World Health Organization

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global health workforce alliance

The Second Global Forum on Human Resources for Health Prince Mahidol Award Conference 2011

25 - 29 January 2011 | Bangkok, Thailand

Reviewing progress, renewing commitments to health workers towards MDGs and beyond

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

**Empower health workers
for health outcomes**

Prince Mahidol Award

Prince Mahidol Award was established in 1992, to commemorate the 100th birthday anniversary of Prince Mahidol of Songkla who is recognized by the Thais as 'The Father of Modern Medicine and Public Health of Thailand'.

His Royal Highness Prince Mahidol of Songkla was born on January 1, 1892, a royal son of Their Majesties King Rama V and Queen Savang Vadhana of Siam. He received his education in England and Germany and earned a commission as a lieutenant in the Imperial German Navy in 1912. In that same year, His Majesty King Rama VI also commissioned him as a lieutenant in the Royal Thai Navy.

Prince Mahidol of Songkla had noted, while serving in the Royal Thai Navy, the serious need for improvement in the standards of medical practitioners and public health in Thailand. In undertaking such mission, he decided to study public health at M.I.T. and medicine at Harvard University, U.S.A. Prince Mahidol set in motion a whole range of activities in accordance with his conviction that human resources development at the national level was of utmost importance and his belief that improvement of public health constituted an essential factor in national development. During the first period of his residence at Harvard, Prince Mahidol negotiated and concluded, on behalf of the Royal Thai Government, an agreement with the Rockefeller Foundation on assistance for medical and nursing education in Thailand. One of his primary tasks was to lay a solid foundation for teaching basic sciences which Prince Mahidol pursued through all necessary measures. These included the provision of a considerable sum of his own money as scholarships for talented students to study abroad.

After he returned home with his well-earned M.D. and C.P.H. in 1928 Prince Mahidol taught preventive and social medicine to final year medical students at Siriraj Medical School. He also worked as a resident doctor at McCormick Hospital in Chiang Mai and performed operations alongside Dr. E.C. Cord, Director of the hospital. As ever, Prince Mahidol did much more than was required in attending his patients, taking care of needy patients at all hours of the day and night, and even, according to records, donating his own blood for them.

Prince Mahidol's initiatives and efforts produced a most remarkable and lasting impact on the advancement of modern medicine and public health in Thailand such that he was subsequently honoured with the title of "Father of Modern Medicine and Public Health of Thailand".

In commemoration of the Centenary of the Birthday of His Royal Highness Prince Mahidol of Songkla on Janurary 1, 1992, the Prince Mahidol Award Foundation was established under the Royal Patronage of His Majesty the King Bhumibol Adulyadej to bestow international awards upon individuals or institutions which have made outstanding and exemplary contributions to the advancement of medical, and public health and human services in the world.

Prince Mahidol Award

The Prince Mahidol Award will be conferred on an annual basis with prizes worth a total of approximately USD 100,000. A Committee, consisting of world-renowned scientists and public health experts, will recommend the selection of awardees whose nominations should be submitted to the Secretary-General of the Foundation before May 31st of each year. The committee will also decide on the number of prizes to be awarded annually, which shall not exceed two in any one year. The prizes will be given to outstanding performance and/ or research in the field of medicine for the benefit of mankind and for outstanding contribution in the field of public health for the sake of the well-being of the people. These two catego- ries were established in commemoration of His Royal High-ness Prince Mahidol's graduation with Doctor of Medicine (Cum Laude) and Certificate of Public Health and in respect to his speech that:

"True success is not in the learning, but in its application to the benefit of mankind".

The Prince Mahidol Award ceremony will be held in Bangkok in January each year and presided over by His Majesty the King of Thailand.

Message from the Chairs of the International Organizing Committee

A strong health workforce is the backbone of a robust health system. Access by everyone to a skilled, motivated and supported health worker is an essential step on the road to achieve the health-related Millennium Development Goals (MDGs) and, ultimately, universal health coverage. The link between adequate health worker availability and access to essential health services is firmly established: the higher the density and the more equitable the distribution, the better the health of the population.

Almost three years ago, at the First Global Forum on Human Resources for Health in Kampala, Uganda, participants including health workforce experts and advocates endorsed the Kampala Declaration and Agenda for Global Action, a historic roadmap laying out key actions required at international, national and local levels to improve human resources for health over the next ten years.

This week, the Global Health Workforce Alliance, the Prince Mahidol Award Conference, the Japan International Cooperation Agency, and the World Health Organization, are convening the Second Global Forum/Prince Mahidol Award Conference on Human Resources for Health, in Bangkok, Thailand.

As participants of this important Forum, we are all tasked with the responsibility to make a difference for the one billion people in the world who face a daily struggle to get basic health care from a skilled worker. Now is the time for all stakeholders to come together to renew commitments and take sustainable actions to make access to health services a reality for all.

As Chairs of the International Organizing Committee, we are very pleased to welcome you to Thailand's capital city, joining more than a thousand fellow champions, with a shared mission. We hope you will use this unique opportunity to share your successes and challenges, strengthen your networks and build new alliances and, above all, strengthen your determination to undertake new actions to deliver on our promises by 2015.

Over the next few days, you will hear first-hand how actions on the ground in a number of countries experiencing most severe health workforce issues are starting to make a difference. You will also hear about outstanding challenges in implementing the Kampala Declaration and Agenda for Global Action particularly with regards to the implementation of national health workforce plans, provision of quality training for all health workers, retention of rural health workers, implementation of the WHO Code and needed resources to fill the critical funding gap.

We have prepared a rich and full agenda with four plenary and 20 parallel sessions during the main conference programme which explore the range of health workforce issues and solutions. We urge you to take advantage of the varied range of 30 side meetings organized by partners. Please also take the opportunity to visit the Marketplace exhibition area where you will find poster displays showcasing case success stories as well as profiles of individual health workers which have been short-listed for awards to be given out during the Forum's closing ceremony. You are also invited to take part in one of the site visits, which will offer you a taste of Thailand's own efforts to strengthen and engage the health workforce.

Message from the Chairs of the International Organizing Committee

We would like to thank the many committed individuals and organizations that have worked together to prepare and execute the plan for this Forum, in particular the international partners, the Prince Mahidol Award Foundation and the Royal Thai Government. We would also like to extend a special welcome to the many individual frontline health workers, whose wealth of experience, knowledge and dedication we will all have the opportunity to benefit from this week.

The importance of the health workforce is increasingly visible on global and national agendas and we believe that more progress is possible. We look forward to joining you in renewing commitments over the next few days and in carrying out sustainable actions, beyond the Forum so that, together, we empower all health workers to deliver better health outcomes for all people.

Dr. Vicharn Panich
Chair
Prince Mahidol Award Conference

Prof. Francisco Campos
Co-Chair
Global Health Workforce Alliance

Dr. Carissa Etienne
Co-Chair
World Health Organization

Mr. Kiyoshi Kodera
Co-Chair
Japan International Cooperation Agency

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Wednesday 26 January 2011		**Room**
07.00 - 18.00	Optional Field trip	Bangkok Convention Centre Lobby, Ground Fl
Thursday 27 January 2011		**Room**
09.00 - 10.30	Opening Session & Keynote Address	Bangkok Convention Centre A2
10:30 - 11.00	Break	Market Place Area
11.00 - 12.30	**Plenary session 1:** From Kampala to Bangkok: Marking progress, Forging solutions	Bangkok Convention Centre A2
12.30 - 14.00	Lunch	Bangkok Convention Centre B2
14.00 - 15.00	**Plenary session 2:** Have leaders made a difference?: how leadership can show the way towards the MDGs?	Bangkok Convention Centre A2
15.00 - 15.30	Break	Market Place Area
15.30 - 17.30	**Parallel session 1:** Leading towards health workforce development at country level: what will it take?	Lotus Suite 1-2
	Parallel session 2: Serving in the frontlines: personal experiences and country strategies for retention of HRH in rural areas	Lotus Suite 3-4
	Parallel session 3: Will the WHO Global Code stop the brain drain? What will it take to succeed?	Lotus Suite 5-6
	Parallel session 4: Do GHIs contribute to equity in access to HRH?	Lotus Suite 7
	Parallel session 6: Overcoming HRH crises in conflict and post-conflict situations	World Ballroom B
	Parallel session 7: High Level Roundtable: Working together for health workers (by invitation)	World Ballroom A
18.00 - 20.30	Welcome Dinner hosted by the Royal Thai Government	Bangkok Convention Centre A2

CONFERENCE PROGRAM IN BRIEF

Friday 28 January 2011		Room
09.00 - 10.00	**Plenary session 3:** Professional Leadership and Education for 21st Century	Bangkok Convention Centre A2
10.00 - 10.30	Break	Market Place Area
10.30 - 12.30	**Parallel session 8:** Building Capacity to Translate HRH Evidence into Action to Sustain HRH Policy, Decisions and System Strengthening	Lotus Suite 1-2
	Parallel session 9: Innovative solutions for strengthening HRH information systems	Lotus Suite 3-4
	Parallel session 10: Scaling up HRH towards equity	Lotus Suite 5-6
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	Parallel session 12: Financing health worker education and training	World Ballroom B
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	Parallel session 14: The UN Secretary General Global Strategy for Women's and Children's health: what will be done about the workforce?	Lotus Suite 7
12.30 - 14.00	Lunch	Bangkok Convention Centre B2
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	Parallel session 16: Innovative education and training for HRH	Lotus Suite 3-4
	Parallel session 17: HRH situation and trend in developed countries and their potential implications to developing countries	Lotus Suite 5-6
	Parallel session 18: Trade in health services and impact on HRH	World Ballroom B
	Parallel session 19: Self reliance to health and well being through local resources and knowledge	World Ballroom C

CONFERENCE PROGRAM IN BRIEF

Friday 28 January 2011		Room
15.30 - 17.30	**Parallel session 20:** Skills mix to achieve universal access to essential health care	Lotus Suite 7
	Parallel session 5: Economic fluctuations, universal health coverage and the health workforce	World Ballroom A

Saturday 29 January 2011		Room
09.00 - 10.30	Synthesis: summary conclusion & next steps	Bangkok Convention Centre A2
10.30 - 11.00	Break	Pre-Function Area
11.00 - 12.30	HRH Awards and Closing session	Bangkok Convention Centre A2

Note : Bangkok Convention Centre, Market Place Area and Lotus Suite 1-7 are on the 22nd floor and World Ballroom A-C are on the 23rd floor

SIDE MEETINGS

Monday, 24 January 2011		
08.00-18.00	HRH in Africa Day: Producing Evidence and Policy through Joint Collaboration by World Bank, African Development Bank, African HRH Platform, Capacity Project (USAID), WHO	Lotus Suite 7, 22nd Fl
10.30-12.30	GHWA Pre-Conference Briefing	World Ballroom C, 23rd Fl
16.00-19.00	WHO Forum Coordination Meeting by WHO	World Ballroom C, 23rd Fl
13.30-16.30	GHD Curriculum Development Meeting	Lotus Suite 11, 22nd Fl

Tuesday, 25 January 2011		
08.00-10.00	Alliance Members' Platform - Taking the HRH Agenda forward (pre forum session) by GHWA	World Ballroom A, 23rd Fl
08.30-10.30	Midwives and others with midwifery skills: the key resource for MDGs 5 and 4 by UNFPA	World Ballroom B, 23rd Fl
09.00-11.00	Understanding Health Workers' Preferences to Address HR Issues by London School of Hygiene & Tropical Medicine (CREHS) / IHPP	Lotus Suite 9, 22nd Fl.
09.00-12.00	Lancet Series launch by the China Medical Board, the Rockefeller Foundation, the Lancet and the Prince Mahidol Award Conference	Lotus Suite 1-2, 22nd Fl.
09.00-12.00	HRH management for Francophone African countries -HRH information system and HRH Observatories by NCGM/JICA	Lotus Suite 3-4, 22nd Fl.
09.00-12.00	Choosing the most appropriate interventions for rural retention of health workers: a methods workshop by WHO	World Ballroom C, 23rd Fl.
09.00-12.00	HRH in Africa : A New Look at the Crisis by World Bank	Lotus Suite 5-6, 22nd Fl.

SIDE MEETINGS

Tuesday, 25 January 2011

09.00-12.30	Transformative scale up of medical, nursing and midwifery education by WHO-HRH/IHPP	Lotus Suite 10, 22nd Fl.
09.00-13.00	From Crisis to Stability: Lessons from Malawi by MSH	Lotus Suite 7, 22nd Fl.
09.00-16.00	Connecting Health Organizations for Regional Disease Surveillance by CHORDS	Lotus Suite 8, 22nd Fl.
09.00-17.00	Positive Practice Environments by International Council of Nurses, World Health Professional Association, and International Hospital Federation	Lotus Suite 11, 22nd Fl.
09.00-17.00	Enhancing Personal Resilience for a Sustainable Health Care Workforce by World Medical Association	Lotus Suite 12, 22nd Fl.
09.00-17.00	Delivering eLearning for Human Resources in Health by AMREF	Lotus Suite 13, 22nd Fl.
11.00-13.00	African Platform on Human Resources for Health Business Meeting by African Platform	World Ballroom B, 23rd Fl
11.30-12.40	Community Health Worker Strategy in Zambia by CHAI	Lotus Suite 9, 22nd Fl.
11.30-13.00	What will it take set a truly 'actionable' global policy agenda to address the global HRH shortage? by HWAI	World Ballroom A, 23rd Fl
11.30-13.00	E-health Capacity Building by IntraHealth	Lotus Suite 14, 22nd Fl.
13.30-15.30	Participatory management activities of 5S-KAIZEN-TQM for promoting mind-set change and leadership by JICA	Lotus Suite 3-4, 22nd Fl.
13.30-15.30	The Italian systemic effort in strengthening human resources for health in developing countries: looking for increased coordination and policy coherence by AMREF	World Ballroom B, 23rd Fl

SIDE MEETINGS

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13.30-16.30	(1) 'Working together' , Increasing the capacity of health advocacy NGOs (2) 'Health Workers Speak' – research from 4 countries on staff motivation, morale and attrition by VSO	World Ballroom C, 23rd Fl.
13.30-16.30	Why HRH Planning and how to prevent failure in planning and implementation by AAAH	Lotus Suite 5-6, 22nd Fl.
13.30-16.30	Global Pharmacy Education Taskforce by The International Pharmaceutical Federation (FIP)	Lotus Suite 7, 22nd Fl.
13.30-16.30	Strengthening Linkages between the Faith-based Health Care Providing Community and Ministries of Health for Quality Health Care for All by Capacity Plus	Lotus Suite 14, 22nd Fl.
13.30-16.30	Generating evidence to inform human resources for health policy by World Bank	Lotus Suite 9, 22nd Fl.
13.30-17.30	PEPFAR and the 140,000 Health Worker Target: A Combination Approach to Strengthening Pre-Service Education by PEPFAR	Lotus Suite 1-2, 22nd Fl.
13.30-17.30	Country Coordination and Facilitation process : Addressing the HRH challenges through multi-sectoral approach by GHWA	World Ballroom A, 23rd Fl
14.00-16.00	Global mapping of medical, nursing & other health professional schools by WHO	Lotus Suite 10, 22nd Fl.
16.00-17.30	Strengthening the contribution of civil society networks in tackling the global HRH crisis - a UK case study by UK Working Group on HRH, under Action for Global Health	World Ballroom B, 23rd Fl
16.00-18.00	Human resource development in community health by JICA	Lotus Suite 3-4, 22nd Fl.

SIDE MEETINGS

Wednesday, 26 January 2011		
09.00-12.00	HRH Expert Group Meeting by Human Resources for Knowledge Hub	Arnoma Hotel

Friday, 28 January 2011		
07.00-08.30	Achieving the MDGs: Accelerating the HRH Agenda for Global Action by WHO / GHWA	Lotus Suite 11, 22nd Fl
12.30-14.00	Education for Health Professionals in the 21st Century	Lotus Suite 11, 22nd Fl
17.30-19.00	Advisory Board Meeting for the State of the World's Midwifery Report by UNFPA	Lotus Suite 11, 22nd Fl
17.30-20.00	Consultative Meeting on Health Information System Components for Human Resources within Health Systems by WHO/IER	Lotus Suite 12, 22nd Fl
17.45-18.30	Report Launch: Universal Access to HIV/AIDS Services-Can MDG 6 Be Achieved With The Health Workforce We Have? by GHWA	World Ballroom A, 23rd Fl
18.15-19.45	Turning Whispers to Voices: Strengthening Southern CS engagement in Global Health Dialogue and Accountability by Centre for Health Sciences Training, Research and Development (CHESTRAD)	Lotus Suite 5-6 22nd Fl

Saturday, 29 January 2011		
13.30-15.00	Alliance Members' Platform - Taking the HRH Agenda forward (post forum session) by GHWA	Lotus Suite 1-4 22nd Fl
14.00-16.30	IOC Meeting by PMAC	Lotus Suite 7, 22nd Fl

Sunday, 30 January 2011		
08.30-17.00	11th GHWA Board Meeting by GHWA	Lotus Suite 7 22nd Fl

LIST OF SPEAKERS, PANELISTS, CHAIRS, MODERATORS AND RAPPORTEURS

Speaker/Panelist	Chair/Moderator	Rapporteur
Keynote Session		
Robert E. Black Finalists for Special Recognition Awards		Jeff John Weerasak Putthasri Iyarit Thaipisutikul
Plenary session 1: From Kampala to Bangkok: Marking progress, forging solutions		
Shahnaz Wazir Ali Carissa Etienne Kiyoshi Kodera Thir Kruy Bjorn-Inge Larsen David Mphande Leochrist Shali Mwanyumba Mubashar Sheikh	Timothy Grant Evans	Hirotsugu Aiga Toomas Palu Passawee Tapasanan
Plenary session 2: Have leaders made a difference?: how leadership can show the way towards the MDGs?		
Michel Kazatchkine Denis Salord Keizo Takemi Sam Zaramba	Carissa Etienne Jason Gale	Rungsun Munkong Alison Osborne Viroj Tangcharoensathien
Parallel session 1: Leading towards health workforce development at country level: what will it take?		
Adang Bachtiar Elsheikh Badr Alberto Baptista Gülin Gedik Hilde De Graeve Christian Habineza Jason Lane Mario Dal Poz	Francisco Campos Suzanne Kodsi	Gulin Gedik Walaiporn Patcharanarumol Ding Yang
Parallel session 2: Serving in the frontlines: personal experiences and country strategies for retention of HRH in rural areas		
Oluyombo Awojobi Carmen Dolea Tetsuro Irohira Wimal Karandagoda Christophe Lemiere Kim Webber E. Grace Allen Young	Ian Couper	Puwat Charukamnoetkanok Carmen Dolea Phrae Jittinan

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Speaker/Panelist	Chair/Moderator	Rapporteur
Parallel session 3: Will the WHO Global Code stop the brain drain? What will it take to succeed?		
Kazem Behbehani Bjorn-Inge Larsen Percy Mahlathi Colin McIff Francis Omaswa Patricia A. Sto. Tomas	Manuel M. Dayrit Mihály Kökény	Suriwan Thaiprayoon Komalrat Turner Pascal Zurn
Parallel session 4: Do GHIs contribute to equity in access to HRH?		
Ruairi Brugha Fuqiang Cui Mary Ann Lansang John Palen David Sanders	Masato Mugitani	Sutayut Osornprasop Cha-aim Pachanee Jennifer Frances dela Rosa
Parallel session 5: Economic fluctuations, universal health coverage and the health workforce		
Hannes Danilov Supon Limwattananon Ann Phoya Kampeta Sayinzoga	David Evans Juan Pablo Uribe	Puwat Charukamnoetkanok Magnus Lindelow Phusit Prakongsai
Parallel session 6: Overcoming HRH crises in conflict and post-conflict situations		
Fariba Al Darazi Fiona Campbell Noriko Fujita Salam T Ismael Ruchama Marton Jihad Mashal Annette Mwansa Nkowane Marivand Pinto	Edward Mills Miriam Were	Saipin Hathirat Mwansa Nkowane Thinakorn Noree
Parallel session 7: High Level Roundtable: Working together for health workers		
Carissa Etienne Michel Kazatchkine Richard Nduhuura Gary Newton Mubashar Sheikh M. Sanoussi Touri	Sigrun Møgedal Mongkol Na Songkhla	Giorgio Cometto Tipicha Posayanond Weerasak Putthasri

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Plenary session 3: Professional Leadership and Education for 21st Century		
Zulfiqar Bhutta Lincoln Chen Thomas Hall Vicharn Panich	Richard Horton Ariel Pablos-Méndez	Saipin Hathirat Cherdsak Iramaneerat Junhua Zhang
Parallel session 8: Building Capacity to Translate HRH Evidence into Action to Sustain HRH Policy, Decisions and System Strengthening		
Irene Akua Agyepong James Buchan Fadi El-Jardali Samuel Mwenda Sania Nishtar	Abdul Ghaffar James McCaffery	Sutayut Osornprasop Abdurachman Saliman Jadej Thammathataree
Parallel session 9: Innovative solutions for strengthening HRH information systems		
Piya Hanvoravongchai Thembisile Khumalo Elikaanan N. Mwakalukwa Mario Dal Poz	Timothy Grant Evans Michael Friedman	Pinij Farungamnuayphol Teena Kunjumen Natalie Phaholyothin
Parallel session 10: Scaling up HRH towards equity		
Zulfiqar Bhutta Ali Babiker Ali Habour Fely Marilyn E. Lorenzo Fitzhugh Mullan Barbara Aranda Naranjo Francis Omaswa Ann Phoya Keat Phuong	Lincoln Chen Marc Danzon	Francesca Celletti Pattapong Kessomboon Sudarat Tuntivivat
Parallel session 11: Seeking the stamp of good quality? Imperatives of HRH regulation and accreditation		
Thamer Kadum Yousif Al-Hilfy Genevieve Howse Jan De Maeseneer Samuel Wong	Salman Rawaf	Akib Kemas Wanipol Mahaarcha Malee Sunpuwan

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Speaker/Panelist	Chair/Moderator	Rapporteur
Parallel session 12: Financing health worker education and trainingKazem Behbehani		
Nigel Crisp Tarun Seem Marie-Odile Waty	Rozenn Le Mentec Maurice Middleberg	Sawarai Boonyamanond Charamporn Holumyong Magnus Lindelow
Parallel session 13: Dedicated Spirit: The Charm and Charisma of HRH		
Daw Nan Than Than Oo Carmen Dolea Saidou Ekoye Ho Thi Thanh Hoa Barbara McPake Ebele Omeke Micheal Leochrist Shali Mwanyumba Karamoko Nimaga P.D. Lalitha Padmini Pakdee Suebnukarn	Bridget Lloyd	Thinakorn Noree Tipicha Posayanond Jennifer Frances dela Rosa
Parallel session 14: The UN Secretary General Global Strategy for Women's and Children's health: what will be done about the workforce?		
Rebecca Affolder Helga Fogstad A.F.M. Ruhal Haque Carol Jenkins Masato Mugitani Angelique K Rwiyereka	Sarah Boseley Gustavo Gonzalez-Canali	Giorgio Cometto Mwansa Nkowane Acharawan Topark-Ngarm
Plenary session 4: Making HRH Innovation Work for Strengthening Health Systems		
Oluwafunmilola Dare Fauzia Tariq Leana R Uys	Francisco Campos Mark Stirling	Jeff John Natalie Phaholyothin Chanwit Tribuddharat
Parallel session 15: Building capacity to generate evidence in HRH action oriented research		
Frances Baum Mickey Chopra Sàbado Girardi Harriet Nabudere	A. Metin Gulmezoglu Pisake Lumbiganon	Supon Limwattananon Nucharee Srivirojana Ji Xu

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Speaker/Panelist	Chair/Moderator	Rapporteur
Parallel session 16: Innovative education and training for HRH		
Manuel M. Dayrit Barbara McPake Vinícius Oliveira Berhanu Feyisa Tilla Hideomi Watanabe	K. Srinath Reddy	Rebecca Bailey Tripop Lertbunnaphong Nonglak Pagaiya
Parallel session 17: HRH situation and trend in developed countries and their potential implications to developing countries		
Elizabeth Adams Linda Aiken Jean Marc Braichet Bjorn-Inge Larsen Chris Rakoum Beth Slatyer	Mark Pearson	Pinij Farungamnuayphol Pongsadhorn Pokpermdee Laura Stormont
Parallel session 18: Trade in health services and impact on HRH		
Nigel Crisp John Hancock Rangarirai Machemedze	Cristian Baeza Nick Drager	Chutima Akaleephan Natalie Phaholyothin Suriwan Thaiprayoon
Parallel session 19: Self reliance to health and well being through local resources and knowledge		
Govindaswamy Hariramamurthi Zhang Qi Yahaya Sekagya Steve An Xue	Vichai Chokevivat	Chalermpol Chamchan Thaksaphon Thamarangsi Ding Yang
Parallel session 20: Skills mix to achieve universal access to essential health care		
David C. Benton Zulfiqar Bhutta Frances Day-Stirk Otmar Kloiber Maxensia Nakibuuka Salman Rawaf Sairam Sadaat	Sheila Dinotshe Tlou Bjarne Garden	Luis Huicho Sakkarin Niyomsilpa George Pariyo

The Second Global Forum on Human Resources for Health
Prince Mahidol Award Conference 2011

Background

In accordance with the Kampala Declaration (KD), the Agenda for Global Action (AGA) is built around six fundamental and interconnected strategies, based on previous actions and commitments. The AGA is a synthesis that specifically highlights challenges and the need for change which reflects the essential continuum of planning, training, deployment and retention. The purpose of AGA is to translate political will, commitments, leadership and partnership into effective actions.

