami and earthquake of December 2004 despite the disastrous loss of life and property provided an opportunity to develop community mental health services as part of a mental health system in Aceh in a way that it has not been approached in other provinces of Indonesia. Funding of community mental health has allowed Aceh to provide a model that is applicable not only to other provinces in Indonesia but also for the region. There was a large influx of donors and international non-governmental organizations who were involved in funding various areas of health.

The 30 year conflict in the Province was also an important factor which drew attention to the mental health of the inhabitants of the province. This conflict impacted negatively on the mental health of the population of the province and hindered the development of quality mental health services. In addition, Aceh has had a largely custodial approach to mental health care with the psychiatric hospital located in the capital Banda Aceh as the only facility for mental health care for a population of some 4.3 million people. In the past there has not been any planning for facilities at the district hospital level and no trained staff in most primary care centres.

Objective
Since 2005, the aim of the CMHN team was to link up with donors to strengthen the capacity of nurses to deliver mental health services first in the areas affected by the tsunami and then extend it to all provinces in Aceh to cover the whole population. The NGO of community mental health nurses first obtained funding from WHO to work at the district level. Links were made on a national level with the Ministry of Health, the Indonesian Professional Nurses Association and the University of Indonesia.

Partnerships for training
As the training of nurses progressed the high quality of the training and the embedding of the work at the district and provincial level attracted more partners to fund the work. An existing USAID project also supported the training of nurses
and subsequently doctors in the provinces in which it worked and the same was true of EXXON Mobil Oil company. The Asian Development Bank who developed a programme on capacity building gave substantial amounts of aid to assist with the development of this programme. The other partner which gave some support in terms of providing transport for nurses to improve outreach was the Cristoffel Blinden Mission (CBM) an international NGO.

The training for nurses is divided to three levels: basic community mental health nursing, intermediate community mental health nursing and advanced community mental health nursing. The programme has covered the 21 districts of Aceh. Nurses trained at the intermediate level have in turn trained existing village workers as part of the programme of “mentally health alert villages” modeled on the national programme “healthy alert villages”. This has been one of several important outcomes of the development of a mental health system for the province.

Results
This funding and support through partnerships at the district, provincial and national level and with international funding, has made it possible to train nurses, medical officers at the primary care level, village health workers and members of civil society such as community leaders and women leaders to provide different types of mental health services.

The programme was evaluated externally and found to be of a high quality and recommended for continued international and national funding to ensure the gains made in the post-tsunami period are not lost. The CMHn programme has become the backbone of mental health service provision in Aceh and is slowly being spread throughout different parts of Indonesia.

The programme has identified 8016 patients in the community (2/1000 population) with mental health problems. The programme not only addresses the needs of persons with mental health problems (covering those affected by the tsunami and the conflict but those with prior mental disorders), but also conducts prevention and promotion activities for better mental health.

The entire training programme is supported by supervision, monitoring and evaluation of the performance of health professionals. Nurses and medical officers become part of team of mental health workers in the community. Community leaders have been trained to be a support cadre for health professionals and a partner of nurses and doctor to conduct the services.
Conclusions

The programme that has been developed through partnerships, has been well received by the provincial government and persons suffering from mental health problems and their families as well as civil society in general. The total number of trained mental health staff in Aceh now stands at 614 nurses, 200 medical officers and 2106 cadres. Now, mental health services exist in the community and are reaching a previously underserved population, although there is still some way to go. Although the programme has received donor support after the tsunami, the government should do more to mainstream the programme which enables task shifting in order to make community mental health service more widely available for other province in Indonesia. The programme has been presented at a WHO global Mental Health Forum in Geneva where is was said to be one of the 2 best programmes of its kind in developing countries and at a Regional Mental Health Forum where it also seen as applicable to other parts of south-east Asia.
Tackling the severe lack of qualified and experienced scientists in Africa: the Multilateral Initiative on Malaria