The six interconnected Strategies are:

1. Building coherent national and global leadership for health workforce solutions
2. Ensuring capacity for an informed response based on evidence and joint learning
3. Scaling up health worker education and training
4. Retaining an effective, responsive and equitably distributed health workforce
5. Managing the pressures of the international health workforce market and its impact on migration
6. Securing additional and more productive investment in the health workforce

Almost three years of implementation of policy and strategies have passed, these having been adopted by the Kampala Declaration at the first-ever Global Forum on Human Resources for Health, which was held on 2-7 March 2008 in Kampala, Uganda. In addition, there are a number of World Health Assembly Resolutions and WHO Regional Committee Resolutions which call for immediate action to solve this global crisis.

The 2nd Global Forum on Human Resources for Health will be held on 25-29 January 2011, in Bangkok, Thailand, in collaboration with the 2011 Prince Mahidol Award Conference. The overall objective is to accelerate the global movement on HRH towards achieving the Millennium Development Goals and universal access to essential health care. In addition, it was agreed at the joint planning workshop among the co-hosts of the Forum on 3-4 December 2009, that the Global Forum will be a combination of technical and policy elements while also focusing on evidence-based actions, existing gaps and how to overcome them. It is the intention of the conference to be crafted along the line of the KD and six strategies of the AGA. It is envisioned that the deliberations will review the development and progress made, and identify challenges met in mitigating global HRH crisis. It should be organized to best support of global movements towards better HRH to achieve universal coverage.

Countries are the indispensable players in solving the human resource crisis, thus, priority shall be given to engage speakers and participants from countries to share experiences and lessons learned. Speakers from international development partners should also play a role in terms of sharing policies and strategies at the international and global levels which have an impact on implementation at the country level. The ratio of country to international partner speakers is proposed to be 3:1.

Theme of the forum

- Reviewing progress, renewing commitments to health workers towards MDGs and beyond

Structure of the Main Conference Program
The 2nd Global Forum on HRH / Prince Mahidol Award Conference 2011 will have 5 main activities, including:
- Side meetings,
- Capacity building workshops,
- Field visits,
- Marketplace,
- Main conference program.

The main conference program consists of the Plenary and Parallel sessions, in addition to the opening, closing and official dinner sessions. The proposed content of the sessions is based on the structure and contents of the Kampala Declaration (KD) and the Agenda for Global Actions (AGA), as well as the results of the on-line survey carried out by GHWA.

Wednesday 26 January 2011

07.00 – 18.00
Field Trip
1. Wat Pra Baht Nam Phu: The Buddhist Temple that Cares for Full-blown AIDS Patients
2. Pra Nang Klao Hospital: Humanized Health Care Volunteers
3. Phnomsarakam Community Hospital: Pay for Performance to Increase Job Satisfaction and Retention
4. Ban Paew Hospital: The First and Only Autonomous Hospital in Thailand
5. Uthong Hospital: Combination of Conventional and Alternative Medicines
6. Taladjinda Health Center and Sampran Hospital: Community Participation
7. Siriraj Hospital: The Role of Medical School in Human Resource Development for Health

Thursday 27 January 2011

09.00 – 10.30
Opening Session & Keynote Address

Opening Ceremony: Her Royal Highness Princess Maha Chakri Sirindhorn

Keynote Speeches:
- Robert E. Black, Professor and Chairman, Johns Hopkins University
- Finalists for Special Recognition Awards

10:30 – 11.00
Coffee Break

11.00 – 12.30
Plenary session 1
From Kampala to Bangkok: Marking progress, forging solutions

Background / Overview
Health workers are the human face of health systems. According to the World Health Report 2006 "Working together for health", the world is faced with a chronic shortage - an estimated 4.2 million health workers are needed to bridge the gap, with 1.5 million needed in Africa alone. The critical shortage is recognized as one of the most

fundamental constraints to achieving progress on health, and reaching health and development goals.

In March 2008, the First Global Forum on Human Resources for Health (HRH), convened by the Global Health Workforce Alliance (the Alliance), adopted the Kampala Declaration and Agenda for Global Action (KD/AGA) as a roadmap for solving HRH crisis. Article 12 of the KD is a commitment for the Alliance to monitor the implementation of the KD/AGA and to re-convene the Global Forum on HRH after two years to report and evaluate progress.

Objectives
This plenary session will: (i) review the progress of the KD/AGA particularly in the 57 crisis countries; (ii) share countries' experiences; and (iii) discuss the way of accelerating the implementation of the KD/AGA and effectively addressing challenges. The primary objective of the plenary session is to further increase awareness of the urgency and importance of addressing the HRH issues among broader audience, particularly among global health leaders and policymakers.

Moderator: Timothy Grant Evans, Dean, James P Grant School of Public Health, BRAC University

Speakers:
1. **Mubashar Sheikh,** Executive Director, Global Health Workforce Alliance
2. **Leochrist Shali Mwanyumba,** District Public Nurse, Tanela District Hospital

Panelists:
1. **David Mphande,** Minister, Ministry of Health, Malawi
2. **Carissa Etienne,** Assistant Director-General, Health Systems and Services, World Health Organization
3. **Shahnaz Wazir Ali,** Special Assistant to Prime Minister, Higher Education Commission
4. **Thir Kruy,** Secretary of State of Health, Ministry of Health, Cambodia
5. **Bjorn-Inge Larsen,** Director-General and Chief Medical Officer of Norway, The Norwegian Directorate of Health
6. **Kiyoshi Kodera,** Vice President, Japan International Cooperation Agency

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12.30 – 14.00
Lunch

14.00 – 15.00
Plenary session 2
Have leaders made a difference?: how leadership can show the way towards the MDGs?

Background / Overview
Without dynamic and effective leadership, we fail to meet our goals. This session will delve into the issues of leadership and the role of leaders in the struggle of countries and the global community to reach the MDGs. The session will strive towards a discussion and understanding of what it takes to lead in a complex environment where competing priorities, contradictory purposes, and many stakeholders operate.

A panel of high-level discussants will answer questions from a seasoned journalist and afterwards, from the audience.

Objectives
At the end of the session, panelists and audience will have derived lessons and actionable ideas on how to exercise leadership to move the HRH agenda towards reaching the MDGs.

Chair: Carissa Etienne, Assistant Director-General, Health Systems and Services, World Health Organization

Moderator: Jason Gale, International Journalist, Bloomberg News

Panelists:
1. **Sam Zaramba,** Former Director General, Ministry of Health, Uganda
2. **Denis Salord,** Head of Unit, European Commission
3. **Keizo Takemi,** Senior Fellow, Japan Center for International Exchange
4. **Michel Kazatchkine,** Executive Director, The Global Fund to Fight Against AIDS, Tuberculosis and Malaria

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15.00 – 15.30
Coffee Break

15.30 – 17.30
Parallel session 1
Leading towards health workforce development at country level: what will it take?

Background / Overview
This session focuses on the issues, experiences, initiatives of people and institutions who lead the work of health workforce development at the country level.
What will it take to build leadership at country level? The session approaches the topic by looking at three components of effective leadership:
- strategic vision
- capacity to lead
- accountability to the public and to partners

How can these components be effectively developed at the country level to sustain health workforce development over the short and long term?. How can we tell that there is effective leadership at the country level?

Strategic vision is embodied and made real through formulation of strategic policy directions. HRH plans can be used as one indicator that strategic vision exists.

The capacity to lead can be assessed by the presence and activities of individuals and institutions (eg. HRH department/unit) which define and implement HRH policy in an effective manner. There are different country models for building capacity.

Accountability to the public and to partners can be reflected in mechanisms which ensure a sustainable and inclusive policy dialogue.

Collective leadership is expressed through participation and coalition building among stakeholders from various sectors. Through this process, vision, capacity, and account ability can be built collectively.

In preparation to the Global Forum, a conference on Responsible governance for improved human resources for health: making the right choices held in March 2010 provided a platform for the planning of this session.

Objectives
Coming after the Plenary Session on leadership, this session is meant to delve more deeply into the issues of leadership at the country level, using the framework proposed.

At the end of the session, the audience will have learned about strategies and practices to build up leadership at the country level to address HRH challenges. They will also have discussed the bottlenecks in strengthening leadership at country level and strategies of to overcome these bottlenecks

Chair: Suzanne Kodsi, Programme Manager - EU policies, European Commission
Moderator: Francisco Campos, Professor, Federal University of Minas Gerais, Barzil

Speakers:
1. **Mario Dal Poz,** Coordinator, World Health Organization
2. **Gülin Gedik,** World Health Organization
3. **Jason Lane,** Senior Health Policy Advisor, European Commission, DEV B3
4. **Alberto Joao Baptista,** Provincial Director, Ministry of Health, Mozambique
5. **Hilde De Graeve,** Medical officer, World Health Organization
6. **Elsheikh Badr,** Director, National Human Resources for Health Observatory
7. **Adang Bachtiar,** Chairman, Department of Health Administration and Policy Studies, University of Indonesia
8. **Christian Habineza,** Director, Health, Development and Performance, Rwanda

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15.30 – 17.30
Parallel session 2
Serving in the frontlines: personal experiences and country strategies for retention of HRH in rural areas

Background / Overview
Many countries in HRH crisis are facing the challenge of acute shortages of health workers, in particular in areas of most need, such as rural or remote areas. This is a severe bottleneck on the road to achieve the Millennium Development Goals and provide adequate health services. However, the inequitable distribution of health workers between rural or remote and urban areas is not only a concern for low-income countries, but also for high-income countries, that have struggled for years to solve this challenge.

In response to many calls for action, including the Kampala Declaration and Agenda for Global Action of the first HRH Global Forum, the WHO has developed evidence-based recommendations on how to attract, recruit and retain health workers in rural and remote areas. Countries are now beginning to implement these recommendations and evaluate their impact.

Objectives

- To highlight the implications, benefits and challenges of rural health practitioners who have committed to work in rural areas
- To share country experiences related to retention of health workers in remote and rural areas
- To discuss retention policies and strategies at country and global level, and the role of various stakeholders in the promotion and successful implementation of retention
- strategies, including the recently published WHO recommendations on retention
- To inspire the audience to take effective action on retention in their respective countries

Moderator: Ian Couper, Professor/Director, Wits University Centre for Rural Health
Speakers:
1. Oluyombo Awojobi, Consultant Rural Surgeon, Awojobi Clinic Eruwa
2. E. Grace Allen Young, Specialist Healthcare Management & Pharmaceutical Services

Panelists:
1. Tetsuro Irohira, Physician, Saku Central Hospital
2. Wimal Karandagoda, Director of Medical Services, Lanka Hospital Corporation, Ministry of Health, Sri Lanka
3. Kim Webber, CEO, Rural Health Workforce Agency
4. Christophe Lemiere, Senior Health Specialist, World Bank
5. Carmen Dolea, Department of Human Resources for Health

15.30 – 17.30
Parallel session 3
Will the WHO Global Code stop the brain drain? What will it take to succeed?

Background / Overview
The recent adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel by the Sixty-third World Health Assembly has generated much enthusiasm and expectation from all stakeholders, including Member States, health personnel, health professional organizations, nongovernmental organizations (NGOs), and recruiters/employment agencies. This landmark instrument marks the first time that a voluntary code has been developed under WHO auspices in 30 years. However, such Code will be successful only if all stakeholders, and in particularly Member States play a key role in its implementation and if proper implementation strategies are developed.

Objectives

- To discuss the implications, benefits and challenges of the adoption of the WHO Code for Member States and other stakeholders
- To review and discuss strategies for a successful implementation of the WHO Code, including the recently published WHO implementation strategy
- To highlight the WHO Code as an impetus for human resources for health development from a country and global perspective

Chair: Mihály Kökény, Former Minister of Health of Hungary
Co-Chair: Manuel M. Dayrit, Director, World Health Organization

Speakers:
1. **Percy Mahlathi,** Deputy Director-General, Ministry of Health, South Africa
2. **Bjorn-Inge Larsen,** Director-General and Chief Medical Officer of Norway, The Norwegian Directorate of Health

Panelists:
1. **Patricia A. Sto. Tomas,** Chair of Board DBP, Secretary of Labor and Employment
2. **Kazem Behbehani,** Director General, Dasman Diabetes Institute
3. **Francis Omaswa,** Chair, Health Worker Migration Global Policy Advisory Council, African Centre for Global Health and Social Transformation
4. **Colin McIff,** Health Attache, Office of the U.S. Global AIDS Coordinator (OGAC), PEPFAR

15.30 – 17.30
Parallel session 4
Do GHIs contribute to equity in access to HRH?

Background / Overview
Global Health Initiatives (GHIs) have the ability to mobilize huge amounts of financial resources which can contribute constructively and positively to national HRH plans. Shortages in HRH are a bottleneck to scaling-up service delivery and a hurdle to effective implementation of GHI-supported programmes. Some anecdotal studies showed that GHI-supported programs cause internal mobility of health workforce, from rural to urban, from public service providers to NGOs program managers, etc. They have been increasingly focusing on retention strategies through training and improvement of working and living conditions of health workers in rural areas.

Objectives
- Provide an overview and analysis of GHI support on national health systems in general and HRH in particular
- Discuss best practices and weaknesses GHI-supported programs and projects in addressing inequities to access
- Explore how GHIs can contribute to improving equity in HRH and in access to health services, particularly on future trends and prospects
- Recommend strategic actions to address inequities in access through GHI-supported programs

Chair: Masato Mugitani, Assistant Minister for Global Health, Ministry of Health Labor and Welfare

Speakers:
1. **Ruairi Brugha,** Chair, Department of Epidemiology and Public Health Medicine, Royal College of Surgeons in Ireland
2. **David Sanders,** School of Public Health University of Western Cape

Panelists:
1. **Mary Ann Lansang,** Director, Knowledge Management Unit, The Global Fund to Fight AIDS, Tuberculosis and Malaria
2. **John Palen,** PEPFAR
3. **Fuqiang Cui,** China CDC

Parallel session 5
Economic fluctuations, universal health coverage and the health workforce

(Rescheduled to Friday 28 January 15.30 – 17.30)

15.30 – 17.30
Parallel session 6
Overcoming HRH crises in conflict and post-conflict situations

Key Message: Create an environment for motivated health workers to optimize their professionalism under conflict and post-conflict situations

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

Although several UN agencies and humanitarian NGOs have shown ways to cope with such HRH crises, more efforts are awaited to give hope to the hopeless - both health workers and the wider populations they serve. In many conflict and post-conflict situations, support is urgently needed both from within and externally. However, where conflict or post-conflict situations are prolonged, a long-term vision is also critical. This is particularly important to avoid fragmented training, and to foster an improved retention mechanism. These situations might also be true after mega-sized natural disasters. In addition to making people free from want and free from fear under such circumstances, we also need to create an environment under which health workers can help people to be free to live in dignity.

Objectives
Part 1: To explore ways to support and manage human resources to respond adequately to emergency situations under a fragile health system.
Part 2: To explore ways to strengthen HRH in chronic conflict situations.
Part 3: To explore ways to strengthen health workforces and health services under post-conflict situations.

Chair: Miriam Were, Board Member, AMREF, MAP International & KACC Advisory Board

Moderator: Edward Mills, Professor, University of Ottawa

Speakers:
1. **Fiona Campbell,** Head of Policy, Merlin
2. **Marivand Pinto,** National Consultant, Pan American Health Organization
3. **Ruchama Marton,** Founder&President, Physicians for Human Rights-Israel
4. **Salam Ismael,** Director, Doctors for Iraq Society
5. **Jihad Mashal,** Director of Health, The Palestinian Health Sector Reform and Development Project
6. **Annette Mwansa Nkowane,** Technical Officer, World Health Organization
7. **Fariba Al Darazi,** Regional Adviser for Nursing and Allied Health Personnel, World Health Organization, Regional Office for the Eastern Mediterranean
8. **Noriko Fujita,** National Center for Global Health and Medicine (NCGM)

15.30 – 17.30
Parallel session 7
Working together for health workers (by invitation)

Background / Overview
This invitation-only session will bring together high level decision makers (Ministers, Secretaries,

Director Generals, Under- Secretaries) from Governments, heads of agencies, and selected highlevel delegates to the 2nd Global Forum on Human Resources for Health. It will be open to high level delegates from relevant line ministries (health, education, finance, civil service or equivalent) from the 57 HRH crisis countries in attendance to the Forum.

This high level session will showcase some examples of government and development partners'commitment to investment in HRH, as well as examples where the key principles of inter-sectoral planning and management of HRH development are being put in practice, generating high-level political commitment for investment in HRH and the roll-out of positive HRH practices in other countries.

Objective
Thepurposeofthisroundtableistogeneratehigh-levelpoliticalcommitmentontheprinciples of increased investment in HRH as pre-requisite for MDG progress, and inter-sectoral and multistakeholder coordination, and to lay the foundations for the development and endorsement of a consensus statement emerging from the Second Global Forum on Human Resources for Health.

Chair: Mongkol Na Songkhla, Chairman of the National HRH Development Committee and Former Public Health Minister

Moderator: Sigrun Møgedal, Chair, Global Health Workforce Alliance

Panelists:
1. **Carissa Etienne,** Assistant Director-General, Health Systems and Services, World Health Organization
2. **Mubashar Sheikh,** Executive Director, Global Health Workforce Alliance
3. **Richard Nduhuura,** Minister of State for Health (General Duties), Uganda
4. **Sanoussi Toure,** Minister, Ministry of Finance, Mali
5. **Michel Kazatchkine,** Executive Director, Global Fund to fight AIDS, Tuberculosis and Malaria
6. **Gary Newton,** United States Government Special Adviser on Orphans and Vulnerable Children

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18.00 – 20.30
Welcome Dinner hosted by the Royal Thai Government

Friday 28 January 2011

09.00 – 10.00
Plenary session 3
Professional Leadership and Education for 21st Century

Background / Overview
In the past decade, seeking to achieve the MDGs, global workforce challenges have mostly focused on overcoming the severe crisis in worker shortages through ramp up of training and deployment of basic health workers. While engagement has been global, special concentration of this strategy has been applied in sub-Saharan Africa which faces the most severe worker shortages and where achieving the MDGs is greatly challenged. There has been also growing concern over mal-distribution of the workforce, both within and across nations, as exemplified by the recently endorsed WHA resolution on international migration.

Almost completely neglected has been the professionally trained cadre in all countries, poorer and richer. These professional cadres take a longtime and a lot of money to educate. In most countries, they have monopoly power over many key health functions such as prescription or diagnostic tests. But post-secondary educated health professionals are also invariably the leaders of the health care system, occupying virtually all of the leadership roles especially in ministries of health, the universities, and even many leading NGOs. In poorer countries seeking to expand coverage, few have addressed the question of what kinds of competencies do such professionals need to join in health teams. This is a critical question because basic worker systems have consistently failed when they are not plugged into or aligned with mainstream health systems. In richer countries, there is also significant and growing mal-alignment with outdated curriculum teaching purely technical skills for professionals who enter into labor markets. While many perform key social roles in society, they also mostly aspire to middle-class life and work styles and exacerbate problems of poor rural coverage, high cost and wasteful health care expenditures, and iatrogenic disease.

Objectives
- To address key challenges of professional education and propose recommendations for education in 21st Century
- To share countries experiences on how to provide education to meet the challenges

Chair: Ariel Pablos-Méndez, Managing Director, The Rockefeller Foundation

Moderator: Richard Horton, Editor-in-Chief, The Lancet

Speaker: Lincoln Chen, President, China Medical Board

Panelists:
1. **Tomas Hall,** Lecturer & Executive Director, UCSF & Global Health Education Consortium
2. **Vicharn Panich,** Chair, Mahidol University Council
3. **Zulfiqar Bhutta,** Aga Khan University, Pakistan

10.00 – 10.30
Coffee Break

10.30 – 12.30
Parallel session 8
Building Capacity to Translate HRH Evidence into Action to Sustain HRH Policy, Decisions and System Strengthening

Key Message: Building capacity at the country level to translate HRH evidence into action is absolutely critical to sustain HRH policy, decisions and system strengthening, and the HRH field needs to consolidate lessons learned and promising practices to build this capacity.

Background/Overview
The second component of the AGA (Agenda for Global Action) is "ensuring capacity for an informed response based on evidence and joint learning". In order to ensure the development and attainment of such capacity, we need reliable indicators, accurate health information (Parallel Session 4) as well as the capacity to address knowledge gaps and generate relevant evidence through action-oriented research in HRH (Parallel Session 6). Once more accurate HRH information and reliable research evidence is available, capacity is needed to use such evidence to guide the development of policies, plans, decisions and systems innovations (Parallel Session 5).

Even when information or evidence does become available, many countries have weak health systems – especially HRH systems – that hinder evidence based policy, planning and decision-making. This is largely caused by a lack of HRM capacity and mechanisms to link routinely available or new evidence to inform system strengthening and decision-making. In this session, we will explore three aspects of this topic:
- How can capacity be strengthened so that HRH information and evidence is considered and used on regular basis to inform policy, decisions, plan implementation and action?
- How can both state and non-state actors increase their capacity to use evidence to strengthen systems related to workforce planning, production, recruitment, deployment, management and retention?
- What kinds of country level success stories exist about how knowledge translation (KT) has helped bring HRH evidence into policy and how it stimulated action? For example, what kinds of communication tools were used with policy makers (i.e. policy brief, policy dialogue meetings, etc.)?

This session is inclusive, and will be enriched by a mixture of stakeholders including those involved with policy making as well as HRM, public sector and private, NGO's and FBOs, country level as well as regional and global.

Objectives
The overall objective of this parallel session is to explore ways to build capacity to translate HRH evidence into action to sustain HRH policy, decisions and system strengthening. This will include looking at mechanisms and tools that can be used translate evidence into action, building a tradition of evidence-based decision making, exploring some of the competencies required and looking at successful cases where this kind of knowledge translation has happened.

Co-Moderators:
1. **James McCaffery,** TRG and CapacityPlus
2. **Abdul Ghaffar,** Executive Director, Alliance for Health Policy and Systems Research, World Health Organization

Panelists:
1. **James Buchan,** Queen Margaret University
2. **Samuel Mwenda,** General Secretary, Christian Health Association of Kenya/Coordinator, Africa Christian Health Association Platform
3. **Fadi El-Jardali,** Assistant Professor, American University of Beirut
4. **Sania Nishtar,** Founding President, Heartfile
5. **Irene Akua Agyepong,** Regional Director of Health Services, Ghana Health Service

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10.30 – 12.30
Parallel session 9
Innovative solutions for strengthening HRH information systems

Key Message: Strengthening HRH information systems to support policy and practice requires not just the bringing together of different types of data, but more importantly the bringing together of different constituencies and stakeholders.

Background / Overview
The availability, accessibility and use of data and information on human resources for health (HRH) are crucial for evidence-based decision making to address HRH challenges in countries and globally. There are many sources that can potentially produce valuable data for HRH measurement and monitoring, including routine administrative records, population censuses and surveys, health facility assessments, and other types of data collection exercises within and outside the formal health sector. The development of a comprehensive evidence base generally requires combining different types of information, frequently scattered across different sources and many of which remain underused in HRH research. Against a backdrop of increasing demand for quality information on HRH, combined with an increasingly crowded landscape of partners and initiatives with the purpose to strengthen health systems and improve health in low-and middle-income countries, an underlying challenge is to optimize available resources (human, financial and technical), reduce overlap and avoiding fragmentation.

The goal of this session is to share good practices and lessons learnt in building national leadership and inclusive stakeholder alliances towards a coordinated, harmonized and standardized approaches to strengthening health workforce information systems based on country needs and priorities. The session will concentrate on: (i) strategies and mechanisms to strengthen health workforce information systems in countries; (ii) sharing and use of different sources of data to understand HRH stock, flows and inequalities; (iii) the challenges of information systems strengthening from governance, human resource capacity and technical perspectives; and (iv) partnership opportunities to ensure sustainability.

Objective
- To share and catalyse ideas that would inspire innovative solutions for strengthening HRH information systems to address knowledge gaps for policy and practice.

Chair: Timothy Grant Evans, Dean, James P Grant School of Public Health, BRAC University

Moderator: Michael Friedman, Medical Officer/ PEPFAR HRH Co-chair, US Centers for Disease Control

Speakers:
1. **Mario Dal Poz,** Coordinator, World Health Organization
2. **Thembisile Khumalo,** Chief Nursing Officer, Ministry of Health, Swaziland
3. **Elikaanan Mwakalukwa,** Assistant Director, Ministry of Health and Social Welfare, Tanzania
4. **Piya Hanvoravongchai,** London School of Hygiene & Tropical Medicine

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10.30 – 12.30
Parallel session 10
Scaling up HRH towards equity

Background / Overview
The shortage of qualified staff in low- and middle-resource countries has reached a crisis point and represents a major barrier to scaling up health care services towards achievement of health related MDGs. Several reports are showing that a shortage of human resources for health is one of the major bottlenecks. It follows, therefore, that rapid strengthening of human resources for health is a vital part of any effort to increase coverage of health services.

To this end, countries and the international community have committed to scale up the heath workforce rapidly and effectively. One of the key component of the current successful experiences is to scale up a mix of health workers that are educated and trained to provide appropriate, accessible and equitable health services towards the attainment of global and national health care goals. What is needed now, is going an extra mile and expand the successful models and implementation plans.

Objective
This session will cover global efforts and countries examples of successful health workforce scale up. Multilateral and development partners will be asked to present initiatives to support scale up of health workers; countries will be asked to focus on implementation plans to increase and transform production of health workers and on the crucial determinants for success.

Chair: Marc Danzon, Former Regional Director, WHO/EURO

Moderator: Lincoln Chen, President, China Medical Board

Speaker: Zulfiqar Bhutta, Aga Khan University, Pakistan

Panelists:
1. **Barbara Aranda-Naranjo,** Director, Global Programs, DHHS/HRSA
2. **Ann Phoya,** Director, SWAP Secretariat, Ministry of Health, Malawi
3. **Francis Omaswa,** Chair, Health Worker Migration Global Policy Advisory Council
4. **Fitzhugh Mullan,** Professor, George Washington University
5. **Keat Phoung,** Director, HRD Department, Ministry of Health, Cambodia
6. **Fely Marilyn E. Lorenzo,** Professor, University of Philippines, Philippines
7. **Ali Babiker Ali Habour,** Dean, Faculty of Medicine, University of Gezira

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10.30 – 12.30
Parallel session 11
Seeking the stamp of good quality? Imperatives of HRH regulation and accreditation

Background / Overview
Regulated and fully accredited workforce at all levels of health systems and professional groups including health managers provide the maximum protection and assurance to the public and service users of the ability and competency of those who provide service to meet their needs While Doctors and Nurses are in groups of professions which are highly regulated in developed countries, this is not necessarily the case in many developing countries. Many other health professional groups are neither regulated nor validated. In many countries much of the training are "informal" and without any proper assessment methods.

International standards for educational certification and accreditation of all health professionals and training institutions in line with medicine and nursing are needed. Such international standards should be supported by independent national bodies who will take responsibility for registration, licensing, monitoring (and revalidation for individual professionals) on regular basis. Such bodies should take responsibility for both formal and informal education (undergraduate) and professional training (postgraduate). With the rapid advancement in health and heath care such regulations are needed now more than ever to protect patients and public and enhance the role of health professionals

Objectives
The overall AIM of the session is to explore the best ways of developing international standards for regulating all health professionals (both formal and informal) including managers and their educational institutions, in line with medicine and nursing

- To identify the best approaches of developing an acceptable international standards
- to all health institutions and professionals based on competencies and skills
- To specify the methods of implementing these standards
- To define the process of monitoring implementations, and
- To engage the public in all these processes which aim to protect both the public themselves and health professionals

Moderator: Salman Rawaf, Professor and Director, WHO Centre Imperial College London

Speakers:
1. **Genevieve Howse,** Adjunct Associate Professor of Public Health Law, La Trobe University
2. **Thamer Kadum Yousif Al-Hilfy,** Consultant in ME and HRH, WHO/MOHE
3. **Samuel Wong,** Professor, Chinese University of Hong Kong
4. **Jan De Maeseneer,** Head department, Family Medicine and Primary Health Care, Ghent University

10.30 – 12.30
Parallel session 12
Financing health worker education and training

Background / Overview
The session will focus on the financing of the education and training of health workers. In many countries, the current levels of health worker production and of investment in health worker continuing education fall very short of meeting the requirements for minimal access to essential health care. Responding to this deficit will require a substantial increase in both the absolute level of investment in education and training and optimal use of available resources.

There are multiple dimensions to responding to the financing gap, including:
- Developing projections of the desired size and composition of the health workforce, which in turn must respond to the health needs of the population;
- Understanding the health training needs of the current health workforce;
- Developing well grounded estimates the cost of education and training;
- Developing projections of the total level of investment in education and training needed to achieve minimal access to essential services;
- Increasing the government contribution to health education and training;
- Encouraging investment by non-governmental organizations, including faith-based organizations, in education and training;
- Creating an enabling environment to stimulate for-profit investment in health education and training;
- Optimizing the contribution of tuition and fees without discouraging enrollment by qualified candidates;
- Increasing and optimizing donor contributions to health education and training;
- Achieving coordination of the multiple streams of financing so that resource allocation addresses issues of equity and access;
- Increasing the efficiency of health school production to address the problem of high rate of failure to graduate;
- Improving health school management so that resources are used efficiently;
- Developing common platforms across health education programs that focus on shared core competencies; and,
- Innovative approaches to expanding access to education and training and lower per capita cost, especially through the use of information and communication technologies.

The session will inform the attendees on these issues and provide insight into current debates. At its core, the session will focus on the need for mobilizing resources from an array of current and potential sources and using available resources optimally.

Objectives
- Draw a portrait of the current state of the financing of health education and training, emphasizing the role played by different actors.
- Identify and discuss policy options for mobilizing resources and using resources to greatest effect that can be addressed to leaders in governments and multilateral organizations.
  Define and debate actions that can be taken by the leaders of educational institutions and programs to make best use of resources.
- Identify steps that can be taken by advocates to encourage greater investment in health education and training.

Moderator: Maurice Middleberg, Vice President for Global Policy, Capacity Plus

Co-Moderator: Rozenn Le Mentec, Technical Advisor, GTZ

Panelists:
1. **Nigel Crisp,** Member, House of Lords
2. **Tarun Seem,** Head, Health Systems Support Unit, Public Health Foundation of Indik
3. **Marie-Odile Waty,** Lead Health Specialist, World Bank Group/International Finance Corporation

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10.30 – 12.30
Parallel session 13
Dedicated Spirit: The Charm and Charisma of HRH

Background / Overview
Ensuring people with access to skilled health workers with good quality of services is a daunting challenge, especially in rural areas and government health facilities where are high burdens of workload.

The set of recommendations by the World Health Organization (WHO) on "increase access to health workers in remote and rural areas through improved retention: global policy recommendations" include a total of 16 interventions under the four main recommendations namely education (A1-5), regulation (B1-4), financial incentives (C1) and personal and professional support (D1-6) recommendations.1[1] The combination or 'bundles' of these interventions is suggested as no one single-bullet solution could solve this complex problem.2[2]

Many interventions by WHO are of special concern to self-esteem of new graduation health workers enrolling in government health facilities for both rural and urban areas and then they could maintain their good spirit to continue working in government sector when they become high skilled staff. The moral responsibility with high ethical concern and other intrinsic motivations have seen as important contributing factors.

This session, therefore, highlights contributing factors from the health workers' preferences which could improve short-term recruitment and long-term retention in rural area from multi-disciplinary, especially from developing countries.

Objectives
This session will provide vivid examples and testimonials of committed health workers who have long experiences in serving health services to the people in developing countries.

[1] WHO. Increase access to health workers in remote and rural areas through improved retention: global policy recommendations. Geneva; WHO 2010.
[2] Dayrit M, Dolea C and Braichet J. One piece of the puzzle to solve the human resources for health crisis. WHO Bulletin 2010; 88: 322 – doi:10.2471/BLT.10.078485.

The issues to be discussed is on intrinsic motivation (the desire to do something for its own sake) to attract the HRH to enroll and to maintain committed HRH in providing health services to the people.

Moderator: Bridget Lloyd, Global Coordinator, People's Health Movement

Speakers:
1. **Pakdee Suebnukarn,** Doctor, Dansai Hospital, Leoi Provinc
2. **Saidou Ekoye,** Doctor at Tahoua Regional Health Office
3. **Leochrist Shali Mwanyumba,** District Public Health Nurse, Tanela District Hospital
4. **P.D. Lalitha Padmini,** Public Health Midwife, Medagama attached to the Medical Officer of Health Office Dimbulagala in the Polonnaruwa District
5. **Karamoko Nimaga,** Doctor at Markakoungo 80 Km from Bamako
6. **Ebele Omeke Micheal,** District Health Officer, Moroto District
7. **Ho Thi Thanh Hoa,** Medical Doctor of A Dot Commune Health Centre, A Luoi District, Thua Thien Hue Province, Vietnam
8. **Daw Nan Than Than Oo,** Midwife, Lwe'Satone Sub-center, Mai Yan Rural Health Center, Tachileik Township, Shan (East), Myanmar

Panelists:
1. **Barbara McPake,** Director, Institute for International Health and Development
2. **Carmen Dolea,** Department of Human Resources for Health, WHO

10.30 – 12.30
Parallel session 14
The UN Secretary General Global Strategy for Women's and Children's health: what will be done about the workforce?

Background / Overview
In the course of 2010 the global development agenda has been dominated by the discourse on MDG 4 and 5 and on health systems. Women's and children's health were the main topic of the Women Deliver and Countdown conferences, the African Union summit of Heads of States and a key focus of the G8 meeting and UN High Level Summit on the MDGs, where the UN Secretary General Global Strategy for Women's and Children's health was launched. The grave impact of the health workforce crisis on the health of women and children was a strong undercurrent in all of these discussions.

Objectives
- Assess the positioning of the health crisis and health workforce in the different maternal, newborn and child health initiatives and review relevant commitments
- Convey the significance of the Global Strategy for Women's and Children's Health in relation to health workforce issues, highlighting the opportunities it opens, and the challenges that need to be overcome to make its ambitious vision a reality
- Catalyse commitment from stakeholders at both global and country level to support the implementation of the health workforce dimension of the Global Strategy.

Chair: Gustavo Gonzalez Canali, Health Special Adviser, Ministry of Foreign Affairs, France

Moderator: Sarah Boseley, The Guardian

Speaker: Helga Fogstad, Coordinator, PMNCH, Norad, Government of Norway

Panelists:

1. **Masato Mugitani,** Assistant Minister for Global Health, Ministry of Health Labor and Welfare
2. **Angelique K. Rwiyereka,** DG Clinical Services, Ministry of Health, Rwanda
3. **A.F.M. Ruhal Haque,** Minister of Health and Family Welfare Government of the People's Republic of Bangladesh
4. **Rebecca Affolder,** Advisor, Global Health Policy and Coordination-Strategic Planning Unit, United Nation
5. **Carol Jenkins,** Chair of Board of Directors, AMREF

12.30 – 14.00
Lunch

14.00 – 15.00
Plenary session 4
Making HRH Innovation Work for Strengthening Health Systems

Key Message: To make a difference in health systems strengthening, HRH innovation should be scaled up innovatively.

Background / Overview

"There is no time for despair. We need hope." These are the words of a Palestinian health professional. For the future of HRH, in the same way, there is no time for despair; we need hope. To cultivate hope, established HRH evidence is not enough; we also need innovations.

Since 2004, when the HRH crisis gained global attention, innovative work has been done in the field of education and retention of health workers. Innovative scaling up of community health workers has been also observed in several countries. Now, it is not too much to say that innovations are mushrooming. Some of them, however, ended up as short-lived innovations, which could never be sustained or scaled up. Some of them, on the other hand, have remained as innovations with real potential and room for further growth, from which countries can draw lessons in their efforts to adapt these innovations to suit their own national health systems contexts.

In particular, we need to draw lessons on how these surviving innovations can improve health system performance, at least on healthcare delivery, one of the six building blocks of health systems. We also need to know why some innovations soon died out.

Objectives

- To synthesize the state-of-the-art knowledge on HRH innovations for scaling up HRH education and training, and community health workers. The synthesis would cover both success and failure cases, focusing on low- and middle-income countries.
- To draw country lessons and review experiences regarding various innovations in HRH.
- To share these lessons in order to advocate piloting and adaptation of these innovations in low- and middle-income countries.

Chair: Mark Stirling, UNAIDS Country Coordinator, China

Moderator: Francisco Campos, Professor, Federal University of Minas Genais, Brazil

Speakers:
1. **Fauzia Tariq,** Technical Advisor for Trainings, National Programme for Family Planning and Primary Health Care
2. **Oluwafunmilola Dare,** Chief Executive Officer, Centre for Health Sciences Training, Research and Development [CHESTRAD]
3. **Leana R. Uys,** Deputy Vice-Chancellor, College of Health Sciences, University of Kwazulu-Natal

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15.00 – 15.30
Coffee Break

15.30 – 17.30
Parallel session 15
Building capacity to generate evidence in HRH action oriented research

Background / Overview
The second component of the AGA (Agenda for Global Action) is "ensuring capacity for an informed response based on evidence and joint learning". In order to ensure the development and attainment of such capacity, we need reliable indicators, accurate health information (Parallel Session 4) and also the capacity to develop and implement in an innovative manner HRH policies in the context of health systems strengthening (Parallel Session 5).

The capacity for an informed response must be based on experience and joint learning gained through the rigorous evaluation of implementation of programmes and policies. It should also be based on the generation of relevant evidence through action-oriented research in HRH and using such evidence to guide the development of policies and systems innovations. The generation of such evidence requires building the appropriate capacity to address knowledge gaps in the field - this will be the focus of this Session. It will also highlight broader links of such capacity building efforts with the strengthening of the health system as a whole.

Objectives
In countries undergoing HRH crisis, many decisions about health workers have been made based on limited knowledge and information and incomplete understanding of the nature, vagaries and dynamics of the health workforce. This session will discuss strategies to build capacity within these crisis countries to generate the necessary evidence to fill the knowledge gaps in the context of 'action-oriented' research. It will naturally link with the next step to strengthen the links between research and policy, the focus of Parallel session 5.

Chair: Pisake Lumbiganon, Dean, Faculty of Medicine, Khon Kaen University

Moderator: A. Metin Gulmezoglu, Department of Reproductive Health Research, World Health Organization

Speakers:

1. **Mickey Chopra,** Chief of Health, UNICEF
2. **Frances Baum,** Professor / Director, South Australian Community Health Research Unit (SACHRU) & Southgate Institute for Health, Society & Equity, Flinders University
3. **Harriet Nabudere,** Project Coordinator, SURE Project, College of Health Sciences, Makerere University
4. **Sàbado Girardi,** Researcher, Universidade Federal de Minas Gerais UFMG

15.30 – 17.30
Parallel session 16
Innovative education and training for HRH

Key Message: "Innovations in education and training of health workers to meet population health needs and strengthen health systems"

Background / Overview

Growing international efforts to achieve the MDGs and universal health coverage, reduce the global burden of infectious diseases and mount an effective response to the rise of chronic diseases have also highlighted the critical role and prevailing inadequacies of human resources for health. These health workforce inadequacies are manifested not only in the size and distribution of the workforce but also in the composition and competencies. The challenge facing many countries is how to educate and train their health workforce to address the prioritized needs of the health system within limited budgets and institutions.

Strengthening health systems calls for new thinking about the kind of education health professionals (doctors, nurses, dentists, paramedics, mid-level workers/non-physician clinicians and community level workers) need so they can better serve their communities to achieve health for all. The education of health professionals should enable them to serve the health needs of the communities where they work. In many countries the expansion of education and training to increase community and mid-level health workers, alongside highly-skilled staff, has become a priority. However, successful implementation of a task shifting approach requires inter-professional collaboration between cadres. Finally, the use of innovative health technologies requires that health workers need to be properly trained for the technologies to have maximum effect, while also appropriately using technologies for expanding and strengthening educational programs.

Innovations in education and training will need to take into account local health needs, the institutional functions (teaching, research and service), as well as the content (curricula), and process (educational programmes, approaches and methods) of educational programs. Policy and institutional innovations are needed to develop a new generation of health professionals who are better equipped to address present and future health challenges and improve population health.

Objectives

- The need for innovation in human resource education and training to achieve the MDGs and universal health care.
- Innovations in human resource education and training in a changing global health and health system landscape in the era of advance information technology.
- Need for inter-professional collaboration for training of mid-level health workers and task shifting

- Significant country level innovations in human resource education and training for achieving the MDGs and universal health care.
- Key policy and institutional reforms in human resource education and training.

Moderator: K. Srinath Reddy, President, Public Health Foundation of India (PHFI)

Speaker: Manuel M. Dayrit, Director, World Health Organization

Panelists:
1. **Vinícius Oliveira,** Coordinator, Open University of the National Health System
2. **Berhanu Feyisa Tilla,** Director, Federal Ministry of Health, Ethiopia
3. **Hideomi Watanabe,** Dean, Gunma University School of Health Sciences
4. **Babara McPake,** Director, Institute for International Health and Development

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15.30 – 17.30
Parallel session 17
HRH situation and trend in developed countries and their potential implications to developing countries

KEY MESSAGE: WE ARE ALL CONNECTED: NATIONAL HRH POLICY DECISIONS HAVE REGIONAL / GLOBAL IMPLICATIONS

Background / Overview
This session will explore the response of developed countries, especially OECD countries, to HRH shortages and other current policy challenges such as funding constraints and the productivity agenda .The Kampala Declaration and Agenda for Global Action recommends that developed countries: commit to supporting and enhancing the education and training of health workers both at home and in source countries; give high priority and adequate funding to train and recruit sufficient health personnel from within their own country; and realize the untapped potential of the health worker diasporas for improving health services in source countries.

Objectives
- To provide an overview of key current trends and health workforce policy responses in developed countries
- To identify the policy responses of developed countries to the global economic crisis/ fiscal deficit and assess national and global health labour market implications
- To assess the implications of the issue of health workforce "sustainability"/ "sufficiency" for developed countries and the related impact on developing countries

Moderator: Mark Pearson, Head of Health Division, OECD

Speakers:
1. **Mark Pearson,** Head of Health Division, OECD
2. **Bjorn-Inge Larsen,** Director-General and Chief Medical Officer of Norway, The Norwegian Directorate of Health
3. **Linda Aiken,** Professor, University of Pennsylvania

Panelists:
1. **Chris Rakoum,** Chief Nursing Officer, Ministry of Medical Services, Kenya
2. **Jean Marc Braichet,** Coordinator, Human Resources for Health Department, World Health Organization
3. **Elizabeth Adams,** International Council of Nurses
4. **Beth Slatyer,** Health Adviser, AusAID

15.30 – 17.30
Parallel session 18
Trade in health services and impact on HRH

Background/ Overview
The increasing trend of trade in health services imposes new opportunities and challenges for health and health systems around the world. These are most directly felt in the movement of health workers as one element of services trade. However, other aspects of services trade will also influence the migration of health workers. For instance, increases in e-health services, such as remote imagining, impacts on the balance of radiographers in exporting and importing countries. Similarly, the movement of patients to consumer care overseas impacts on the (profile of the) health workforce in the exporting and importing countries.

Consideration of trade and HRH occurs in a number of venues. Perhaps the highest in profile from the trade side is that under the WTO GATS, which covers four modes of trade in health services:

Mode 1: Cross border supply are services remotely provided from one country to another country through electronic means or so-called e-health.
Mode 2: Consumption abroad refers to patients of one country receiving health care abroad.
Mode 3: Foreign direct investment refers to investment of one country in another country.
Mode 4: Movement of national person refers to temporary movement of health workforce from one country to provide health services in another country.

A recent important development from health side is the recent adoption by the 63th WHA of the WHO Code of Practice..., which clearly sets out a specific perspective on the balance between trade and health with respect to HRH from a health perspective. However, there are also interactions within and between regional levels and also bi-lateral initiatives. Consideration of the issue of trade and HRH therefore needs to consider factors concerning the individual migrants, the health systems to which they move from and to, the economic and trading relationships of countries and other factors.

Objectives
This session will explore the critical interaction between trade and HRH, and especially aspects related to the new trade environment of regional and global agreements in light of the WHO Code. This will include an overview of critical issues, and then perspectives from international, regional and country level trade and health representatives. For instance, what are the risks and benefits of bi-lateral, regional and multi-lateral trade in health workers? Are there synergies between health worker movement and other forms of trade? What policy options are used in countries to tackle movement of health workers? Etc….

Chair: Cristian Baeza, Director, Health, Nutrition and Population, Human Development Network, The World Bank

Moderator: Nick Drager, Professor, LSHTM/McGill University

Panelists:
1. Nick Drager, Professor, LSHTM/McGill University
2. Nigel Crisp, Member, House of Lords, United Kingdom
3. John Hancock, Counsellor, World Trade Organization
4. Rangarirai Machemedze, SEATINI/EQUINET

15.30 – 17.30
Parallel session 19
Self reliance to health and well being through local resources and knowledge

Background / Overview[1]
The People's Charter for Health is a statement of shared vision, goals, principles and action and is the most widely endorsed consensus document on health since the Alma Ata Declaration. The People's Charter calls for the provision of universal and comprehensive primary health care and "calls on people of the world to support, recognise and promote traditional and holistic healing systems and practitioners and their integration into Primary Health Care"

Traditional medicine (TM) is widely used in Africa, Asia and Latin America. According to WHO, approximately 80% of people in Africa use TM. It is estimated that there are approximately 400 million Traditional Health Practitioners (THPs) around the world, often providing access to health care in remote and rural areas. Apart from frequently being available in areas with poor access to public health facilities (e.g. rural areas), traditional healers also treat illnesses in a more holistic and comprehensive way, recognizing the relationship between the environment, social circumstances, mental health and illness and disease.

Unlike institutionalised medicine such as western biomedicine, traditional health practice is primarily healer or physician centred. Through non institutionalised training and oral transmission, healers develop skills and utilise ways of knowing and validation which have evolved from traditions. Governments need to recognise traditional health systems in their entirety and create space for oral transmission, to ensure that this knowledge is enhanced rather than lost. The practices of THPs need to be fully legalised at an appropriate level of the health system.