Authors

> Jane Kengeya-Kayondo (contact author), strategic alliances coordinator, Special Programme for Research and Training in Tropical Diseases, World Health Organization, 20 Avenue Appia, CH-1211 Geneva 27, Switzerland, kengeyakayondo@who.int

> Olumide Ogundahunsi, scientific research manager, Special Programme for Research and Training in Tropical Diseases, World Health Organization, 20 Avenue Appia, CH-1211 Geneva 27, Switzerland, ogundahunsio@who.int

Context

Efforts targeted at poor countries often lack channels through which multiple partners and donors can join efforts, agree priorities, share roles and engage recipient countries, institutions and individuals as equal partners. The Multilateral Initiative on Malaria (MIM), launched in 1997, is a global response to the need to strengthen and sustain the capability for malaria research in Africa. MIM serves as a tested model for addressing research manpower strengthening in developing countries.

Pillars of the MIM model

- The identification of and agreement on shared priorities through a global approach engaging researchers, policy-makers, implementers, the donor community and bilateral agencies.

- Agreement to pool financial resources and an agreed transparent mechanism for financial dispensation to research and capacity-building projects.

- Partners doing what they are best at. TDR manages research and capacity-building grants, MIMCom facilitates reliable access to global scientific and health information. MR4 provides high-quality reagents and protocols and a secretariat coordinates the activities and organizes the global malaria conference.

- Letting those with the problem be in the driving seat. African scientists and institutions have primary responsibility for MIM activities and for establishing North-South and South-South collaborations.
Achievements of MIM

- Results from MIM projects have influenced global, regional and national malaria control policies.
- Research capacity built through MIM has been utilized by countries and donors for leadership in malaria research and for research on other infectious diseases. Less than 2% have emigrated to resource-rich countries.
- The MIM secretariat is now based in Africa with strong leadership and ownership of MIM by Africa and closer engagement with NEPAD and the African Union.

Conclusion

In order to tackle the increasing need for a wide range of indigenous research capacities in developing countries, significant long-term multilateral efforts driven by developing countries are necessary.
Health human resources in Canada: lessons learned in building partnerships, leading and managing the health workforce 2003–2008

Authors
> Judy Lifshitz (contact author), senior policy analyst, Health Human Resources Policy and Planning, HHRSD, Health Canada, tel. 613 946 8636, judy_lifshitz@hc-sc.gc.ca
> Margaret Gillis, director, Health Human Resources Strategies Division (HHRSD), Health Canada, margaret_gillis@hc-sc.gc.ca
> Bentley Hicks, manager, Health Human Resources Policy and Planning, HHRSD, Health Canada, bentley_hicks@hc-sc.gc.ca

Context
Canada’s health-care system: health services delivery and health human resources

The presentation will begin by discussing Canada’s health-care system, including the delivery of health services and health human resources planning. There will be a review of Canada’s current challenges with health system delivery. This will include a discussion of how the federal, provincial and territorial governments developed partnerships and linked with each other for action to overcome barriers in their efforts to strengthen the health workforce and thus provide timely access to quality care for all Canadians and renew and sustain publicly funded health care into the future.

Pan-Canadian collaboration: successes and challenges

Through the Pan-Canadian Health Human Resources Strategy (HHRS), including the Framework for Collaborative Pan-Canadian Health Human Resources Planning, federal, provincial and territorial governments are collaborating to secure and maintain a stable and optimal health workforce in Canada and support overall health-care renewal. This article will review the successes and challenges of governments with respect to leading and managing HHR planning and developing partnerships and linking with each other for action in stabilizing the health workforce. Examples of initiatives, such as the Framework for Collaborative Pan-Canadian HHR Planning in Canada, that the federal, provincial and territorial governments have taken to address the shortage of health-care providers and overcome barriers to strengthening the health workforce, will be reviewed.
Findings and lessons learned

The presentation will conclude with a review of key findings and lessons learned from the collaboration of federal, provincial and territorial governments on health human resources issues. These key findings will be useful to other countries in addressing their health workforce crises.
The challenges and opportunities in developing comprehensive human resources for health strategy in Côte D’Ivoire