[1] This session proposal draws on a policy brief developed at a Healers Exchange, held in Bangalore India in late 2009. The exchange hosted 200 traditional healers from 18 countries. The policy brief is available on http://www.compasnet.org/afbeeldingen/IHE-policybrief%2023%20december.pdf

Objectives

- To explore models to prevent the loss of traditional knowledge and underlying principles of practice of Traditional Health Practitioners
- To explore models for regulation and accreditation of THP's, including self regulation
- To explore different training models for THP's and the regulation thereof.
- To explore how THP's can be better integrated and utilized within the health system, with particular focus on PHC and in remote and rural settings
- To propose processes required to ensure effective and sustainable utilization of THP's

Moderator: Vichai Chokevivat, Director, Institute for the Development of Human Research Protection (IHRP)

Speakers:

1. **Qi Zhang, Coordinator,** World Health Organization
2. **Govindaswamy Hariramamurthi,** Assistant Director, Centre for Local Health Traditions, Institute of Ayurveda and Integrative Medicine (IAIM)
3. **Steve Xue,** The University of Hong Kong
4. **Yahaya Sekagya,** Director, PROMETRA Uganda

15.30 – 17.30
Parallel session 20
Skills mix to achieve universal access to essential health care

Background / Overview

Recognizing that many countries are concerned about the acute shortage of human resources for health (HRH) as a key constraint in the struggle to achieve universal access[2] to essential health services, there is a growing interest in the role played by Community Health Workers (CHWs) and Mid-level health Providers (MLP) in delivering care. Cognizant of this, the Global Health Workforce Alliance (the Alliance), UNICEF, UNFPA, WHO and other agencies have commissioned studies to gather the current evidence on wide-scale use of CHWs, MLPs and skills mix needed to deliver services.

A number of countries have been implementing CHW and MLP programmes on a wide scale and others are interested in scaling up the production and role of these front-line health care providers. The debate on the role CHWs, MLPs and other cadres can and do play in delivering essential care will be served by gathering available evidence and convening a round table discussion/debate on the question of skills mix in scaling up delivery of essential health services and care in settings where it is neither feasible nor practical to have a high level health professional such as a nurse, midwife or doctor.

Objectives

The purpose of this session will be for a cross-section of health workers, experts and policy makers to debate the issue of using CHWs, MLPs and other cadres to ensure equitable access to health workers to achieve universal access to essential health services, including strategies for scaling up production and integrating these cadres into national HRH management. Experiences and viewpoints from various stakeholders will be shared. Discussions will include issues/experiences on typology, training, certification, regulation, performance management, monitoring and evaluation of these cadres.

[2]"Access" is understood as a broad concept that measures three dimensions of key health sector interventions: availability, coverage, and outcome and impact (WHO, UNAIDS, UNICEF, 2010). Universal access is sometimes defined as coverage of at least 80% of the population in need.

Chair: Sheila Dinotshe Tlou, Director, UNAIDS Regional Support Team for East and Southern Africa
Moderator: Bjarne Garden, Assistant Director Norwegian Agency for Development Cooperation, Global Health and AIDS Department

Speaker: Zulfiqar Bhutta, Professor and Chair, Department of Maternal, Newborn and Child Health, Aga Khan University, Pakistan

Panelists:
1. **Otmar Kloiber,** Secretary-General, World Medical Association
2. **Frances Day-Stirk,** Vice-President, International Confederation of Midwives
3. **David C. Benton,** Chief Executive Officer, International Council of Nurses
4. **Maxensia Nakibuuka,** Community Health Worker, Lungujja Community Health Caring Organization, Uganda
5. **Sairam Saadat,** Program Coordinator, Community Midwifery School, Badakhshan, Afghanistan
6. **Salman Rawaf,** Professor of Public Health, Imperial College London

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15.30 – 17.30
Parallel session 5
Economic fluctuations, universal health coverage and the health workforce

Background / Overview
Economic downturns and upturns can affect the health sector and health workforce in many ways depending on how governments react with their economic and social protection policies. During economic downturns, household expenditure on health typically falls because household incomes fall. People sometimes people switch from using the private to the government sector as a result. Government revenues also fall putting pressure on domestic government expenditures and external assistance contributions. How governments react to economic downturns is a matter of choice - most frequently they reduce overall spending including on health, but sometimes they protect health and social welfare. This was observed during the most recent economic crisis when some countries actively sought to protect social sector spending, or increased spending as a way of stimulating economic growth. Others cut spending, they place an added burden on public-sector health workers who must deal with high, and sometimes an increasing demand, while budgets are being squeezed. An important problem at the moment is in countries that are reliant on external funding for health. They are facing an uncertain wait to see how the bilateral donors react to the large increases in public debt in their own settings, and to see if the last decade of increasing priority for health in aid budgets will be replaced by other priorities such as climate control, or economic growth.

Objectives
- Understand how much is currently spent on health and on the health workforce in particular, and how this is influenced by economic fluctuations and government policies
- Discuss the latest information on aid flows, to assess if the need to reduce government debt in the OECD countries or changing donor priorities is likely to have an adverse consequences for aid flows for health and for HRH
- Evaluate possible ways low and middle income countries can continue to move closer to universal coverage despite economic fluctuations and changing donor interests

Chair: Juan Pablo Uribe, Health Sector Manager EAP, World Bank

Moderator: David Evans, Director, World Health Organization

Panelists:
1. **Hannes Danilov,** Chairman of Management Board, Estonian Health Insurance Fund
2. **Ann Phoya, Director,** SWAP Secretariat, Ministry of Health, Malawi
3. **Kampeta Sayinzoga,** Permanent Secretary and Secretary to the Treasury, Ministry of Finance and Economic Planning, Rwanda
4. **Supon Limwattananon,** Khon Kaen University, Thailand

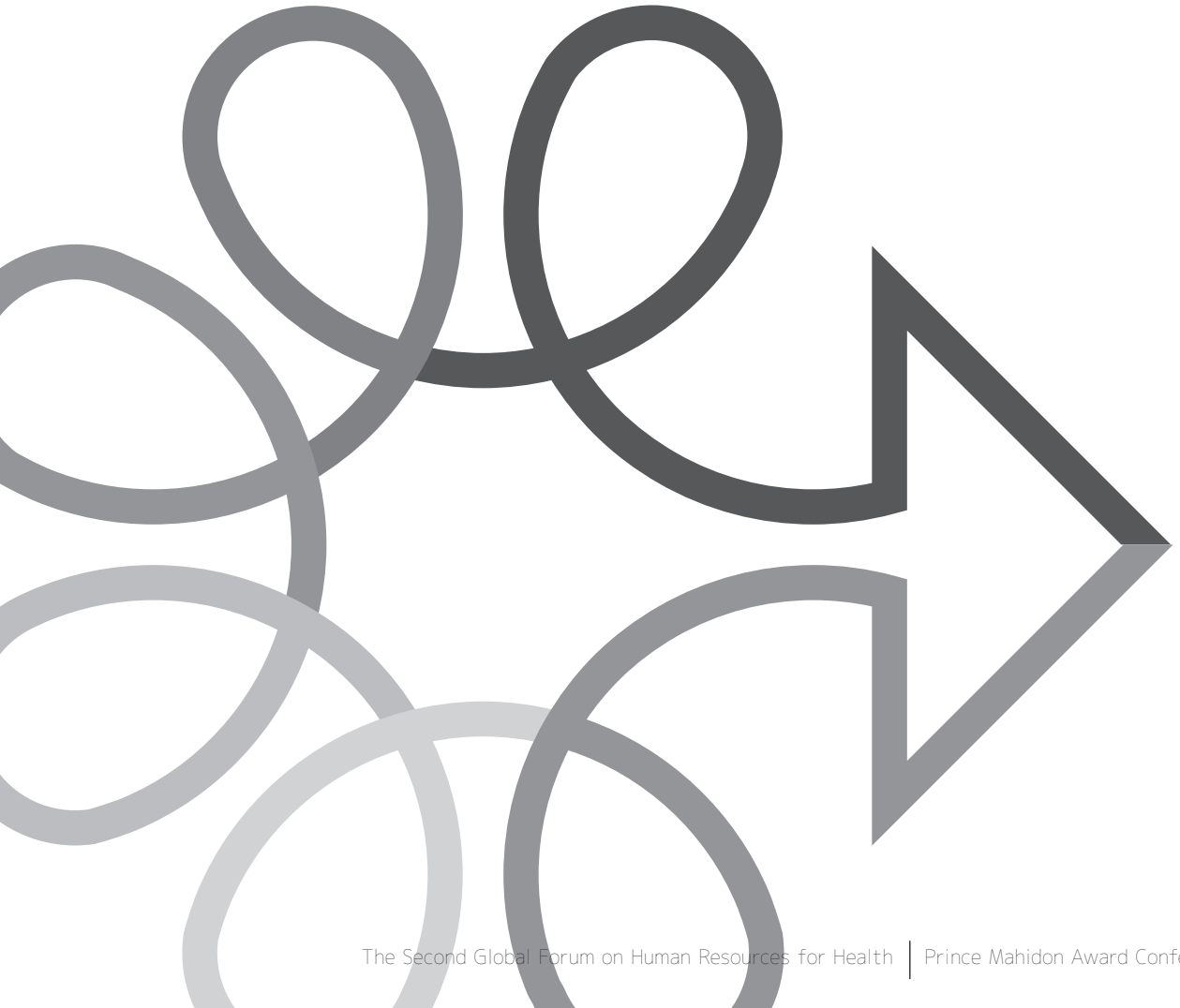
Saturday 29 January 2011

09.00 – 10.30
Synthesis: summary conclusion & next steps

10.30 – 11.00
Coffee Break

11.00 – 12.30
HRH Awards and Closing Session

KEYNOTE SESSION



ROBERT E. BLACK

PROFESSOR AND CHAIRMAN
JOHNS HOPKINS UNIVERSITY
UNITED STATES

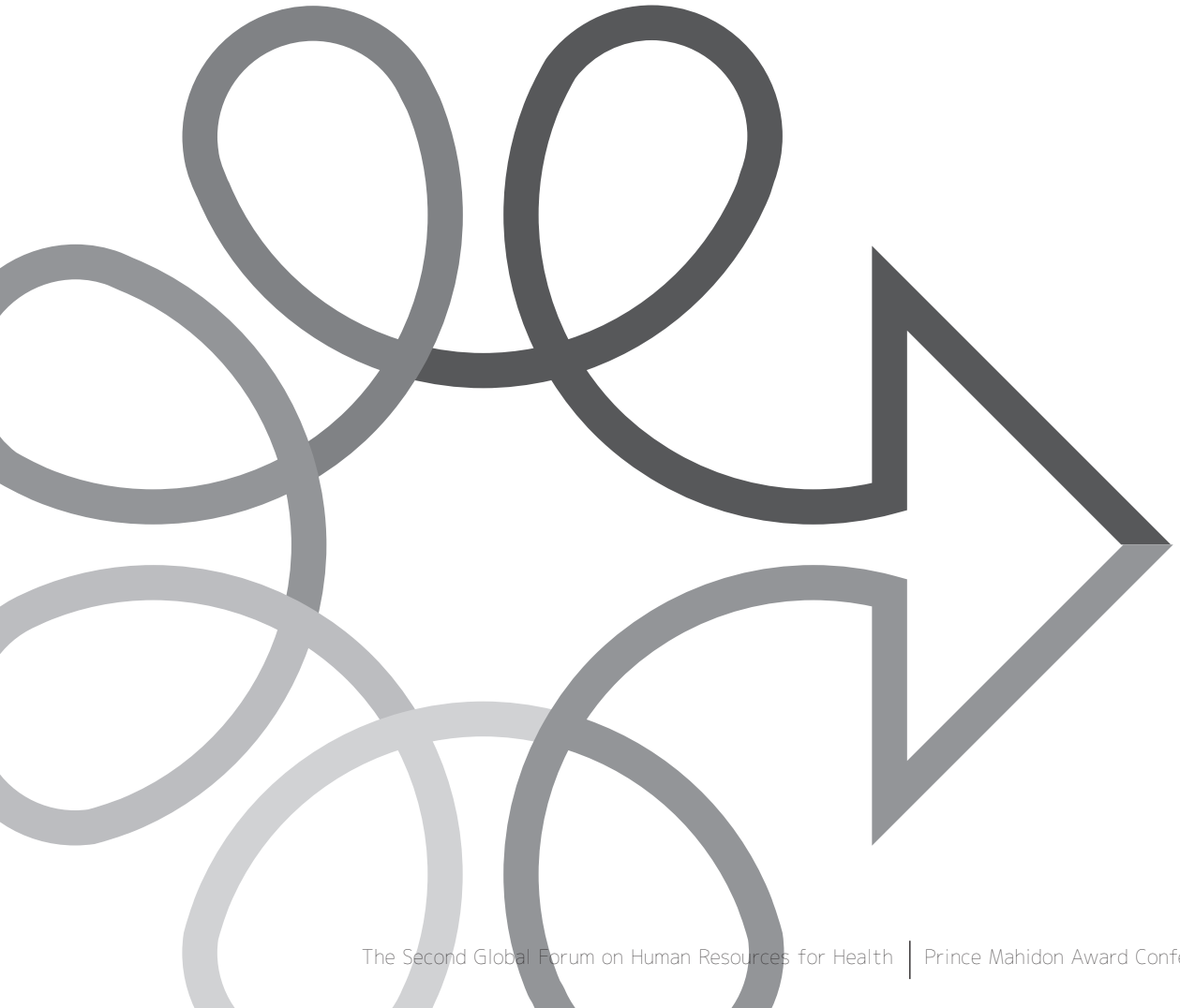
Robert E. Black, M.D., M.P.H. is the Edgar Berman Professor and Chair of the Department of International Health and Director of the Institute for International Programs of the Johns Hopkins Bloomberg School of Public Health in Baltimore, Maryland. Dr. Black is trained in medicine, infectious diseases and epidemiology. He has served as a medical epidemiologist at the Centers for Disease Control and worked at institutions in Bangladesh and Peru on research related to childhood infectious diseases and nutritional problems.

Dr. Black's current research includes field trials of vaccines, micronutrients and other nutritional interventions, effectiveness studies of health programs, such as the Integrated Management of Childhood Illness approach, and evaluation of preventive and curative health service programs in low- and middle-income countries. His other interests are related to the use of evidence in policy and programs, including estimates of burden of disease, the development of research capacity and the strengthening of public health training.

As a member of the US Institute of Medicine and advisory bodies of the World Health Organization, the International Vaccine Institute, and other international organizations, he assists with the development of policies intended to improve child health. He currently chairs the Child Health Epidemiology Reference Group and the Child Health and Nutrition Research Initiative. He currently has projects in Bangladesh, Benin, Ghana, India, Mali, Pakistan, Peru, Senegal, Zanzibar and Zimbabwe. He has more than 450 scientific journal publications and is co-editor of the textbook "International Public Health."

PLENARY SESSION 1 :

From Kampala to Bangkok: Marking progress, forging solutions



REVIEWING PROGRESS, RENEWING COMMITMENTS
FIRST progress report on the
Kampala Declaration and Agenda for Global Action
in priority countries
By the Global Health Workforce Alliance

Executive summary

The first ever Global Forum on Human Resources for Health was held in Kampala, Uganda in March 2008. The Kampala Declaration and Agenda for Global Action that emerged from this meeting committed participants to an ambitious agenda to invest in and improve human resources for health (HRH), particularly in countries facing critical health workforce challenges.

The Alliance was given the mandate to monitor progress against the AGA strategies. In the run-up to the second Global Forum on Human Resources for Health to be held in Bangkok, Thailand in January 2011, the Alliance conducted a survey among the 57 priority countries to assess the extent to which they are making progress. A questionnaire was drawn up and sent to focal persons in the ministries of health in each priority country in July 2010. Respondents were asked to fill in the forms online or by e-mail. Nine proxy indicators were developed to track each of the strategies of the Agenda for Global Action.

In parallel, an open call was launched for country case stories that illustrate best practices in tackling health workforce challenges, to add a qualitative dimension to the analysis.

This report is based on analysis of the responses to the questionnaire, combined with excerpts from submitted case stories and reference to secondary literature. The case stories were filtered using five criteria, i.e. those that are relevant to the AGA themes, show success in tackling challenges, are recent, show evidence of sustainability and have a clear narrative.

A one-page country brief has been prepared for each of the priority countries to give an update on their HRH status and progress. The briefs contain background demographic, health, health system and HRH statistics, as well as scores for responses to the tracking survey.

Limitations of this analysis include the absence of baseline data with which to compare these responses (to understand the trends), the self-reported nature of the responses (which are therefore prone to a certain level of subjectivity) and the focus on process issues and binary (yes/no) questions. The latter, for example, precludes an analysis of the quality and comprehensive nature of plans, the level of functionality of coordination mechanisms and other governance structures, or the extent of additional investments.

The findings of the analysis, summarized below, only reflect data from countries that responded to the questionnaire (51 of 57 priority countries, 89%).

- Most countries (44, 86%) have an HRH plan, although there is slower progress in developing a supporting cost estimate and budget (25, 49%). Implementation is also lagging behind planning, which may be because many plans have only recently been drawn up.
- Thirty-three countries (65%) have a national coordinating committee for HRH, most with some degree of representation beyond the ministry of health.
- Fewer than half the respondents (22, 43%) reported having a mechanism to inform policy-making through data sharing.
- Countries reported having statistics for higher level cadres, but less so for community health workers (CHWs). Around half the countries reported having updated their HRH statistics once or twice in the last two years. Data are mostly available on employment status and distribution, but not on migration patterns.
- Most countries (47, 92%) reported increased enrolment of higher level cadres in training since 2008. Around 60% increased training opportunities for CHWs, scholarships, and/or started new training schools for physicians or nurses. A high proportion (around 70%) has modified their training curricula.
- Thirty-two countries (63%) reported having implemented strategies such as increased salaries, allowances or benefits to attract and retain workers in underserved areas.
- Most countries also reported improvements to career development for physicians, nurses and midwives (the range for different cadres was 53% to 69%), although for CHWs the proportion was less than a third.
- Increased recruitment (a reflection of increased allocation of domestic resources) was reported by around 80% of countries for physicians, nurses and midwives, although the proportion was lower for CHWs (just over half).
- Thirty-nine countries (76%) reported receiving support from donors to implement some or all of their HRH plans.

The publication of this first progress report on the Kampala Declaration and Agenda for Global Action represents a new milestone in HRH, providing an essential foundation for future analysis and a snapshot of the impact of HRH improvements that stakeholders can use to review progress collectively, to hold one another accountable and to renew their commitments to sustainable HRH solutions.

The report shows that the Kampala Declaration and Agenda for Global Action remain valid and relevant to the needs of countries in their

efforts to improve human resources for health. The six recommended strategies of the Agenda for Global Action (AGA) are providing pertinent and useful guidance on actions needed to improve the health workforce situation. Several countries reporting good progress across all or most indicators are also on track to improve overall health outcomes in line with the targets of the United Nations Millennium Development Goals.

While progress is not even across all countries, the reported data show that countries are making improvements in terms of leadership (AGA 1), especially in relation to the development of national HRH plans. However, the results show slower progress in terms of costing, funding and therefore implementation of the plans. Countries and partners should enhance efforts in this respect as well as ensure broader engagement and integration with a range of country stakeholders, within and outside the public sector.

Further efforts are also required in the area of evidence (AGA 2). Countries, development partners and academia need to collaborate to increase capacity to track data on health workforce education, distribution, employment status and rural to urban, as well as international migration patterns. These data need to be accessible to, and used by HRH stakeholders to better inform managerial and policy decisions.

Many countries have reported increases in education (AGA 3) and training for health personnel, especially for the traditional cadres of doctors, nurses and midwives. Greater attention should, however, be given to the quality of education and improvements for non-traditional cadres such as community-based and mid-level health workers, who can contribute to a more efficient and sustainable skills mix in the health workforce.

In the critical area of retention (AGA 4), countries need to make more progress in deploying and retaining health workers in underserved areas. This could be achieved by considering the policy recommendations in the WHO guidelines for rural retention of health personnel and lessons learnt from best practices like the Emergency Human Resources Programme in Malawi, employing both financial and non-financial incentives.

With regard to international migration (AGA 5), both source and destination countries should work collaboratively to develop laws, systems and administrative procedures to effectively implement and measure the impact of the WHO Code of Practice on International Recruitment of Health Personnel.

In terms of investment (AGA 6), the funding gap to meet HRH needs over the next five years in the majority of priority countries is estimated at some US$40 billion. Countries should increase domestic allocations, with the support of International Financial Institutions to relax macroeconomic restrictions when these hamper health workforce improvements. In many low-income countries, however, domestic resources will not be enough, and significant sustainable external funding is required to address country-specific health workforce needs. In this context, important new opportunities have been opened by the commitments made in support of the United Nations Secretary-General Global Strategy for Women's and Children's Health and the establishment of a joint funding platform for health system strengthening.

In future, in order for reports such as this to provide a stronger evidence base upon which to adopt interventions, it will be important to analyse factors that underpin the quality and successful implementation of HRH plans, the determinants of effective functioning of national HRH coordination mechanisms, the evolution of training curricula and competency frameworks that enable an optimal skills mix, and trends in health expenditure for HRH. The focus should also shift from input and process indicators (e.g. the existence of policies and plans) to output indicators (e.g. the availability and distribution of health workers). It will also be important for individual countries to set up their own monitoring and tracking mechanisms to assess progress at local and national levels.

In summary, this report shows that while actions on the ground in a number of countries are starting to make a difference, considerable work remains to be done to implement fully the Kampala Declaration and Agenda for Global Action in the majority of priority countries. HRH stakeholders share clear and collective responsibility for identifying and honouring the individual actions that will turn many of the outstanding commitments into practical reality.

Number of countries that have developed and implemented:
(1) costed and evidence-based HRH plans;
(2) an intersectoral coordination mechanism for involving relevant stakeholders in HRH development;
(3) a national mechanism with processes and/or tools for HRH data users and producers to inform policy-making and management of the health workforce;
(4) a well functioning HRH information system;
(5) programmes to increase the production of doctors, nurses/midwives and community health workers;
(6) strategies/approaches to attract and retain the health workforce in underserved areas;
(7) policies to favour in-country retention of personnel;
(8) increased budgetary allocations for community health workers as a proportion of the health sector budget;
(9) additional investment from multilateral and bilateral partners for HRH plans.

SHAHNAZ WAZIR ALI

SPECIAL ASSISTANT TO PRIME MINISTER
HIGHER EDUCATION COMMISSION
PAKISTAN

Ms. Shahnaz Wazir Ali's career spans 37 years of experience in policy and practice in the education sector in government and the private sector. Currently she is Special Assistant to the Prime Minister on Social Sector. Prior to this assignment she was the Executive Director of the Pakistan Centre for Philanthropy (PCP), in Islamabad, Pakistan. The Centre was established in late 2001 to support and promote philanthropy in Pakistan, with the specific objective of enhancing social investment for development. She has been elected to UNESCO Executive Board member for a 4 years term (2007 to 2011). She has also been elected to the National Assembly of Pakistan in 2008 Elections as a Member National Assembly of Pakistan.

From 1997-2001, she served as the Senior Education Specialist at the World Bank in Islamabad. Her principal assignment was to provide policy, program and technical advice and assistance to the Federal and the 4 Provincial governments to facilitate the implementation of the countrywide Education Sector Social Action Program (SAP).

Serving in key decision making positions in government, she actively contributed to the social agenda of the government and was a senior member of Pakistan's delegations to major World Summits.

In particular, her significant contributions were in the health and education sector, which included the concept, design, planning and implementation of a major primary health care initiative more commonly known as the Lady Health Workers Program which delivered preventive and promotive health services to women and children through the village based LHWs, which is now is the largest PH program of the world with 100,000 LHWs serving rural communities and urban slums. She also galvanized the National Immunization Days for Polio into an intensive country wide campaign, started the Iodized Salt Program and Community Oriented Medical Education and instituted these initiatives into mainstream government health services.

Her career in and commitment to education can be traced back to 1965, when she commenced teaching primary school children of deprived communities in Karachi, and subsequently spent about 20 years in teaching and administrative positions in the private sector, which included being Principal at the Lahore American School. She is also a Trustee of the Education Trust established by her family which runs Nasra Schools for children of low-income families in Karachi and provides K 10 education to more than 12,000 students.

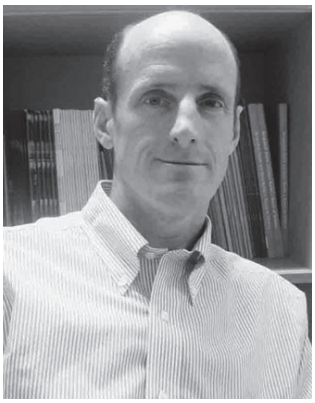
CARISSA ETIENNE

ASSISTANT DIRECTOR-GENERAL
HEALTH SYSTEM AND SERVICES
WORLD HEALTH ORGANIZATION
SWITZERLAND

Carissa F. Etienne assumed the role of Assistant Director-General for Health Systems and Services in February 2008. Prior to that, she was the Assistant Director of the Pan American Health Organization. As Assistant Director in PAHO from July 2003, she directed five technical areas - health systems and services; technology and health services delivery; health surveillance and disease management; family and community health; and sustainable development and environmental health.

A national of Dominica, Dr Etienne began her career as a medical officer at the Princess Margaret Hospital in her country, where she eventually became the Chief Medical Officer. Other high-level posts she has held include the Coordinator of Dominica's National AIDS Programme, Disaster Coordinator for the Ministry of Health of Dominica, Chairperson for the National Advisory Council for HIV/AIDS and the Director of Primary Health Care for Dominica.

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



TIMOTHY GRANT EVANS

DEAN
JAMES P GRANT SCHOOL OF PUBLIC HEALTH, BRAC UNIVERSITY
BANGLADESH

Tim Evans is a dual national of Canada and the United States. Following under-graduate training in social sciences at University of Ottawa, he obtained a D.Phil in Agricultural Economics at University of Oxford on a Rhodes Scholarship. He subsequently trained in medicine at McMaster University in Hamilton and completed a research-residency in Internal Medicine at the Brigham and Women's Hospital in Boston with a joint appointment as a MacArthur post-doctoral fellow at the Harvard Center for Population and Development Studies. From 1995 through to 1997, he was an Assistant Professor, International Health Economics, at Harvard School of Public Health as well as an Attending Physician, General Internal Medicine, at the Brigham and Women's Hospital. In 1997, he was appointed the Director, Health Equity at the Rockefeller Foundation in New York. There he led the development of a programs related to new drugs and vaccines for neglected diseases, tobacco control, access to HIV treatment, disease surveillance, enhancing information systems capacity for vital statistics, disease surveillance and the monitoring of inequities in health, and a global learning initiative on human resources for health. During his tenure, he was a co-founding Board member of the Global Alliance on Vaccines and Immunization (GAVI) and the Global Forum for Health Research. In 2003, he joined the World Health Organization as an Assistant Director General with responsibility for Evidence, Information, Research and Policy. During his tenure, he pioneered institution-wide strategies for health systems, knowledge management and research and oversaw the annual production of the World Health Report. He led the global Commission on Social Determinants of Health and was a co-founder of various partnerships for strengthening health systems including the Health Metrics Network; the Global Health Workforce Alliance; the World Alliance for Patient Safety and the Providing for Health Partnership. In July 2010, he took up the post of Dean at the James P. Grant School of Public Health at BRAC University and ICDDR,B in Bangladesh. Dr. Evans has written numerous journal articles, chapters and books on a wide array of topics in global health and development with a particular focus on health equity, health systems and health research policy. He is currently a Commissioner on the Commission on Health Professional Leadership in the 21st Century, a member of the Board of the Public Health Foundation of India and serves as a scientific advisor to the Institute of Population and Public Health of the Canadian Institutes for Health Research. He previously served as Chair of the Board of Trustees of ICDDR,B and on the Board of BRAC.

KIYOSHI KODERA

VICE-PRESIDENT
JAPAN INTERNATIONAL COOPERATION AGENCY
JAPAN

Kiyoshi Kodera is appointed as Vice-President of Japan International Cooperation Agency (JICA), the world's largest bilateral aid agency in April 2010. He brings substantial experience in international economics, finance and development, which he acquired through a successful career at the Ministry of Finance, Japan and various senior level assignments at Multilateral Development Banks such as the World Bank, the African Development Bank, and Inter-American Investment Corporation. He was a panelist at two side events at 2010 UN MDG Summit : "No Health Workforce. No Health MDGs" and "Focus Group on MDGs in Asia".

When he was Alternate Executive Director for Japan at the World Bank (1991-1994), he contributed as important interlocutor to fund and deliver the famous 'East Asian Miracle' study by the World Bank. In 1997, he returned to the World Bank and served as Country Director for Central Asia. Mr. Kodera then returned to Japanese finance ministry where he served as Deputy Director-General in International Bureau, in charge of the Multilateral Development Banks. He proactively contributed to policy formation for IDA, African development Fund, Asian Development Fund, and Multilateral Investment Fund of Inter-American Development Bank through their replenishment process. In 2005 he was promoted to Deputy Vice-Minister of Finance for international affairs. Since 2006 until spring 2010, he served as Executive Secretary of the joint World Bank-IMF Development Committee, where 24 finance and development ministers discussed financial resource transfer, monitoring of the Millennium Development Goals, international aid architecture, response to triple crises, climate change, and voice and participation of developing and transition countries in the World Bank Group. He assisted Chairs, President of the World Bank, and the Managing Director of the IMF to produce meaningful guidance to the World Bank management at the ministerial meetings. He was a G20 Deputy representing Development Committee.

Mr. Kodera graduated from the University of Tokyo, Japan. He has a Bachelor degree in Law, and a Master degree in Economics from Tsukuba University.

THIR KRUY
SECRETARY
STATE OF HEALTH
CAMBODIA

Thir Kruy is currently the Secretary of State for Health responsible for pre-service education of medical and co-medicals, and works as the President of the Medical Councils of Cambodia. He received his Diploma of Medicine from the University of Health Sciences in 1980 as a general Practitioner and his specialty in Pediatrics from France in 1990. During that time he worked as the Deputy Director of a National Hospital in charge of Pediatric Ward. From 1980, he gave lectures at the University of Health Sciences, Faculty of Medicine and was nominated as a professor of Pediatrics at the University in 1990.

To update his knowledge and skills, Prof. Thir has attended many international workshop and training programs. Prof. Thir has transforming and sharing his knowledge and skills as well as his professional experiences to the MD students at the clinical setting to ensure the quality of MD students for better health service delivery. He was assigned as the Vice-President of the Medical Councils of Cambodia in 2002 and was selected as the President of Medical Councils of Cambodia in 2010. In this position, he commits to oversee and manage the quality of professional practice as well as contributes to the improving and promoting the quality of MD education of both public and private institutions.

In 2009, he was appointed as the under Secretary of State of Health and promoted as the Secretary of Health in 2010 responsible for professional education, quality of health services, and oversees the Medical Councils, Midwifery Councils and Nursing Councils in Cambodia. With the tremendous efforts he has made with the involvement from all partners, he is committed to introduce the Licensing and Registration System for the quality of education and professions in the near future. Facing with the fast growing of Private training Institutions, he tried his best to convince the top Government for maintaining the quality of education for health. A series of training standards has been implemented and enforced for the quality. With these challenges, he tried to work closely with relevant stake holders for resource mobilization, mapping together to reach the ultimate goal.

On the other hand, his contribution towards the equally distributed of qualified health workforce, especially to the front line and remote of health services is very crucial in Cambodia. With the support from all partners, a great achievement was realized related to recruitment of the nursing and midwifery students from the local community to be trained and allocate them back to the community. This strategy was endorsed by the Government through planning and monitoring post-based demand of the MoH.

Prof. Thir Kruy's professional interest is communication and advocacy of social mobilization, development and promotion of responsive and accountable government.

BJØRN-INGE LARSEN
DIRECTOR-GENERAL OF HEALTH
CHIEF MEDICAL OFFICER OF NORWAY
NORWAY

Dr. Bjørn-Inge Larsen is a graduate of the University of Oslo Medical School and University of California, Berkeley. He did his residency training in internal medicine, surgery and primary care in Harstad, before serving as a Lieutenant and physician in the Airborne Special Forces of the Norwegian Army. He then worked as a physician in the Department for Preventive Medicine in the Norwegian Board of Health. This was followed by a period as Deputy County Medical Officer in Buskerud. In 1994, he became Chief County Medical Officer of Finnmark, the northernmost county of Norway. After a period of three years, he moved south and became Chief County Medical Officer of Vestfold. Here, he served another four years, which was followed by a short period as Deputy Director-General of the Norwegian Board of Health. In 2001 he was appointed Director-General of the Norwegian Directorate of Health and Chief Medical Officer of Norway. Dr. Larsen is currently Chair of the National Advisory Board on Quality and Priorities in the Health Sector, Chair of the Norwegian Council on Health Preparedness, Chair of the Norwegian Pandemic Flu Committee, Chair of the National Campaign for Patient Safety, and member of the Norwegian Health Library Board and the Norwegian Preparedness Board.

Dr. Larsen has been engaged in and committed to global and regional health issues over the last decade. He has been a Norwegian Delegate to the World Health Assembly and the Regional Committee for Europe since 2002. He became a member of the Standing Committee for the Regional Committee in 2006, becoming Vice-Chair in 2007 and Chair from 2008 to 2009. In 2010 he became a member of the Executive Board of the World Health Organization. As a consequence, Dr. Larsen has extensive experience of global and regional health governance institutions.

Dr. Larsen is interested in a broad range of global health issues. He has paid particular attention to the health workforce crisis. Here, he has initiated projects in Norway, paying attention to developed countries' responsibilities towards developing countries, and in WHO and WHO EURO, where he played a significant role in the adoption of the WHO global code on international recruitment of health personnel at the 63rd World Health Assembly in 2010. Dr. Larsen has also been active in promoting the importance of tackling non-communicable diseases, particularly in regards to reducing the marketing of unhealthy foods and beverages to children. He is also concerned with health system strengthening, and the potential negative effects of the current financial

crisis on health systems and health outcomes. One constant in Dr. Larsen's engagement in global health, and one which he intends to carry into his future work in the Executive Board, is his concerns for equity - between and within countries. He is particularly mindful of the needs of developing countries, and the urgency that is required in order to improve health outcomes in these countries.

DAVID KAPENYELA MPHANDE

MINISTER
MIISTRY OF HEALTH
MALAWI

David Kapenyela Mphande is a retired Minister of Word and Sacrament. He received Bachelor and Master of Theology (M.Th) from Mc Gill University, Canada in 1978 and 1980 and PhD in Social and Religious Anthropology from University of Malawi, 1998.

From 1982 July to 1990 July he taught at the Malawi Institute of Education where he rose to senior curriculum specialist in Religious anthropology Education for Democracy and Human Rights.

From 2001 February to 2008 November 20 he taught at the University of Mzuzu in Malawi where he rose to be Professor in Religious and Social Anthropology.

He entered politics in 2009 and is currently the political head of the Ministry of Health in Malawi.

Professor Mphande has published widely in the field of religious education and education for democracy with emphasis on secondary and tertiary education.

In 2010 he was awarded the Gold Medical by the American Biographical Institute for passion, courage, commitment, success, excellence, virtue, and spirit based on his contribution to his country and people.

LEOCHRIST SHALI MWANYUMBA

DISTRICT PUBLIC HEALTH NURSE
TAVELA DISTRICT HOSPITAL
KENYA

Leochrist Shali Mwanyumba is a registered community health nurse. She holds a diploma in community health nursing from Kenya medical training college, a diploma in leadership development programme sustainability , a certificate in modern clinical nursing from second medical military university in shanghai China and is currently pursuing a bachelors degree in nursing at the Kenya Methodist university on distance learning mode.

She has also done a number of short courses in counseling, HIV management, nutrition and reproductive health.

She started her carrier in 2003 working for the ministry of health. Between 2004 and 2008 she was the officer in charge of the maternal and child health department of Taveta hospital in one of the remote hardship areas of Kenyan coast. This is a key department in implementation of strategies aimed at achieving the MDGS. Her work basically included care of under fives in immunization, growth monitoring, curative and promotive care. Offering ante natal, post natal and family planning services to women of child bearing age and partners. And even comprehensive HIV. Care to the infected and affected.

It was during this time that she managed to revive focused antenatal care and comprehensive prevention of mother to child transmission strategies to the pregnant mothers which included early infant diagnosis to the HIV exposed babies. She also worked with partners and started the malaria prevention programmes for under fives and pregnant women. She streamlined implementation of PHC activities, strengthened community involvement and ownership through health education, training of community health workers, home visiting and community outreach programmes on child survival and reproductive health programmes. And it was during this time that she won the award for the outstanding nurse of the year in Kenya.

From 2009 to date she is working as the district public health nurse Basically working with communities at the lower levels of community units, dispensaries and health centre levels focusing more on preventive and promotive health care for all cohorts as stipulated in the Kenya national health sector strategic plan.

MUBASHAR SHEIKH
EXECUTIVE DIRECTOR
GLOBAL HEALTH WORKFORCE ALLIANCE
SWITZERLAND

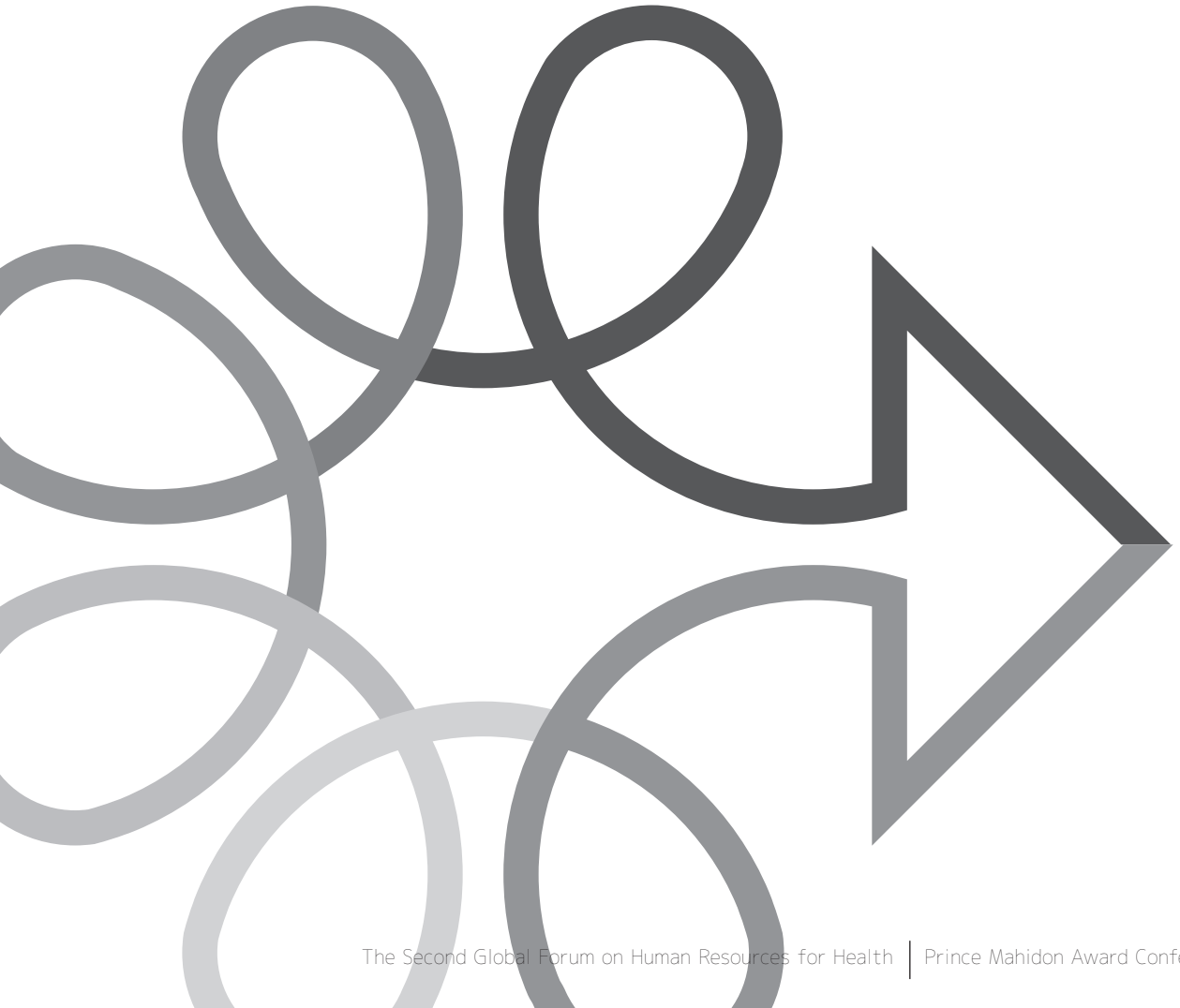
Mubashar Sheikh, is a medical doctor and a specialist in health system policy and planning. Dr. Sheikh started his public health career in 1987 with the Ministry of Health in Pakistan. During this period he managed different departments and spearheaded various projects including the flagship National Primary Health Care program (also known as the Lady Health Workers program). This initiative, the largest in social sectors, was introduced in 1994 to ensure universal access to essential health care at the grass roots and underserved areas for the provision of essential services including integrated management of childhood illnesses, maternal health, water and sanitation, nutrition and promotion of healthy lifestyles. The program is recognized by WHO as the 'best practice' among its 192 member states and has so far been replicated by many countries in Asia and Africa.

In 1998, Dr Sheikh joined the Eastern Mediterranean Office of World Health Organization as Regional Adviser in the department of Health Systems. On this position, Dr. Sheikh also developed strategies for the advocacy and implementation of Community and Sustainable Development initiatives aimed at reducing poverty and social inequalities. In 2004 Dr. Sheikh was assigned to WHO office in Iran as Country Representative, where he also served as Resident Coordinator of the UN system as well as Representative for Food and Agricultural Association.

At present, Dr Sheikh is holding the post of the Executive Director of the Global Health Workforce Alliance based at the WHO Headquarters in Geneva. In this capacity, he is playing the lead role for the development of national policies and plans in 57 countries in Asia, Africa and Latin America aimed at ensuring that all people, everywhere, have access to skilled, motivated and supported health workers within a robust health system...Dr Sheikh is chairing and also acting as member of various expert committees and task forces at the international and regional levels. He is the author and co-author of numerous policy documents, training manuals and guidelines. He is also writing regularly in well reputed journals on various aspects of health systems and human development.

PLENARY SESSION 2 :

Have leaders made a difference?: how leadership can show the way towards the MDGs?



CARISSA ETIENNE

ASSISTANT DIRECTOR-GENERAL
HEALTH SYSTEMS AND SERVICES
WORLD HEALTH ORGANIZATION
SWITZERLAND

Dr Carissa F. Etienne assumed the role of Assistant Director-General for Health Systems and Services in February 2008. Prior to that, she was the Assistant Director of the Pan American Health Organization. As Assistant Director in PAHO from July 2003, she directed five technical areas - health systems and services; technology and health services delivery; health surveillance and disease management; family and community health; and sustainable development and environmental health.

A national of Dominica, Dr Etienne began her career as a medical officer at the Princess Margaret Hospital in her country, where she eventually became the Chief Medical Officer. Other high-level posts she has held include the Coordinator of Dominica's National AIDS Programme, Disaster Coordinator for the Ministry of Health of Dominica, Chairperson for the National Advisory Council for HIV/AIDS and the Director of Primary Health Care for Dominica.

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

JASON GALE
INTERNATIONAL JOURNALIST
BLOOMBERG NEWS

Jason Gale has been a journalist for almost two decades, including 11 years with the international news organization Bloomberg News. He grew up on a farm in rural South Australia and initially studied agricultural science, setting himself up for a career reporting on beef, wheat and other commodities.

In 2005, as the H5N1 avian influenza virus began spreading outside Asia, Jason's Singapore bureau chief made him "the bird flu guy," pushing him into a world of pathogens, public health and pharmaceuticals which he knew nothing about. He took up the challenge -- even getting "up close and personal" with H5N1 in Sumatra -- and has stuck with health and science since.

Jason now leads a team of medical reporters covering the Asia-Pacific region. He has advised the World Health Organization on influenza pandemic communications and has been invited to speak to public health and veterinary officials at meetings in Stockholm, Muscat and Bangkok.

In 2010, Jason won the Overseas Press Club of America's Whitman Bassow Award for environmental reporting for a story on India's sanitation challenges. While pandemics and outbreaks of infectious disease may get more media attention, he finds health stories linked to poverty, globalization and economic transition particularly interesting and compelling.

MICHEL D. KAZATCHKINE

EXECUTIVE DIRECTOR
THE GLOBAL FUND TO FIGHT AIDS, TB AND MALARIA
SWITZERLAND

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

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

Dr Kazatchkine has spent the past 25 years fighting AIDS as a leading physician, researcher, administrator, advocate, policy maker, and diplomat. He attended medical school at Necker-Enfants-Malades in Paris, studied immunology at the Pasteur Institute, and has completed postdoctoral fellowships at St Mary's hospital in London and Harvard Medical School. His involvement with HIV began in 1983, when, as a young clinical immunologist, he treated a French couple who had returned from Africa with unexplained fever and severe immune deficiency. By 1985, he had started a clinic in Paris specializing in AIDS - which now treats over 1,600 people - and later opened the first night clinic for people with HIV in Paris, enabling them to obtain confidential health care outside working hours.

Prior to joining the Global Fund, Dr Kazatchkine was Professor of Immunology at Université René Descartes and Head of the Immunology Unit of the Georges Pompidou Hospital in Paris. He has authored or co-authored of over 500 articles in peer reviewed journals, focusing on auto-immunity, immuno-intervention and pathogenesis of HIV/AIDS. In addition to his clinical teaching and research activities, Dr. Kazatchkine has played key roles in various organizations, serving as Director of the National Agency for Research on AIDS (ANRS) in France (1998-2005), Chair of the World Health Organization's Strategic and Technical Advisory Committee on HIV/AIDS (2004-2007), member of the WHO's Scientific and Technical Advisory Group on tuberculosis (2004-2007), and French Ambassador on HIV/AIDS and communicable diseases (2005-2007).

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

While recognizing the enormous challenges of tackling AIDS, tuberculosis and malaria globally, Dr Kazatchkine believes that the progress made in recent years - particularly through programs supported by the Global Fund - has been extraordinary. "The mission and mandate of the Global Fund developed seven years ago were visionary and aspirational", he says. "Since then, an additional 5 million people have been treated for TB with Global Fund support. More than 70 million bed nets have been distributed to protect families against malaria. And the Fund has contributed to a major scale up of AIDS treatment and prevention". Dr Kazatchkine notes that, by 2009, the Global Fund's objective of making a sustainable and significant contribution to the achievement of the Millennium Development Goals is actually being accomplished. He also emphasizes that the Fund's focus on results and performance is key to its success. "The unprecedented mobilization for the health of the poor in the past few years is producing results which can actually be measured in terms of lives saved", he says.

DENIS SALORD

HEAD OF UNIT, EUROPEAID-AIDCO/C/4
EUROPEAN COMMISSION
BELGIUM

Mr Denis Salord is a French citizen and a senior European Commission official with over twenty years of experience in the service. At present he is responsible for Cooperation with the Africa, Pacific and Caribbean countries in the unit dealing with large Intra-ACP Projects within EuropeAid Development and Co-operation Directorate General (DEVCO). His department implements almost 12% of all the European Development Fund, covering programmes in the areas such as: climate change, education, health, migration etc. In his previous posts he was: leading a department dealing with legal matters, member of Cabinet of the Commissioner responsible for the Customs Union and an assistant to the Director General responsible for Latin America. Mr Salord has a degree in Law and in History from Sorbonne and is a graduate of the prestigious Paris Institute of Political Studies

KEIZO TAKEMI

SENIOR FELLOW, JAPAN CENTER FOR INTERNATIONAL EXCHANGE

RESEARCH FELLOW, JAPAN MEDICAL ASSOCIATION RESEARCH INSTITUTE

PROFESSOR, SCHOOL OF POLITICAL SCIENCE AND ECONOMICS, TOKAI UNIVERSITY

ADVISOR TO THE SASAKAWA MEMORIAL HEALTH FOUNDATION

Prof. Keizo Takemi is a prominent Japanese political leader who is currently a senior fellow at the Japan Center for International Exchange (JCIE) and research fellow at the Japan Medical Association Research Institute. Since September 2007, he has been leading a policymaking platform of public and private partnership for global health, known as the study group on "Challenges in Global Health and Japan's Contributions" before it was restructured as the executive committee of JCIE's program on Global Health and Human Security in August 2009. He was a research fellow at the Harvard School of Public Health in 2007–09 and became Advisor to the Sasakawa Memorial Health Foundation in August 2009.