Authors
> Kone Mamadou (contact author), consultant, Abt Associates, Inc., 17 BP 1393 Abidjan 17, Côte d’Ivoire, tel. 225 07 09 96 73, konemadu@africaonline.co.ci
> Monica Nolan, consultant, Abt Associates, Inc., monicanolan2005@yahoo.com
> Affoue Hortance Kouame, deputy director, Department of Human Resources, Ministry of Health, Côte d’Ivoire, hortaffo@yahoo.fr
> Gilbert Kombe, senior technical advisor, Abt Associates, Inc., gilbert_kombe@abtassoc.com
> Dyana Kadio, program coordinator, Abt Associates, Inc., dykadio@gmail.com

Context
Côte d’Ivoire is confronted with insufficient human resources for health (HRH). The HRH problem took on new dimensions with the arrival of HIV/AIDS and the population’s increasing health needs. Efforts at problem resolution have not led to the adoption of clear policies or effective plans of action. The socio-political crisis, emerging in 2002, heightened inequities in HRH distribution and reduced training school production capacity.

Key HRH problems include: chronic underfunding for public sector care; high attrition rates; disparities in HRH distribution; weak administrative and management systems; training inadequacies; and weak HRH strategic information and evaluation.

Methods
A comprehensive HRH evaluation was conducted with technical support from the Abt Associates Health Systems 20/20 project. Using evaluation evidence, internal and external actors formed a steering committee to develop a national HRH policy strategy under Ministry of Health leadership. Several consultations were held with key stakeholders to build consensus on issues the strategy should address. The result was a strategic plan for HRH sector development (2008–2012) that centralizes the HRH problem in health system organization. It seeks innovative approaches that overhaul old frameworks and adjusts to the evolution and demands of health. It aims to reinforce the planning framework and strategic information for HRH; assure adequacy between HRH production and health system needs; reinforce HRH capacities; reinforce the HRH administrative system; and improve HRH use and evaluation.
Conclusions

Improvement requires a complete rethinking of the HRH problem and devising creative, cohesive solutions based on cooperation and collaboration. Public-private partnerships and formal linkages are vital for a comprehensive reform process. These linkages were essential in devising a plan that reflects the priorities of all health systems actors. The plan must focus on promoting professional development and joining all sectors.
Community mobilization strategy for community-based interventions: the ART literacy project experience

Authors

> Wanda Mthembu (contact author), project facilitator, Health Systems Trust (HST), 401 Maritime House, Salmon Grove, Victoria Embankment, PO Box 808, DBN 4000, tel. +27 31 3072954, wanda@hst.org.za
> Oluseyi Oyedele, M&E advisor, oluseyi@hst.org.za
> V Mtshali, project facilitator, vmtshali@yahoo.com
> Thulisile Tabethe, project facilitator
> Thando Ngomane, senior project manager, thando@hst.org.za
> Nomonde Bam, director, nomonde@hst.org.za

Introduction

The Department of Health, Mpumalanga Province, with the introduction of antiretroviral therapy (ART) in the public health system in 2003, was concerned that care and treatment should be integrated with prevention efforts and linked to existing HIV interventions. In April 2005 a partnership was developed between the Mpumalanga Department of Health and HST aimed at strengthening the links between primary health-care facilities and community-based services through community mobilization.

Project goal

To use community mobilization strategies in promoting ART literacy and treatment support in the clinic catchment areas (CCAs) of the 72 feeder clinics that supports the seven accredited ART sites in Mpumalanga Province.

Strategy

The strategy is based on the rationale that treatment literacy is a key component of the ARV roll-out. Accordingly the strategy aims to increase understanding about HIV transmission, prevention, treatment, care and support in order to effect behaviour change.
Methodology

HST’s community mobilization strategy encourages increased community participation by providing the interphase between public health facilities and the communities. HST facilitators train and empower local partner community-based organizations (CBOs) and volunteers to act as facilitating and implementing agents within communities in which they reside. At the community level each partner CBO and volunteers are responsible for project implementation across five CCAs. The facilitators provide ongoing mentorship, support and in-service training to the CBOs and volunteers, thus strengthening their skills, knowledge base and ability to implement project activities.