Until August 2007, he was a member of the House of Councillors of Japan's National Diet, and he served in the Abe Cabinet as Senior Vice Minister for Health, Labour and Welfare from September 2006 to August 2007. An influential voice on foreign affairs in the Liberal Democratic Party, he held a wide range of legislative posts during his 12-year tenure in the Diet, including chairman of the House Standing Committee on Foreign Affairs and Defense.

Professor Takemi is known for his expertise on foreign policy, ODA, human security, health system reform, and the United Nations system. In 1999, as State Secretary for Foreign Affairs in the Obuchi Cabinet, he led the initiative to establish the UN Trust Fund for Human Security, and in 2006 he was named by Secretary-General Kofi Annan to serve as a member of the High Level Panel on UN System-Wide Coherence in Areas of Development, Humanitarian Assistance, and Environment. His many legislative accomplishments include the 2006 restructuring of Japan's ODA system.

He received his undergraduate and graduate degrees from Keio University and he was vice chairman of the Institute of Strategic Peace and International Affairs at Tokai University. He is currently a professor of political science and economics at Tokai University. He has also been an anchor on CNN Day Watch in Japan and a visiting scholar at the Fairbanks Center for East Asian Research at Harvard University. He appears frequently on TV and radio programs as a commentator on issues ranging from international affairs and defense issues to social security.

SAM ZARAMBA

SENIOR CONSULTANT SURGEON, FORMER DIRECTOR GENERAL OF HEALTH SERVICES
MINISTRY OF HEALTH
UGANDA

Sam Zaramba, MD, is Senior Consultant Surgeon, and the former Director General of Health Services in Uganda. Prior to that position, he was the Director responsible for Clinical and Community Health in the Ministry of Health of Uganda.

Dr Zaramba has extensive experience in Health Service Delivery in developing countries and globally. Dr Zaramba practiced clinical medicine for over 10 years at Mulago National Referral Hospital as a specialist surgeon in otorhinolaryngology. He then chose to work in Health Services Management with its challenges in a resource-poor country. He has a special interest in tropical infectious diseases, including particularly the neglected tropical diseases impacting Uganda and the region.

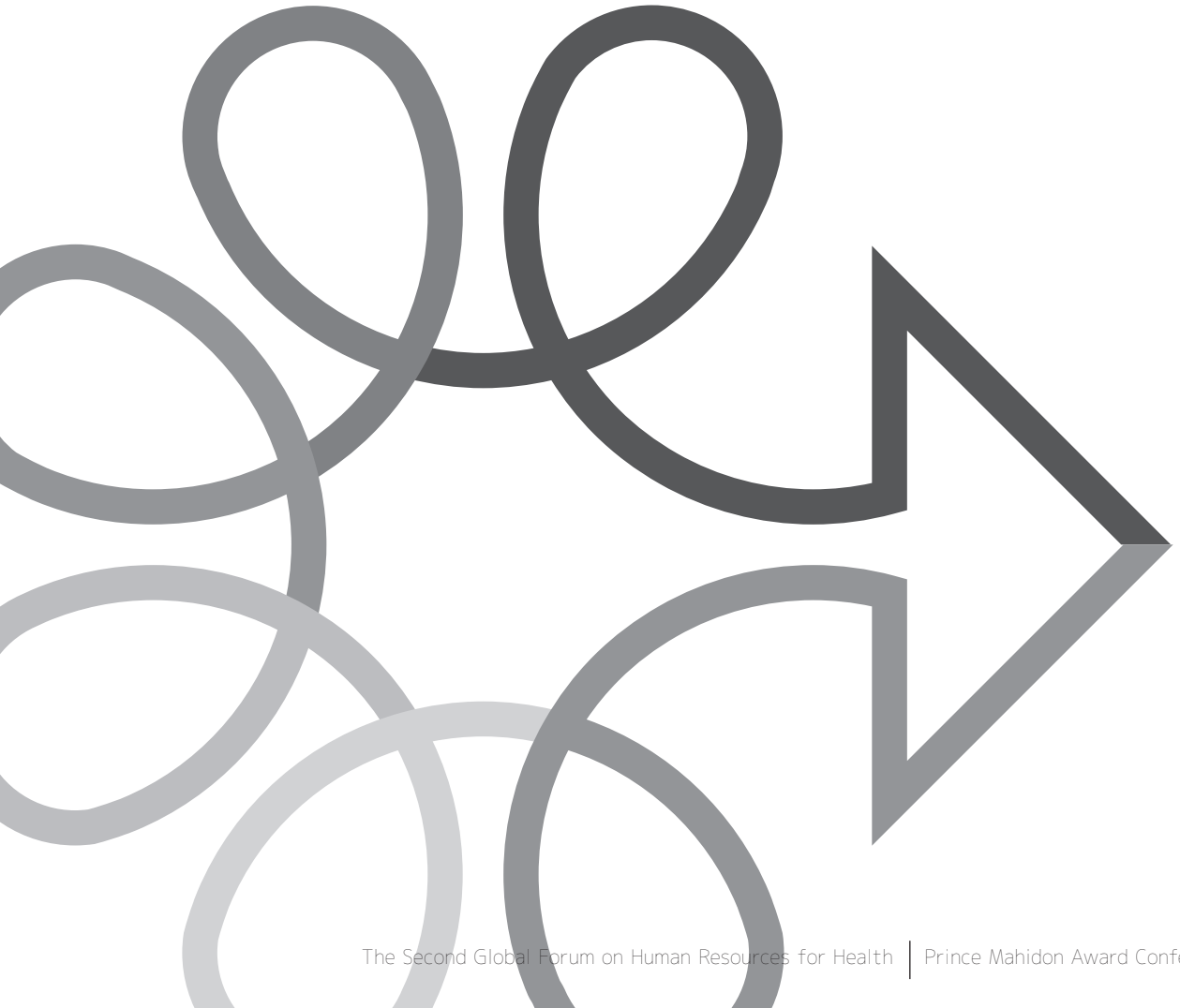
He has advocated for integrated disease control and vector control nationally and globally, as well as the successful strategy of the "Child Health Days Plus" campaign in Uganda. He also initiated several other public health related projects in Uganda such as routine immunization, improved nutrition, health education and hygiene, distribution and treatment of insecticide impregnated nets. He was instrumental in development of the ten year health policy and the strategic plans guiding health services delivery in Uganda.

He chaired the WHO AFRO Regional Program Committee 2007/2008 and was the Chairperson of the WHO Executive Board in Geneva for its 125th and 126th meetings. He is a member of the WHO Strategic and Technical Advisory Group for Neglected Tropical Diseases (STAG-NTD).

Dr Zaramba has co-authored articles on neclected tropical diseases with colleagues at the Vector Control Division of the Ministry of Health. He is a graduate of Makerere Medical School for both graduate and undergraduate studies. He received Health Services Management training at Birmingham University, UK, Boston University, USA, and Harvard University, USA.

PARALLEL SESSION 1 :

Leading towards health workforce development at country level : what will it take?



Health Workforce Observatories as mechanisms for strengthening leadership: An experience from Sudan

Dr Elsheikh Badr; elsheikh941@gmail.com

National Human Resources for Health Observatory (NHRHO), Sudan P.O.Box 978 Khartoum Sudan

The National Human Resources for Health Observatory (NHRHO) in Sudan was established in 2006 as part of the global and regional movement for improving HRH information, evidence and governance. Soon after its inception, NHRHO emerged as a leading observatory in the Eastern Mediterranean Region with premises, technical secretariat and a comprehensive electronic HRH database. The observatory developed a unique stakeholder convening role and advocacy tools including a website and publications. Since its inception, NHRHO is boosting the strategic HRH shift in the country with special contribution to HRH leadership, multi-stakeholder collaboration and evidence-informed policy decisions.

To strengthen leadership, NHRHO has played catalytic role for strategic positioning of HRH function in the country. This was achieved through raising awareness about the strategic nature of HRH and through pushing the debate around health workforce issues to the highest levels in the health sector and the government. Currently, HRH representation fairs well strategically in terms of structures and level of discussion. The observatory, building on the strategic transformation of HRH in the Federal Ministry of Health (FMOH), also managed to present the domain of HRH as a field of study and not just as a function that is taken for granted as was the concept and practice in the country. On another important front, NHRHO also played an initiation and catalytic role in preparing the national HRH strategic plan for Sudan, the first of its kind. The strategy document emerged as a comprehensive work in terms of both its content and process with wide involvement of related stakeholders. Through knowledge generation, advocacy for the field and coaching of young public health professionals, the observatory is contributing to building the foundations of the future leadership in HRH and health system of the country.

In another aspect related to leadership and HRH strengthening, NHRHO has been playing a fundamental role in stakeholder coordination in Sudan. Recognising the complexity and multi-faceted nature of HRH, the observatory conducted stakeholder mapping and analysis and eventually established a stakeholder forum that is bringing in institutions and bodies related to health workforce issues around one table. The breakthrough strategy adopted was based on taking HRH issues beyond ministry of health, beyond health sector and beyond public domain. Hence, the observatory forum brings together other

governmental ministries besides ministry of health, related agencies in health and non health sectors, professional associations and private sector. To inculcate ownership and sustain involvement, NHRHO adopted an approach towards stakeholders based on involving senior persons, using multiple entry points to institutions and stressing win-win approach where stakeholders accrue benefits in terms of information availability and capacity strengthening while feeding their data into the main hub of the national observatory. The observatory technical secretariat is supported by the FMOH and WHO in providing technical assistance to stakeholders in aspects of information generation and management.

On the evidence-based policy decisions, the observatory has implemented vital steps in establishing, operating and sustaining a dynamic human resource information system (HRIS) in Sudan. For the first time in the country, a national HRH census was conducted in 2006 through support of the FMOH and the WHO. The observatory analysed and stored the survey results in an accessible electronic database. This has helped immensely in producing a situation analysis report that formed the basis for development of the HRH strategic plan for the country. The electronic database has been receiving updates through routine sources of information and, a second national HRH survey is planned to be conducted in the first quarter of 2011.

NHRHO conceptualised the HRIS based on the lifespan and labour market models (WHO, 2006, Vujicic and Zurn, 2006). This work culminated in production of a diagrammatic depiction of the HRIS which helped significantly in clarifying the scope and delineating the information points and sources along the continuum or life span of the health workforce: entry, active workforce, and exit. Based on this conceptualization, the observatory embarked on establishing satellites (information stations) in stakeholder institutions with some fully functional now. Similar to the approach adopted in broadening the umbrella of stakeholders; HRIS was likewise taken beyond the ministry of health staff, beyond workers in the health sector and beyond the public sector domain. Thus; personnel in health agencies other than ministry of health, health workers in allied sectors such as banks, and private practitioners were included in the database. Previously, health workforce data was limited to staff working in the ministry of health and universities resulting in considerable underestimation of the size of the country health workforce. The observatory also adopted a template for HRIS with more comprehensive parameters on health workers such as age, gender and educational attainment, all not usually captured in the previous system. To facilitate data collection and improve monitoring, NHRHO produced a set of indicators on HRH together with a data dictionary that explains terms and classifications. Coverage of the database expanded to include

educational institutions together with their students and staff. To enhance dissemination and use of evidence, work is currently ongoing to establish a web-based system for data display with authorised levels of access for policymakers, senior managers, health workers and researchers. To continuously update the HRH database, NHRHO is providing technical and logistic support for further developing and sustaining the satellites at stakeholder institutions to instantly link to managerial and routine processes of data generation. These satellites will, as mentioned earlier, provide information for the local use of stakeholders while feeding their updates into the main database server hosted in NHRHO secretariat. For better integration and contextual use of HRH information within the health system, NHRHO is linking to the National Centre for Health Information (NCHI) at headquarter of the FMOH. Efforts are underway for mainstreaming HRH data into the overall health information system that is being renovated itself.

To improve scope, depth and quality of evidence, the observatory has addressed HRH research hand in hand with establishment of the HRIS. For the first time in the country, HRH research agenda and priorities were identified through a nationwide exercise that involved policy makers, managers and health workers in the decentralized health system of the country. NHRHO produced some HRH reports and studies, engaged in supervision of research projects as a recognized training centre by the Sudan Medical Specialization Board and established a research forum to promote capacity and joint learning for HRH research. Currently, the observatory is collaborating with the Public Health Institute of the FMOH on a major Global Fund supported research project on retention, migration and gender, all top priorities identified in the earlier exercise carried by the observatory.

The evidence coming out of HRIS, reports and research has shown promising results in informing and affecting important policy decisions. One example is the move in the country to scale up and strengthen nursing and allied health education based on the evidence generated on the accelerating skill mix imbalance in the Sudanese health work-force. Another example is the incorporation of priority HRH research projects on retention, migration and gender into the Global Fund proposal submitted by Sudan based on data generated on those issues and on the results of the priority setting exercise. A third example is the inception of a committee in the Ministry of Higher Education to look strategically into harnessing the role of public and private sector institutions in production of health workers for health system needs. The inauguration of this committee was informed by evidence produced by NHRHO on the lack of strategic orientation of health workforce production in public sector as well as the rapidly increasing private sector intuitions. Last but not least, the expansion of continuing professional development (CPD) structures and activities

in Sudan was largely informed by the information generated by the 2006 census showing that, three quarters of the health workforce did not receive in-service training over the last five years preceding the census (Badr, 2007).

Critical success factors for the observatory achievements portrayed here, included a political environment conducive to promoting HRH function, high commitment from the FMOH and encouraging response from HRH stakeholders. The core team of public health professionals working in HRH arena was also instrumental to success of this work through demonstration of leadership and persistence. The WHO and the Global Health Workforce Alliance (GHWA), among other partners, also played important roles in catalysing and supporting this movement on HRH evidence and governance. The work of the observatory was much supported by the leadership that emerged in the HRD department in the FMOH following its promotion to a general directorate headed by assistant undersecretary.

The work of the observatory was, however not free of challenges. Prominent among these is the challenge of maintaining stakeholder thrust and joint work to address HRH issues. Commitment of some stakeholders has been affected by changes in leadership. Involvement of the rapidly expanding private sector institutions also proved to be difficult in view of the lack of representative umbrella associations. Another challenging area is expansion of the observatory network to involve lower levels of the decentralized health system of Sudan. Although work was initiated on this front, the issue remains somewhat cumbersome in a huge country like Sudan. Capacity development for different dimensions of HRH function is an overarching challenge. Special mention is worthy of leadership development across the decentralized levels and institutions.

Given the record of achievements, the growing interest in HRH, the generally supportive country context and the strategic positioning of HRH structures; the prospects for the observatory in Sudan are promising. Its work on evidence, stakeholder coordination and leadership could effectively boost the efforts on human resource development and consequently, health system strengthening and improvement of population health in Sudan and beyond.

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ADANG BACHTIAR

CHAIRMAN
DEPARTMENT OF HEALTH ADMINISTRATION AND POLICY STUDIES UNIVERSITY OF INDONESIA
INDONESIA

EDUCATION

Medical Doctor, from University of Indonesia, 1980
Master of Public Health, from Harvard University, 1987
Doctor of Science, from Johns Hopkins University, 1992

CURRENT ACTIVITIES

- President, Indonesian Public Health Association (IPHA), 2007-2010 and 2010-2013
- Expert Member, Poverty Reduction Special Task-force under the Vice President of Republic of Indonesia, 2010-now
- Head of Indonesian CCF Secretariate Office under Coordinator Minister of People's Welfare, Republic of Indonesia, 2010-now
- Head of Master program in Hospital Administration (MHA), University of Indonesia, 2007-now
- Vice-chair of Health Sciences Integration and Development, consisting medical, dental, nursing, pharmacy, and publich health to the world class university, at University of Indonesia, 2008-now
- Chairman of Health Policy and Management Department, School of Public Health, University of Indonesia, 2007-now
- Director of Centre for Health Administration and Policy Studies, University of Indonesia, 2008-now
- Member of Expert Committee, National TB Program of MoH, 2001-now
- Director, Global Fund for TB Porgram, at School of Public Health, University of Indonesia, 2009-now
- Member of Expert Committee for the development of HRH Information System, MoH, 2010-now
- Co-chair of Health Profession Education Quality (HPEQ) for public health profession of the World Bank project, 2010-2015
- Member of Advisory Board of National Agency fo HIV/AIDS Control with related ministers, e.g., Ministers of Health, Education, etc, 2008-now
- Member of Expert Committee for the Development of Healthcare service, at Remote areas, State Borderlines and Small Islands of the MoH, 2007-now
- Member of Expert for National Resilience Institute of R.I, 2010-now

ELSHEIKH BADR

DIRECTOR
NATIONAL HUMAN RESOURCES FOR HEALTH OBSERVATORY
SUDAN

Dr Elsheikh Badr is a consultant public health physician with expertise in health system and human resource development. He gained his basic medical degree and postgraduate public health diploma and fellowship from Sudan. He also obtained masters degree in health policy, planning and management from the University of Leeds UK and was admitted as fellow of the Faculty of Public Health of the Royal Colleges of Physicians of the United Kingdom. Dr Badr is currently positioned as the Deputy Director General for Human Resource Development in the Federal Ministry of Health (FMOH) Sudan. He is, as well the founding director of the National Human Resources for Health Observatory (NHRHO). Dr Badr has been actively involved in health system strengthening over the last ten years through his senior positions in different departments of the FMOH. He developed his interest and expertise in the field of human resource development (HRD) and participated actively in different dimensions of HRH reforms in Sudan and beyond. Contributions of Dr Badr included leadership and direct involvement in the work of the Academy of Health Sciences (AHS) established by the FMOH to address the critical shortages of nurses, midwives and allied health professions in Sudan. He also initiated the work on human resource information system through the observatory and participated actively in HR policy review and preparation of human resources for health strategic plan for Sudan. Dr Badr has also contributed to some other areas of HRD including the country initiative on continuing professional development (CPD) for health workers, capacity strengthening for decentralized HR structures and the multi-stakeholder coordination for HRH. He is also involved in developing capacity for health system and HRH research in Sudan and has conducted and supervised studies in some areas including medical migration, retention, health professions education and role of professional associations and private sector in HRD.

Dr Badr currently serves as member in several platforms on HRH issues in Sudan. These include the high level HRH committee under auspices of the Council of Ministers, the Medical and health professions education committee in the Ministry of Higher Education, the Migration and Population Centre of the Secretariat for Sudanese Working Abroad and the HRH chapter of the National Council for Health Care Coordination.

Regionally and globally, Dr Badr has been part of several HRH initiatives over the last few years. He served as Deputy Secretary General for

the Arab Medical Union and has been designated an Arab Migration and Population Expert by the Arab League. He is also involved in some WHO collaborations and consultancies including promotion of health workforce observatories and development of regional HRH strategy for the Eastern Mediterranean Region. Internationally, Dr Badr serves as member of the high level Global Health Worker Migration Policy Council under the auspices of the Global Health Workforce Alliance (GHWA). He worked as well in some task forces with GHWA including the technical working group on monitoring implementation of Kampala Declaration.

FRANCISCO CAMPOS

PROFESSOR
FEDERAL UNIVERSITY OF MINAS GERAIS
BRAZIL

Francisco Campos was the National Secretary of Labor and Education Management in Health of the Ministry of Health - Brazil from 2005 to 2010. Graduated in Medicine, Dr. Campos holds a Doctoral Degree in Public Health and has been a Full Professor at the Medical School of the Federal University of Minas Gerais for the last 30 years. His main areas of professional involvement are human resources for health (HRH), with focus on Medical Education and more specifically on the professional education and the scaling up of HRH education in developing countries. From 1989 to 1996, while working for the Human Resources Development Department of the Pan American Health Organization (PAHO/WHO), in Washington D.C., he was responsible for the Education Sector. Lately, in addition to being responsible for developing and coordinating Brazil's policies and strategies on HRH, he is also a Board Member of the Global Health Workforce Alliance, a partnership dedicated to identifying, implementing and advocating solutions for the critical shortage of HRH in the world.

GÜLIN GEDIK
PHYSICIAN
WORLD HEALTH ORGANIZATION
SWITZERLAND

Dr. Gülin Gedik is a physician with postgraduate training in public health (MSc and PhD) and health economics. She has been working in the area of health systems for over 20 years, with experience in health policies and human resources development at national, regional, and international levels and also in private sector. She started her career as general practitioner at district level and then worked for the Turkish Ministry of Health in the National Health Policies Coordination Committee and then as the Deputy Coordinator of the Health Reform Project, MOH (responsibilities included development of National Health Policy, design of health reforms, human resources development). She joined the WHO Regional Office for Europe: worked in Bishkek, Kyrgyzstan for two years as resident adviser coordinating MANAS Health Reform Project of Kyrgyzstan to develop a comprehensive health care reform master plan; then undertook the responsibility for health care policies and systems in Central Asian Republics at the WHO regional office in Copenhagen. Joined WHO/HQ to the Department of Health Services Provision and After the restructuring in the organization in 2004, joined the Department of Human Resources for Health (HRH) focusing on health workforce governance and country support. The work includes strengthening HRH governance capacities, health workforce policies and planning, health workforce observatories, aid effectiveness for HRH development, facilitation of multisectoral policy dialogues.

HILDE DE GRAEVE

HEALTH SYSTEMS PROGRAM OFFICER
WORLD HEALTH ORGANIZATION
MOZAMBIQUE

Since 2007 Dr Hilde De Graeve works as health systems program officer at WHO Country Office in Mozambique. She contributes to policy and strategic planning of health services from a health systems perspective with focus on human resources for health. She supports the Ministry of Health in the implementation of the human resources development plan. As co chair of the HRH working group she facilitates coordination and communication between development partners and the MoH within the context of the health SWAp.

She previously worked for the Ministry of Health of Zimbabwe for 14 years where she held different positions. She has experience in clinical maternal and child health care, tuberculosis, district health services management, hospital management & administration and public health.

She graduated as a medical doctor from the University of Ghent in Belgium, with post graduate education in tropical medicine and sexual & reproductive health. She holds a masters degree in health systems management from the London School of Hygiene and Tropical Medicine.

CHRISTIAN HABINEZA

DIRECTOR, EXECUTIVE BOARD OF HEALTH DEVELOPMENT AND PERFORMANCE
RWANDA

Mr. Christian Habineza, Rwandese, Administrator, currently Director of Executive Board of Health, Development and Performance (H.D.P). HDP is a non lucrative organization. I acquired a long experience in managing
non governmental organization. During the past period I headed a team which started an innovative financing strategy in the Health sector known as Performance Based Financing. One of the major focuses in its implementation concerns the empowerment of multi actors in the sector in respect of separation of functions defined as: Regulator
(administration and technical acts; Service providers and the beneficiaries - community). The focus for the organization I represent is currently oriented to the reinforcement of the community voice.

Additional information on field experience:
Setting up district health systems in developing countries. The relevant experience acquired is in the Rwandan context after the genocide working as a project Advisor in Western part of the country. The work done was mainly to set up and make functional the health district model in those areas. Before the 1994 Genocide, Rwanda had already adopted the Bamako initiative on the health district model. In practice this was not yet functional.

The activities focused on:
- Mapping health facilities and defining catchments area based on a district hospital surrounded by a number of health centres for a population of approximately 150 000.
- Reinforcing the planning session on both district and health facilities level.
- Capacity building on the health district team for management and supervision.

Health sector financing; on both supply and demand side. Throughout my carrier I worked several years on development of different strategies on health financing issues. Results based financing (or Performance based financing) is one of the fields of my biggest experience whereby the strategy is used to better organize financial resources meant for the service providers. My experience on RBF (PBF) work is conducted in close collaboration with organizations such as Cordaid, MSH, KIT, Antwerp Institute, BTC in Rwanda, etc. With in the same area but as

a complimentary to the health financing component, the integration of health activities such as HIV and primary health care activities as a comprehensive package; the integration of the health sector within the general administrative system on central or decentralized level, the motivation and retention of health professionals are part of the experience acquired during the implementation of PBF initiatives.

Emergency and reconstruction in the health sector: from the situation in Rwanda, Burundi and RDC, I acquired a long experience on managing health services in an emergency context and how to integrate the intervention in an existing country structure.

Community participation: in the health financing component, few actions are oriented to the capacity building of communities who are also beneficiaries of the health services. This action is meant to help the population understand and be aware of their rights for accessing health services. This approach makes automatically this actor very important as all interventions integrate during the implementation process and try to measure their satisfaction throughout.

The emphasis is also kept to users for them to understand that health services have a cost. Some one is committed to help and pay for them in a very limited period but as ultimate beneficiaries the shift needs to be done for them to take over the cost. My experience in the last few years is the work with community based health insurance to introduce this thinking combined with the PBF strategy. The aim is to organize the community to develop solidarity and saving mechanism in order to facilitate financial access to health services.

SUZANNE KODSI

SENIOR EUROPEAN COMMISSION PROGRAMME MANAGER

EUROPEAID DEVELOPMENT AND CO-OPERATION DIRECTORATE GENERAL (DEVCO)

BELGIUM

Suzanne Kodsi is a Belgian citizen and a senior European Commission official with over ten years experience in Commission's services. She is a programme manager and in charge of EC policies and external relations within the EuropeAid Development and Co-operation Directorate General (DEVCO) unit in charge of the design and implementation of both the European Development Fund (Intra-ACP envelope), and multi-country interventions, funded under the Thematic Budget Lines. The unit deals with the Cooperation with the African, Pacific and Caribbean countries. Mrs. Kodsi is managing EC contributions to several International Organisations. In her previous post, she was in charge of the social sector in the EU Delegation to the Democratic Republic of Congo, in charge of the political sector dialogue and cooperation with national authorities.

Mrs. Kodsi is a medical doctor with a public health specialisation and a Master's degree in Biomedical Sciences from Leuven University in Brussels.

JASON LANE
SENIOR HEALTH POLICY ADVISOR
EUROPEAN COMMISSION
BELGIUM

A UK qualified doctor with further education in Tropical Medicine and International Public Health. After the UK I worked as a physician in the Amazon region of Brasil. I then spent 10 years with DFID either in the human development field (Kenya, Bolivia, Malawi) or as Head of Office (Kyrgyz Republic). I helped design the Kyrgyz Health SWAp and helped implement the Malawi Health SWAp. In both of these processes the issue of Human Resources for Health was central. I have significant experience in aid effectiveness, both generally, and specifically on health. I am interested in improving the impact of our aid programmes, and focus all my efforts on trying to ensure aid is used effectively and delivers results. I have been with the European Commission on secondment from the UK Government since August 2010.

MARIO ROBERTO DAL POZ

COORDINATOR
DEPARTMENT OF HUMAN RESOURCES FOR HEALTH
WORLD HEALTH ORGANIZATION
SWITZERLAND

Mario Roberto Dal Poz: Brazilian, a paediatrician with a passion for Public Health, has been working in the area of health systems for over 25 years, gaining vast experience in the development of human resources at regional, national and international levels. He has a Master of Sciences in Social Medicine with a focus on health delivery models in the context of the growing urbanization in Brazil, and a Doctorate in Public Health with the elaboration of a new methodology for policy analysis of human resources for health development.

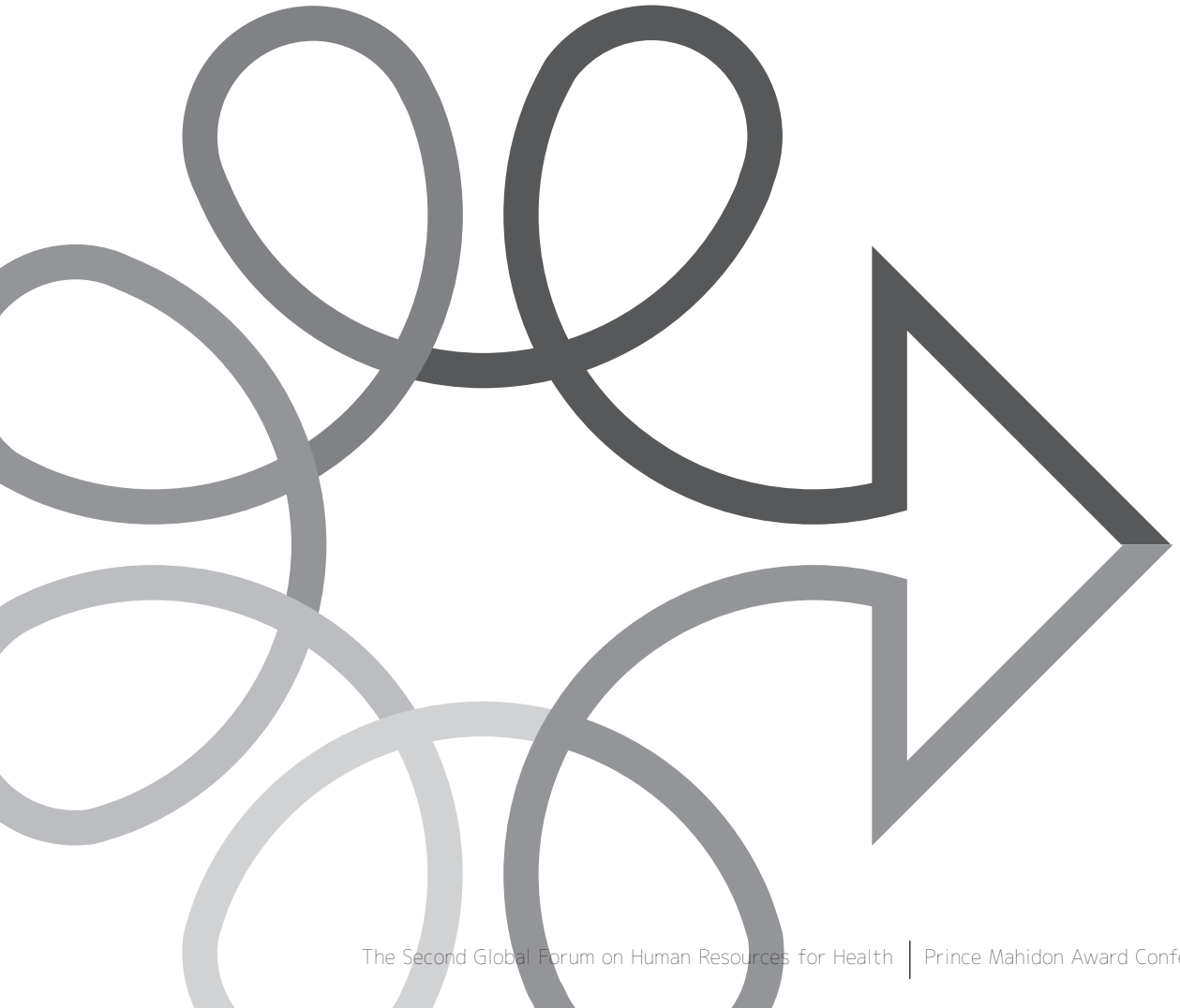
Associated professor and former deputy director of the Social Medicine Institute at the University of the Rio de Janeiro State (UERJ), he worked extensively in the Brazilian Health System (SUS). At the World Health Organization (WHO), has been working on human resources for health development and policies initially as a scientist and then coordinating the Health Workforce Information and Governance Unit within Department of Human Resources for Health.

He worked in several countries in Latin America, Africa, Middle East, Europe and Asia, mostly assisting countries on human resources for health (HRH) development, health workforce information system and health system performance. He also works on technical cooperation on HRH policy and planning implementation at national and sub-national level.

Published more than 60 articles in peer-review and specialized journals, 6 books and contributed for more than 10 book chapters in the área of human resources for health. Additionally he is the current Editor-in-Chief of the Human Resources for Health electronic journal [http://human-resources-health.com/].

PARALLEL SESSION 2 :

Serving in the frontlines: personal experiences and country strategies for retention of HRH in rural areas



'From rural practice to policy definition and implementation – the journey of a Jamaican pharmacist'
E. Grace Allen Young JP DPharm

Abstract

The personal experience of a pharmacist who served at the two extreme ends of the public health care sector in Jamaica will be given. Her first job was in a small rural government hospital. The last job was as head of the administration of the nation's health service as Permanent Secretary.

Experiences focus on the issues and challenges of rural hospital pharmacy practice which also spanned primary care, and those of a healthcare practitioner occupying the highest civil service position in a Ministry to which a person could be appointed.

Oversight of the direction, financing and staffing of the public health care system with first hand knowledge of the impact of resource allocation and public health policy on healthcare at the 'grass roots' will be discussed.

The journey from rural practice to policy advice, policy implementation and health system management will be shared under the headings:

- Overview
- The rural experience
- Arriving at the top
- Application of the Global Policy Recommendations

WHO's Global Policy Recommendations on Increasing access to health workers in remote and rural areas through improved retention will be used as the template to highlight some of the initiatives that from personal experience can have the desired outcome.
November 30, 2010

Oluyombo A Awojobi

ABSTRACT

"The area of human resources for health (HRH) has been identified as the single most critical constraint to the achievement of health and development goals, and yet the world still continues to witness a global health workforce crisis. With only five years left to 2015 and to achieve the MDGs, it is urgent that all stake holders working toward HRH and health systems strengthening, to respond appropriately, efficiently and effectively to the crisis."

Having worked in a rural area of southwestern Nigeria for 27 years,

the problems of retaining human resources for health in the rural and remote areas include:

1. The level of competence required of a medical officer to perform effectively in the remote rural setting.
2. The prospects for professional advancement while still based in the rural setting.
3. The infrastructural inadequacies in the health institution.
4. The inappropriate administrative milieu in the health institution he will work in.
5. The social problems of raising his family and securing a job for the spouse in the rural setting.

My proposed solutions are:

1. Level of competence. The current training programme that produces a full-fledged general surgeon is not adequately coping with the magnitude of the problem in Nigeria. Our experiences have shown that there is the urgent need to train middle level surgical manpower specifically to address the health care problems of the rural populace.

2. Professional advancement. The frame work should provide for opportunities to undergo more training with the ultimate goal of becoming a consultant surgeon if so desired. A staged training programme will be more appropriate in keeping the medical officers in the rural setting. The universities should be encouraged to initiate Master of Science (Primary Care Surgery) programme similar to the Master of Public Health degree. This will allow for the academically inclined rural practitioner to seek employment in the university after providing service and undertaking research in the rural area.

The universities should as a matter of urgency create Departments of Family Medicine but the faculty staff should be based in rural health institutions.

3. Infrastructural inadequacies. The problems of infrastructure and medical devices have been fully addressed and solved by the WHO First Global Forum on Medical Devices held in Bangkok in September 2010.

4. Inappropriate administrative milieu. The administrative structure in operation at present is inimical to the efficient running of rural health institutions. Governments should be encouraged to adopt the Bamako Initiative of revolving funds in the procurement of materials needed to efficiently run rural health institutions.

Accountability in financial matters could be assured by the open accounting system in which ALL members of staff constitute the auditing team that meets EVERY month and the medical officer in charge sends written reports signed by ALL heads of departments quarterly to the headquarters. Involving the junior staff is an antidote to embezzlement and other corrupt practices.

We initiated these programmes while we worked at the District Hospital, Eruwa 1983 – 86 and continued in our private clinic, Awojobi Clinic Eruwa, 1986 to date.

5. Social problems. The social problems of raising a family are critical to retaining medical officers in rural areas. However, we have shown that it is safer, better and cheaper to do that in the rural area where there is a constant relationship between parents and their children while they are growing up.

Our two sons went to public schools although there were private primary and secondary schools. We engaged teachers to give extra coaching to them after school hours and during the holidays. Of course, we started off at home before they were five years old when formal education began in the public school.

We developed laboratories for physics and chemistry at home and used the hospital laboratory for biology. At the end of their secondary school years, we donated the instruments and chemicals to their school. The total cost of all these was much less than sending the children to a private school in the city. The joy and satisfaction of seeing them grow to their adolescence was gratifying.

The older son has graduated as an electrical/electronics engineer from Obafemi Awolowo University, Ile-Ife, Nigeria – a public university. He is self-employed in the city of Ibadan producing inverters and rechargeable dc lamps. The younger son is a medical student at the same university.

My wife is a radiographer. So, it was easy for us to be employees of the State Government before we decided to establish our practice in the same town. We did this to obtain job satisfaction which was not

possible in a public institution due to bureaucratic bottlenecks and the community was very cooperative in this regard.

There should be close collaboration between the governments at the three levels and the private sector in the rural setting to provide job opportunities for the spouses (usually the wives). Where the wife decides to be self-employed, soft loans from the banks should be guaranteed by the employer of the husband.

OLUYOMBO AWOJOBI

CONSULTANT RURAL SURGEON
AWOJOBI CLINIC ERUWA
NIGERIA

Dr Awojobi Oluyombo obtained his medical degree from the University College Hospital in Ibadan, Nigeria, in 1975 where he earned the Adeola Odutola prize for the best final-year medical student. He worked as a surgeon at the District Hospital Eruwa for three years before setting up his own rural clinic in Eruwa in 1986.

Other awards he has received include the Oyo State Merit Award for rural medical practice, the National Agency for Science and Engineering Infrastructure Prize and the College of Medicine, University of Ibadan Award for his contribution to the Ibarapa Community Health Project. In 2000, the King of Eruwa offered him the chieftaincy title of Baasegun of Eruwa.

Although a rural surgeon, fabricating and inventing machines and medical devices are his hobby.

IAN COUPER

PROFESSOR OF RURAL HEALTH
UNIVERSITY OF THE WITWATERSRAND
SOUTH AFRICA

Ian Couper is Professor of Rural Health at the University of the Witwatersrand (Wits), Johannesburg, South Africa. He is director of the Wits Centre for Rural Health, which was launched in 2009. He holds a joint appointment in the North West Provincial Department of Health, South Africa, as Head: Clinical Unit (rural medicine).

He is a family physician by training, and is currently acting head of the Wits Department of Family Medicine.

His areas of activity are in health service development, supporting rural students, undergraduate and postgraduate education, research and advocacy. These interests were nurtured during nine years spent in a rural district hospital in northern KwaZuluNatal province.

He was active in the formation of the Rural Doctors Association of Southern Africa (RuDASA) more than 12 years ago, and currently chairs the international Working Party on Rural Practice of the World Organisation of Family Doctors (Wonca). He chairs the steering committee of the Rural Health Advocacy Project.

He serves as editor of the African section of the international journal Rural and Remote Health.

He was a member of the expert panel that produced the WHO Global

Policy recommendations "Increasing access to health workers in remote and rural areas through improved retention."

He was previously a senior lecturer in the Department of Family Medicine and Primary Health Care at the Medical University of South Africa (Medunsa). He has been an honorary lecturer at University of KwaZuluNatal, South Africa, and an adjunct lecturer at James Cook University, Australia. He has also held visiting appointments in the Monash University Centre for Rural Health and the Flinders University Rural Clinical School in Australia.

CARMEN DOLEA

MEMBER OF THE WHO GUIDELINES REVIEW COMMITTEE
WORLD HEALTH ORGANIZATION

Dr. Carmen Dolea is a physician by training, with extensive international experience in public health and health systems policies, particularly in health workforce development. She graduated medical school in 1994 in Romania and specialized in family medicine. After four years of clinical practice in Romania she moved into a public health career, and earned her Masters degree in public health and management of health services in Romania in 2000. Following a research fellowship with London School of Hygiene and Tropical Medicine in 2001, she started to work with the World Health Organization in Geneva, initially with the burden of disease group, producing global estimates for the burden of disease of maternal conditions. Since 2002 she has been heavily involved in WHO's work on health workforce development, providing policy analysis, research and technical support to countries on many topics in this field. In 2006 she was part of the team that produced the "World health report: working together for health", and in 2008 she was a member of the WHO Secretariat in the Global Health Workforce Alliance Task Force on scaling up education and training of health workers. In the latter capacity, she contributed substantially to the production of the task force report "Scaling up, Saving lives". Most recently, she managed the production of the WHO global recommendations on increasing access to health workers in remote and rural areas through improved retention. This involved a year-long consultative efforts and management of a large group of international experts, as well as coordination of the research and writing activities for the production of these recommendations. As part of this work, Dr Dolea also managed a special theme issue on health workforce retention hosted by the Bulletin of the World Health Organization. Dr Dolea also serves as editorial adviser for the Bulletin of the World Health Organization, and was recently nominated to be a member of the WHO Guidelines Review Committee, a body that advises on the production of evidence-based guidelines in WHO.

TETSURO IROHIRA

CHIEF MEDICAL DOCTOR
COMMUNITY HEALTH CARE
SAKU CENTRAL HOSPITAL
JAPAN

Dr. Tetsuro IROHIRA was born in Yokohama, Kanagawa Prefecture in 1960. After quitting the University of Tokyo, he travelled all over the world and entered the Faculty of Medicine, Kyoto University, to become a doctor. Upon graduation from the University in 1990, Dr. Irohira has been working in Saku Central Hospital which is known as a pioneer hospital in the field of rural health in Japan, and has been working as its Chief Medical Doctor of Community Health Care.

In 1996, he was seconded from the Hospital as Director of Nobeyama remote-area medical clinic in Nagano Prefecture and was appointed as Director of a Clinic in the Minami-Aiki village in Nagano Prefecture. He worked as the only doctor in the Minami-Aiki village with 1,100 inhabitants out of which 39 per cent was over 65 years old, for ten years. In 2005, he returned to the Saku Central Hospital. Also, he is dispatched to the Oodo Clinic in Nagano Prefecture from the said Hospital regularly and is active in the front lines of rural health. His commitments to rural health and to the villagers and non-Japanese migrants in the area attract many medical and nursing students and he receives almost 100 students a year for training from all over the country.

While working as a general practitioner in the rural area, Dr. Irohira has been working as the Executive Director of a NPO "ISSAC" which supports the non-Japanese living with HIV from the aspects of medical care, employment and living, as well as their return-home. In 1995, they received grant for their activities from the Thai Government.

CHRISTOPHE LEMIÈRE
SENIOR HEALTH SPECIALIST
WORLD BANK

Before joining the Bank in 2007, Christophe Lemière has worked as a hospital manager in France for 5 years. During his period, one of his assignments was as HR manager in a teaching hospital with over 3,500 staff. He then moved as a consultant in health care management and has worked in dozens of countries, in Eastern Europe, Caucasus and West Africa.

He holds an Msc in Health Economics (Paris University) and an MBA (Harvard University).

KIM WEBBER
CHIEF EXECUTIVE OFFICER
RURAL HEALTH WORKFORCE
AUSTRALIA

Dr Kim Webber has a strong interest in public policy and its impact on community health.

As the Chief Executive Officer of Rural Health Workforce Australia (RHWA), she is a passionate advocate for a health workforce providing accessible, quality health care services in rural and remote Australia. A not-for-profit organisation, RHWA is funded by the Australian Government's Department of Health and Ageing to manage national programs that address the shortage of rural and remote health professionals.

This includes recruitment and retention programs, run in partnership with state and territory Rural Workforce Agencies for which RHWA is the peak body.

RHWA also has a focus on future workforce, by engaging students in rural health careers and advocating on their behalf. It administers Australia's National Rural Health Students Network - a multi-disciplinary body of 9,000 university health students.

Dr Webber has worked in the rural health sector for most of her career. Before joining RHWA in 2006, she was a senior program manager with beyondblue, Australia's national initiative to combat depression.

At beyondblue Dr Webber was responsible for developing and leading strategies around depression issues for rural and Indigenous communities as well as leading online health programs.

Other key appointments include Deputy Head of the University of Sydney's Northern Rivers University Department of Rural Health in New South Wales. During this time she delivered public health leadership curriculum to 15 World Bank and WHO sponsored fellows.

Dr Webber has also held various positions in the Australian public service, including managerial roles in the Office of Rural Health within the Department of Health and Ageing. While there, she was responsible for advancing the Australian Government's rural health services agenda.

Her expertise and policy advice continues to be sought by government, media and peers.

Since 2008, she has been a technical advisor to the WHO project on international guidelines for retention of health workers in rural and remote areas. As part of this activity, she has spoken on behalf of the WHO group at meetings in Geneva, Hanoi and Beijing.

Dr Webber has also briefed the China government on effective rural health workforce strategies and been an international expert advisor to two projects on rural health workforce retention in China.

With a PhD in Pharmacology from Monash University in Melbourne, Dr Webber maintains a commitment to life-long learning as a leader and teacher.

Away from work, she likes to relax with a glass of wine, a good book and contemplating some faraway place.

Rural Health Workforce Australia
Phone + 61 3 9860 4700 Email info@rhwa.org.au
Web www.rhwa.org.au
Suite 2, Level 5, 10 Queens Road, Melbourne, Australia 3004

GRACE ALLEN YOUNG

FORMER PERMANENT SECRETARY
MINISTRY OF HEALTH
JAMAICA

Dr. E. Grace Allen Young was Permanent Secretary for the Ministry of Health, Jamaica from July 2001 to August 31, 2009 when she retired. A pharmacist who commenced her career in a small rural hospital in Jamaica, she is the first healthcare professional to attain such a role in the public service. She was previously the Director of Standards & Regulations and Director of Pharmaceutical Services in the Ministry.

As Permanent Secretary, she played a role in the establishment of the National Health Fund, developed strategies for, and led the implementation of, the abolition of user fees for minors 2007 and the abolition of user fees island-wide in 2008. As Director of Pharmaceutical services she was a principal architect of the Jamaica Drugs for the Elderly Programme established in 1997 that benefits over 200,000 persons.

In the two years prior to retirement, she led the transformation of the public health sector including the restructuring of the Ministry of Health. In 2006, the Ministry partnered with Dalhousie University's WHO/PAHO Collaborating Centre on Health Workforce Planning and Research, the Brazil Ministry of Health, the Pan American Health Organisation, and Health Canada to undertake a project on needs-based health workforce planning. She noted the early findings that identified the need for a Centre of Excellence this area and advanced the Ministry's proposal which led to the country being designated the Caribbean Centre of Excellence for Health Workforce Planning and Research in 2009.

Dr. Allen Young has served on several Expert/Advisory Panels of the World Health Organization (WHO) and Pan American Health Organization (PAHO) and was a member of the Core Expert Group working on WHO Policy Recommendations and Guidelines on Increasing access to health workers in remote and rural areas through retention.

She holds the Doctor of Pharmacy, University of Derby (England), M.Sc. (Government), University of the West Indies (UWI, Mona), Post Graduate Diploma in Clinical Pharmacy, Queen's University of Belfast (Northern Ireland), B.Sc. in Management Studies (UWI, Mona), Bachelor of Pharmacy, Bath University (England) and Pharmacy Diploma - College of Arts Science & Technology (now University of Technology - UTECH, Jamaica). She has pursued professional development courses in International Health Leadership at the Judge Institute, Cambridge University (England), Leadership and Development at the Kennedy School of Government, Harvard University and Decentralization of Health Services and Public Private Partnerships at the Harvard School of Public Health (USA).

The first Caribbean national and woman to be President of the Commonwealth Pharmacists Association (CPA) 2003-2007, she was also the first female President of the Caribbean Association of Pharmacists having been a President of the Pharmaceutical Society of Jamaica.

Her community service in Jamaica is through boards of non-governmental organisations boards, as a Justice of the Peace (Kingston), and an accredited local preacher in the Methodist Church.