Findings

Some project achievements:

- 586 community members trained as community volunteers;
- improved access to condoms: 401 community-based condom distribution points set up;
- increased support and access to health literacy for communities;
- increased access to IEC materials: 17 functional community-based multipurpose resource centres established;
- increased collaboration between community and government structures;
- strengthened collaboration between project volunteers and home-based carers.
Partnership and link-up for action on human resources for health

Author
> Paul Moses Ndegwa, chairman, Ambassadors for Change, Box 71, Nakuru, Kenya, tel. +254 727 611175, paulmoseskirobia@yahoo.com

Context
- Addressing need to scale up partnership with stakeholders for strengthened systems, utilization of available human resources;
- Challenges facing public health sector workforce retention – issues weakening the system;
- Reversing health gains due to TB/HIV pandemic, rapid population growth, extreme poverty;
- Distribution of skilled health professionals heavily skewed towards urban areas.

Objectives
- How to improve work conditions;
- Scale up advocacy initiatives, increase workforce motivation;
- Create linkage with communities affected by diseases;
- Involvement in finance and systems;
- Development of capacity of health staff for data analysis;
- Address baffling migration of health staff;
- Power sharing to influence decisions on how resources for health are allocated, shared;
- Doctor-patient confidentiality;
- Health financing as a core part of health sector development;
- New tools to improve diagnosis and treatment;
- Overcrowding in some health settings.

Barriers
- Lack of essential facilities, especially laboratory for screening, culture sensitivity;
- Stigma in respect to some health issues;
- Ineffective drug supply and management;
- Poor supervision due to personnel shortage;
- Lack of collaborative activities with civil society organizations;
- Bureaucratic funding systems;
- Inadequate power of community advocacy.
Conclusions

- Scaling up collaborative activities;
- Increased investment in health;
- Joint approach to strengthen systems;
- Increase role of advocacy in building political will, increased resources;
- Inclusion of civil society, affected communities in developing policies;
- Mobilization of patient groups for advocacy;
- Identification of advocacy networks and champions;
- Increased environmental controls of infectious diseases through, for example, natural ventilation and personal protection using respirators;
- Providing accountability and setting priorities.
Elements of successful family planning programs: A worldwide knowledge-sharing initiative

Author
> Catherine Richey, senior technical writer, INFO Project, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, 111 Market Place, Suite 310, Baltimore, MD 21211, USA, tel. 410 659 6135, crichey@jhuccp.org

Context
The brain drain has left many developing countries with a shortage of knowledgeable professionals needed to design and carry out health-care programmes. While long-term structural solutions are needed, Internet technologies and tools offer the potential for online knowledge sharing that can help fill the gap in the interim.

Objectives
- Establish a virtual community of practice, centred in Africa, of health-care professionals focused on successful family planning programmes;
- Create a framework and toolset that enable members of the community of practice to share knowledge and solve problems;
- Support the community of practice with a comprehensive online information resource.

Methods
Using a knowledge management framework, the INFO Project at the Johns Hopkins Bloomberg School of Public Health has rolled out a three-part initiative. First, nearly 450 health-care professionals from 98 countries responded to an online survey on elements of successful family planning programmes. Second, a moderated online forum generated discussion among nearly 300 practitioners worldwide. Finally, survey results, forum discussions and research findings were channelled into a web-based resource for knowledge sharing. The site serves as “home base” for a network of family planning professionals in several African countries and other countries around the world. Through social networking capabilities, the site enables its users to support each other’s efforts and solve problems together.
Findings
Family planning programme managers worldwide find virtual communities of practice and social networking opportunities an effective and engaging way to share knowledge and improve programming. Programme managers will apply the knowledge garnered through this process and from the site to improve programmes in Africa and in other developing countries.

Conclusions
An Africa-centred online community of practice, furnished with an array of communication tools and information resources, can help to create the critical mass of expertise needed to design and carry out effective health-care programmes.
The power of partnerships: grassroots action against HIV/AIDS in South Africa

Author
> Dr Harold E. Robles  Medical Knowledge Institute, PO Box 332, 3233 ZG, Oostvorne, the Netherlands, tel. +31 181 486804, fax +31 181 483206, http://www.infomki.org

Context
The Medical Knowledge Institute (MKI) and its partners are attacking the intervention gaps and lack of access to health services and treatment for population groups in areas of South Africa afflicted with HIV/AIDS.

1. Mother and Child First: preventing mother-to-child transmission; empowering midwives and local South African women

Partners: International Confederation of Midwives; VU Medical Center, Amsterdam, Dutch Red Cross; local South African health departments; local South African women infected with HIV/AIDS; Mothers’ Creations; TNT Express South Africa.

Workshop method, trainees and outcomes: Training of trainers using WHO Integrated Management of Adolescent and Adult Illness (IMAI); midwives who will train others in local settings to develop continuing education strategies, conduct skills workshops to midwives and other health-care workers, and establish follow-up and sustainability procedures.

Results
July 2006 was first workshop in South Africa; 25 midwives trained; workshops now being conducted in the nine provinces of South Africa.

Related activities: Mothers’ Creations trains local women infected with HIV to design and produce beaded jewellery and provides income to jewellery makers by purchasing jewellery to market globally; TNT Express transports the jewellery to Holland free of charge; proceeds used for workshops.

2. MKI health information centres: fostering individual and community self-reliance in tackling health problems

Partners: Southern Africa-Netherlands Chamber of Commerce; WHO Health Academy; Teaching Aid at Low Cost (TALC); Desmond Tutu HIV Foundation; Mothers to Mothers pilot centre at Baphumelele Orphanage, township Khayelitsha.
Results
Centres to provide updated health-care education and health-care information to the general public for purposes of health improvement; training courses teaching different life skills; simple public health library; sites of future training of trainers for midwives in Mother and Child First project.

3. HIV/AIDS Workforce Policy Development and Education Programme: addressing the challenge posed by HIV epidemic to employees, their families, business operations and economic and social development

Partner: Southern Africa Services SETA (Sector Education and Training Authority) with 300 000 small and medium enterprise members.
Pilot workshop: July 2007 for 200 human resource managers from SETA members.

Result
Discussion with South Africa-Netherlands Chamber of Commerce to join partnership and expand scope of project.
An international partnership in planning human resources for health

Authors
> Gail Tomblin Murphy (contact author), PhD, MN, BN, RN Associate Professor School of Nursing Dalhousie University 5869 University Avenue Halifax, Nova Scotia Canada B3H 3J5 Telephone: (902) 494-2228 Fax: (902) 494?3482, gail.tomblin.murphy@dal.ca
> Francisco Eduardo de Campos, Secretary, Ministry of Health, Brazil, francisco.campos@saude.gov.br
> Gail Hudson, Ministry of Health, Jamaica, Hudson@moh.gov.jm
> Felix Rigoli, Pan American Health Organization, rigolife@paho.com
> Mario Dal Poz, World Health Organization, Geneva, dalpozm@who.int
> Sandra MacDonald-Rencz, Health Canada, Office of Nursing Policy, Government of Canada, Sandra_macdonald-rencz@hc-sc.gc.ca
> Margaret Gillis, Health Canada, Human resources Strategies Division, Health Care Policy Directorate, Health Policy Branch, Government of Canada, margaret_gillis@phac-aspc.gc.ca

Context
Human resources for health (HRH) planning presents challenges to health systems around the globe. Partners from Brazil, Canada, Jamaica, PAHO, and WHO are collaborating on a programme to enhance health-care systems through HRH planning. This planning is based on the health needs of populations and considers demographic, gender and equity, political, social, economic, technological and geographic factors.

Objective
The programme aims to improve health system governance and performance by developing, through international collaboration, workforce planning models that are focused on the health care needs of specific populations and testing the relative effectiveness of HRH policies and programmes in those areas.
Methods
This innovative programme consists of three components: (a) needs-based HRH planning; (b) capacity building and knowledge translation; and (c) evaluation. The objective is to build capacity in Brazil, Canada and Jamaica for addressing issues in planning for HRH in the context of population health needs. Specific objectives include:

- developing and testing country-specific planning tools;
- applying these tools to estimate, in each country, over the next decade the providers required and available, and the difference between the two;
- identifying the factors affecting the supply of and requirements for providers, and translating these factors into policy options;
- creating capacity for needs-based planning and management by engaging policy-makers, managers and researchers;
- sharing lessons learned in building local capacity in the participant countries with other countries.

Conclusions
This programme builds on previous and ongoing work of the Canadian team members, while contributions from Brazil and Jamaica will help adapt methodologies to accommodate the values, needs and policy constraints of different low- to middle-income countries. This international partnership permits the validation of methods and practices so that knowledge can be transferred globally. Lessons learned to date will be shared through Brazil and Jamaica case studies.
The benefits of public-private mix (PPM) in health care

Authors

Sharon White (contact author), managing director, Re-Action! 7 Selby Road, Rosebank, Gauteng, South Africa, tel. +27 11 880 6993, fax +27 11 880 6980, mobile +27 82 414 3730, http://www.re-action.co.za, sharon@re-action.co.za

M Taljaard, Re-Action! South Africa

B Shinners, Re-Action! South Africa

Z Mohammed, Re-Action! South Africa

Context

The aim of this abstract is to examine and discuss the benefits of public-private mix (PPM) in health care, with a focus on communities in rural settings.

The debate about PPM in the provision of health care has its roots in the principle of how to maximize benefits for the local community from the existing resources within the private, public and donor sectors. Through co-investment by all sectors this mix of services and resources will provide universal and comprehensive coverage of health-care interventions to communities.

The relatively conservative role of government as the primary service provider in the health-care sector has changed significantly over the last few years in that the private sector, specifically the workplace, has become a valid entry point into the local community through the acknowledgement that employees do not exist in isolation, but form part of a bigger family unit and population. However, the provision of workplace-based wellness programmes at a shop floor level meant that employees had access to health-care services, but due to local health system challenges in many cases dependants and the broader community did not have equal or sustainable access. In addition, in resource-poor settings capacity and financial support are competed for by both public and private sector organizations, thereby creating the notion that these sectors work against each other. This counteractive approach stifles the public sector’s ability to deliver basic health-care services, negatively influencing communal health.

PPM is an effective solution to these challenges. PPM promotes new approaches and partnerships for delivery of treatment, care and support by engaging a mix of health-care providers from all levels. This benefits all – the health-care providers, the sick patient, the local and provincial health-care objectives, the private sector and, ultimately, the health of the entire population.
PPM as a formal mechanism for partnership will allow for all sectors to access capacity, technical assistance and financial support from a pool of resources to more effectively and efficiently deliver health-care programmes. The strengthening of health-care systems and service delivery is now reliant on the scaling up and extension of PPM initiatives.

Objectives
This presentation will discuss the benefits of PPM as a means for scaling up universal access to basic health-care services. In addition a case study on how PPM coinvestment successfully consolidated the donor, private and public sector health-care services in a rural setting in Mpumalanga, South Africa, will be presented.

Methods
Together with private and public sector and development partners, Re-Action! has identified the opportunity to document and share community-based examples of how PPM can galvanize co-investment for social development and common good. A literature review will be conducted and a case study will be documented from a current PPM programme in a rural setting in Mpumalanga, South Africa.

Lessons learned/conclusions
PPM provides a mechanism for improving the effectiveness of health and sustainability responses through complementing and leveraging collective resources. PPM is also likely to become a more acceptable option for engaging government and international partners because it promotes harmonization and alignment of resources and programmatic actions.