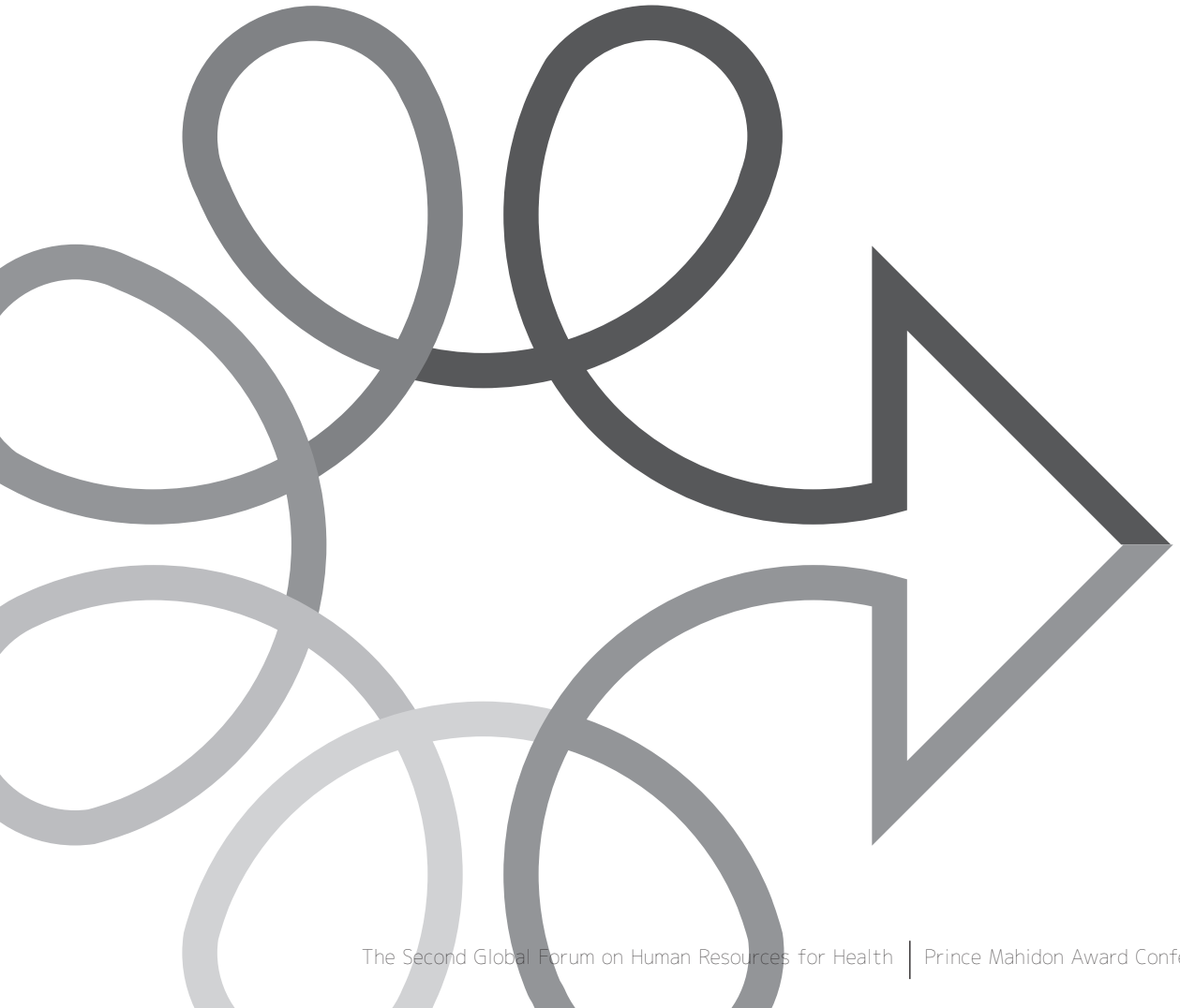
She lectures part-time at UTECH in the Bachelor of Pharmacy and Doctor of Pharmacy (PharmD) Programmes and provides advisory services as a Specialist in Healthcare Management and Pharmaceutical Services.

(493 words)

November, 30 2010

PARALLEL SESSION 3 :

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



MANUEL M. DAYRIT

DIRECTOR, DEPARTMENT OF HUMAN RESOURCES FOR HEALTH
WORLD HEALTH ORGANIZATION
SWITZERLAND

Manuel M. Dayrit was Secretary of Health (Minister) of the Philippines from 2001 to 2005. Under his guidance, national coverage of social insurance doubled from 30 to 60%, lower priced generic medicines became more widely available through the government supply chain, the national TB control program achieved its global targets, and SARS was contained to 14 cases during the SARS epidemic of 2003. He led 2 national immunization campaigns to stop the spread of the vaccine-derived polio virus, immunizing 12 million children in each round. During his term, the Department of Health was highly regarded by the public and the media for its measures to fight corruption. Dr. Dayrit gained wide recognition for his transparency and leadership as evidenced by high approval ratings in public opinion surveys and citations from private sector and non-governmental stakeholders. This is a legacy which his successors have successfully continued.

Dr. Dayrit began his public health career 33 years ago. Working with his wife Elvira as community physicians in the villages of Davao del Norte, Mindanao during the martial law period, he trained community health workers, organized community-based TB programs and coordinated a Church-affiliated program across the different dioceses of the Catholic Church in Mindanao in Southern Philippines. During this time, he also taught medical students at the Davao Medical School. Established in 1977, the school sought to educate doctors for the Mindanao region. In 1980, Dr. Dayrit became a founding member of the Asian Community Health Action Network (ACHAN) which sought to promote community-based health action in Asia.

Dr. Dayrit joined the Department of Health in 1984 as a research epidemiologist. He was the founding director of the Philippine Field Epidemiology Training Program in 1986 and directed it till 1997. For his work in AIDS, cholera, and red tide, he was named Outstanding Young Scientist by the National Academy of Science and Technology of the Philippines in 1990.

Dr. Dayrit's private sector experience includes working as Vice-President for Health Services of Aetna HMO in Manila, a subsidiary of the multinational insurance firm. He also worked for a Filipino-owned pharmaceutical company United Laboratories Inc. setting up the Office of Regulatory Affairs and a subsidiary company HMO to service its employees.

A Bachelor of Arts honors graduate of the Ateneo de Manila University, Dr. Dayrit earned his Doctor of Medicine degree from the University of the Philippines in 1976. In 1981-82, he was awarded a British Council Scholarship to the London School of Hygiene and Tropical Medicine (LSHTM) where he completed a Master of Science in Community Health with a mark of distinction. In 2006, in recognition of his service in public health to millions of his countrymen, Dr. Dayrit was made an Honorary Fellow of LSHTM.

Dr. Dayrit joined the World Health Organization in August 2005 and has since been involved in working closely with partners on global health workforce issues. He is Director of the Department of Human Resources for Health in WHO/HQ which has tackled global HRH issues including: a code on international recruitment for health personnel, retention guidelines, and scaling up of education for health workers particularly in countries with critical shortages of health workers.

MIHÁLY KÖKÉNY

CHAIRMAN OF THE EXECUTIVE BOARD
WORLD HEALTH ORGANIZATION
HUNGARY

Mihály KÖKÉNY, M.D., former M.P. (1950), Hungarian, trained for medicine, cardiology and political sciences, Member of the Hungarian Parliament between 1994 and 2010. Served in various political positions including health and welfare minister (1996-1998, 2003 -2004), government commissioner for public health coordination (2004-2006), chairman of the health committee of the Hungarian Parliament (1998-2002, 2006-2010). Dr. Kökény elaborated the first national public health programme in Hungary in 1987 as the advisor of the then deputy prime minister. As cabinet member he participated in major reform processes regarding the pension system, downsizing the hospital sector, involving private sector to health development, etc.

International activities covered broad fields of health promotion, environment and health and health care reforms as WHO, World Bank and EC consultant and speaker of major conferences. As of 2008 he was elected to be the member, later the chairman of the Executive Board of WHO until May 2011.

Address: 1037 Budapest, Folyondár u.5
E-mail: mkok@t-online.hu, mihaly.kokeny99@gmail.com

BJØRN-INGE LARSEN

DIRECTOR -GENERAL OF HEALTH
CHIEF MEDICAL OFFICER OF NORWAY
THE NORWEGIAN DIRECTORATE OF HEALTH
NORWAY

Dr. Bjørn-Inge Larsen is a graduate of the University of Oslo Medical School and University of California, Berkeley. He did his residency training in internal medicine, surgery and primary care in Harstad, before serving as a Lieutenant and physician in the Airborne Special Forces of the Norwegian Army. He then worked as a physician in the Department for Preventive Medicine in the Norwegian Board of Health. This was followed by a period as Deputy County Medical Officer in Buskerud. In 1994, he became Chief County Medical Officer of Finnmark, the northernmost county of Norway. After a period of three years, he moved south and became Chief County Medical Officer of Vestfold. Here, he served another four years, which was followed by a short period as Deputy Director-General of the Norwegian Board of Health. In 2001 he was appointed Director-General of the Norwegian Directorate of Health and Chief Medical Officer of Norway. Dr. Larsen is currently Chair of the National Advisory Board on Quality and Priorities in the Health Sector, Chair of the Norwegian Council on Health Preparedness, Chair of the Norwegian Pandemic Flu Committee, Chair of the National Campaign for Patient Safety, and member of the Norwegian Health Library Board and the Norwegian Preparedness Board.

Dr. Larsen has been engaged in and committed to global and regional health issues over the last decade. He has been a Norwegian Delegate to the World Health Assembly and the Regional Committee for Europe since 2002. He became a member of the Standing Committee for the Regional Committee in 2006, becoming Vice-Chair in 2007 and Chair from 2008 to 2009. In 2010 he became a member of the Executive Board of the World Health Organization. As a consequence, Dr. Larsen has extensive experience of global and regional health governance institutions.

Dr. Larsen is interested in a broad range of global health issues. He has paid particular attention to the health workforce crisis. Here, he has initiated projects in Norway, paying attention to developed countries' responsibilities towards developing countries, and in WHO and WHO EURO, where he played a significant role in the adoption of the WHO global code on international recruitment of health personnel at the 63rd World Health Assembly in 2010. Dr. Larsen has also been active in promoting the importance of tackling non-communicable diseases, particularly in regards to reducing the marketing of unhealthy foods and beverages to children. He is also concerned with health system strengthening, and the potential negative effects of the current financial crisis on health systems and health outcomes. One constant

in Dr. Larsen's engagement in global health, and one which he intends to carry into his future work in the Executive Board, is his concerns for equity - between and within countries. He is particularly mindful of the needs of developing countries, and the urgency that is required in order to improve health outcomes in these countries.

PERCY MAHLATHI

DEPUTY DIRECTOR GENERAL
MINISTRY OF HEALTH
SOUTH AFRICA

Dr Percy Mahlathi was born in Mount Frere, Eastern Cape, Republic of South Africa and received his tertiary education received at University of KwaZulu-Natal, University of Stellenbosch and University of Fort Hare. He holds the following degrees: Bachelor of Medicine & Surgery (KwaZulu-Natal); Master of Philosophy (Value Analysis & Policy Formulation) (Stellenbosch) and PhD (Development Studies) (Fort Hare). He also holds a certificate in Advanced Management Programme (Foundation for Professional Development/Manchester Business School).

He currently occupies the post of Deputy Director-General: National Department of Health, South Africa. This post is one of the second most senior administrative positions in the Ministry of Health and exists within the South African Public Service and denotes Deputy Head of a Government Department. In this position he is responsible for health workforce policy development and coordination including interaction with institutions of higher education (universities and colleges) across the country. He is also responsible for international relations on health workforce matters impacting on the department. His portfolio includes the following subdivisions: HR Policy, Research and Planning; Health Sector Labour Relations and HR Development and Management.

He has experience gained from being an activist in the health field during apartheid days as a member of the National Medical and Dental Association (NAMDA). He played a key role in the formation of the South African Medical Association later becoming its Chief Executive before joining the National Department of Health. Percy has been a member of several national committees that addressed several key policy issues affecting health and health sciences education and training the recent one being the Health Sciences Education Review Committee of the Department of Higher Education and Training, South Africa.

At a regional level he is actively assisting the SADC Health Desk's Human Resources for Health Technical Committee on several issues. At an international level he played an active role as a member of the Health Worker Migration Global Policy Advisory Council of the World Health Organisation which drafted the Code of Practice. He was also a member of WHO's Core Expert Group on Health Worker Retention in Remote and Rural Areas which developed guidelines in this area. He was an active member of the World Medical Association's Socio-Medical Affairs during his stint as the Chief Executive Officer of SAMA.

As the human resource policy head Percy has spearheaded a number of actions and policies that are of critical importance to the health sector especially in the areas of nursing, health sciences education and training, remuneration of health professionals, recruitment and employment of foreign health professionals etc. He has addressed a number of conferences and workshops on workforce and health leadership issues.

COLIN MCIFF

HEALTH ATTACHE
U.S. MISSION GENEVA
UNITED STATES

Colin McIff currently serves as the Health Attaché at the U.S. Mission in Geneva. From April 2010 to August 2010 Mr. McIff was the Acting Director for Multilateral Affairs at the Office of Global Health Affairs at the U.S. Department of Health and Human Services, leading U.S. negotiations on the Code of Practice on the International Recruitment of Health Personnel adopted by consensus at the 63rd World Health Assembly. From November 2004 to April 2010, Mr. McIff served as Multilateral Organizations Officer for the President's Emergency Plan for AIDS Relief (PEPFAR) at the Office of the U.S. Global AIDS Coordinator. While with PEPFAR, Mr. McIff led coordination efforts with multilateral organization partners such as the Joint UN Program on HIV/AIDS (UNAIDS), UN Office of Drugs and Crime (UNODC), and UN Children's Fund (UNICEF). Prior to joining PEPFAR, Mr. McIff served with the Bureau of Oceans, International Environmental and Scientific Affairs and the Office of Japan Affairs at the U.S. Department of State and with the U.S. Agency for International Development. Throughout his State Department career, Mr. McIff covered a wide range of multilateral organizations and their issues such as the UN General Assembly, UN Food and Agriculture Organization, and Convention on International Trade in Endangered Species. Mr. McIff received his Bachelor of Arts in History and East Asian Studies from the University of Arizona (1994) and his Master of Pacific International Affairs from the University of California San Diego (1998).

FRANCIS GERVASE OMASWA

CHAIRMAN
HEALTH WORKER MIGRATION GLOBAL POLICY ADVISORY COUNCIL
UGANDA

Professor Francis Omaswa is the Executive Director of the African Centre for Global Health and Social Transformation (CHEST), an initiative incorporated in Uganda and promoted by a network of African and International leaders in health and development. It is an independent "Think Tank and Network" that works stimulate the growth of African rooted capacity for leadership and excellence in health and to make Africa a stronger player in international health.

Until May 2008, he was Special Adviser to the WHO Director General and founding Executive Director of the Global Health Workforce Alliance (GHWA) a partnership that is dedicated to identifying and providing solutions to the global health workforce crisis. This work culminated in the first ever global forum on human resources for health, organized by Professor Omaswa and adopted the "Kampala Declaration and Agenda for Global Action" that now guides the global response on health workforce development.

Between 1999 – 2005, he was the Director General of Health Services in the Ministry of Health in Uganda during which time he was responsible for coordinating and implementing major reforms in the health sector in Uganda which included the introduction of the Swaps, quality assurance and decentralization. He has a keen interest in cost-effective approaches for increasing access of the poor to quality health care and spent five years at the remote Ngora mission hospital testing various models and innovations for this between 1982 and 1987.

His academic career includes serving as Head of Cardiothoracic Surgery at the University of Nairobi and Kenyatta National Hospital in Kenya and founding Director of the Uganda Heart Institute and Associate Professor of Surgery at Makerere University, Kampala Uganda. He has also taught at Liverpool University in England. He is the founding President of the College of Surgeons of East, Central and Southern Africa whose head office is in Arusha, Tanzania. He has published in the areas of surgery, infectious diseases, and health system reform and health services management including human resources for health. He is the lead editor of the Manual for Quality Assurance of Health Care and has contributed to chapters in other books. His current research interests are in Leadership Capacity of Ministers and Ministries of Health, Health Systems Governance, Capacity Needs of African Medical Schools and Health Worker migration, retention and distribution.

In the community, he has served on many boards in schools and universities, civil society, the private sector and parastatals in several cases as the Chair of these boards. For this, he has received multiple meritorious awards and in his home town of Soroti, a street has been named after him.

At the global level is the current chair of the GAVI Independent Review Committee, Senior Advisor to the Ministerial Leadership Initiative for Global Health, Co Chair of the Health Worker Migration Policy Council and the Sub-Saharan African Medical Schools Study. He has also served as founding Chair of the Global Stop TB Partnership, Chair of the Portfolio and Procurement Committee of the Global Fund Board. He was a member of the steering committee of the High Level Forum on health-related MDGs. At the African level, he has served on many committees and expert panels: he was the lead consultant who developed the African Union HIV Policy, was on a panel of experts who developed guidelines for monitoring of implementation of the African Union Abuja Declaration on HIV, a member of WHO Afro Task Force on Poverty and Health He has served as an adviser to governments on health policy and strategy in developing and developed countries and has access to a wide network of contacts in international health.

Professor Omaswa is a graduate of Makerere Medical School, Kampala, Uganda, a Fellow of the Royal College of Surgeons of Edinburgh, founding President of the College of Surgeons of East, Central and Southern Africa and is a Senior Associate at the Johns Hopkins Bloomberg School of Public Health. He has several qualifications in health services management and medical education.

PATRICIA A. STO. TOMAS

CHAIR OF BOARD DBP
SECRETARY OF LABOR AND EMPLOYMENT
PHILIPPINES

Ms. Patricia A. Sto. Tomas is a proven leader in the areas of public administration and governance, human resource development and management, organizational development, development communication, employment and migration, built on more than three decades of solid work in the bureaucracy and academe.

Ms. Sto. Tomas is the former Chairman of the Board of the Development Bank of the Philippines (DBP) from July 2006 to August 2010. She's also the secretary of the Department of Labor and Employment from February 2001 to June 2006. During her stint as Labor Chief, she reoriented the department toward achieving its core mandates of employment facilitation, enhancement and promotion of industrial peace, workers' welfare and protection, and commitment to prompt and adequate service delivery.

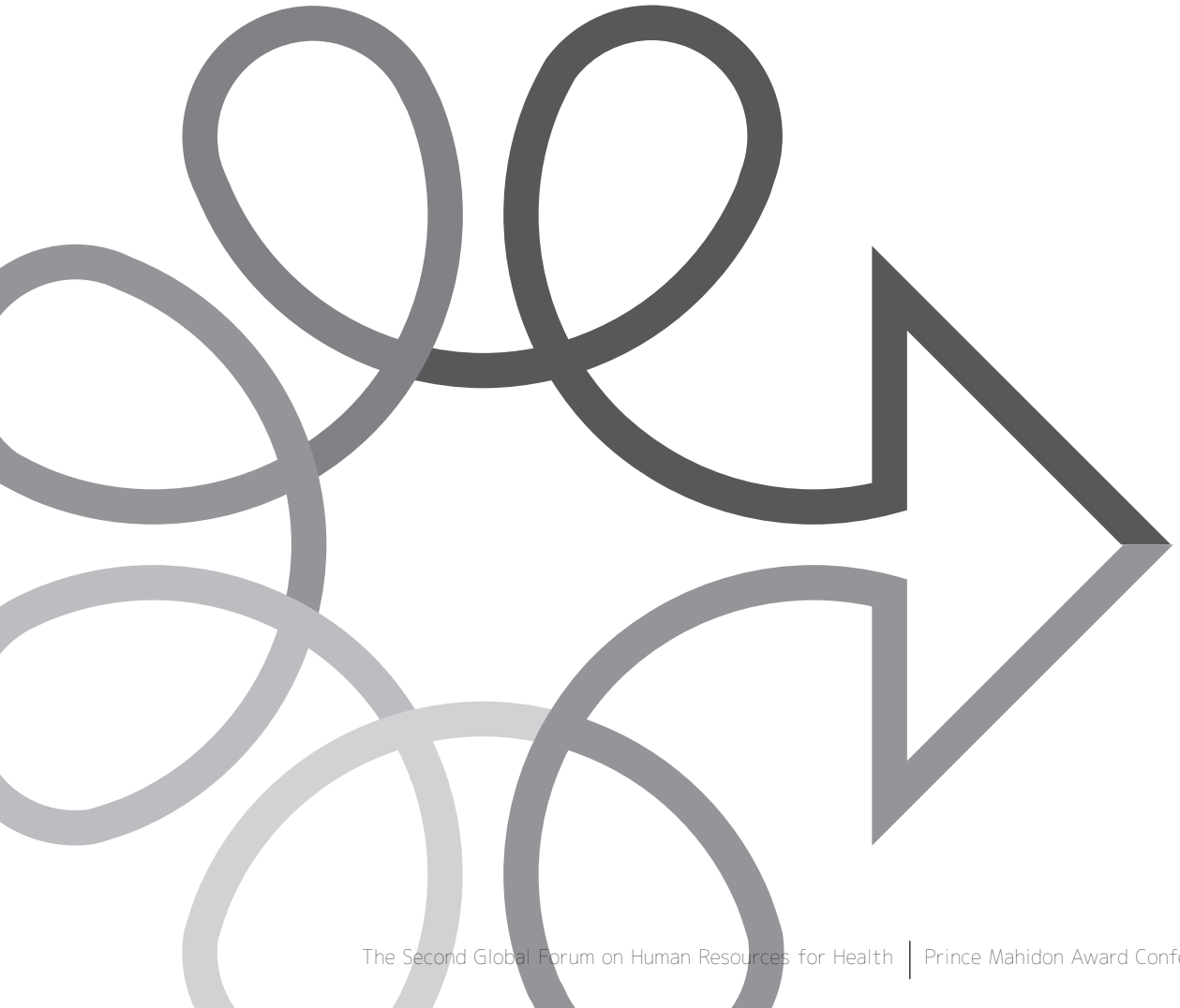
From 1988 to 1995, she chaired the Civil Service Commission, where she initiated reforms to improve the quality of public service, public accountability and discipline. She also pursued advocacy for equality in opportunities for female employees, as well as merit and fitness principles in employee entry and selection for government posts.

Ms. Sto. Tomas was the first head of the Philippine Overseas Employment Administration (POEA) when it was established in 1982. She also served as Undersecretary of the Department of Labor and Employment (DOLE), Assistant Secretary of the Department of Education (DepEd), Executive Director of the National Wages Commission (NWC) and Executive Director of the Institute for Labor and Manpower Studies (ILMS). She also served at the Girl Scouts of the Philippines (GSP), the Board of Investment (BOI), the University of the Philippines Los Baños (UPLB), the University of the Philippines National College of Public Administration and Governance (UP NCPAG) and the Ateneo Graduate School of Governance.

She has earned numerous citations for her distinguished career in the public sector. She was conferred of Presidential Award as Order of Lakandula, Rank of Bayani by the Office of the President on March 2010. She was named Outstanding Woman in Government Service by the National Council of Women of the Philippines in 2002, and was a Ten Outstanding Women in the Nation's Service (TOWNS) awardee for public administration in 1982.

PARALLEL SESSION 4 :

Do GHIs contribute to equity in access to HRH?



How dose China conducted the universal hepatitis B vaccination project under GAVI support in the context of financial shortage to achieve the equity of vaccination and strength the human resources?

Fuqiang Cui, China CDC

China received GAVI support in 2001 because of (1) high prevalence of hepatitis B in face of lower of hepatitis B vaccine coverage in western areas and central national poverty counties (Where economic status was poor); (2) GDP per capita < $1000 in the country with a Government unable to afford universal free vaccination ; (3) strong Governement will to protect infants at risk. Hepatitis B is a severe disease transmitted through blood exposure, birth and sexual contacts.

China/GAVI project was implemented since 2002, the 76 million USD project was funded 50% by GAVI and 50% by the Government of China. The purpose of the project was to (a) increase coverage of hepatitis B vaccine through a pro-poor approach targeting all counties of the 12 Western provinces and poverty counties of the 10 Central provinces, (b) accelerate integration of hepatitis B vaccine into routine immunization, and (c) assure immunization injection safety. The central and sub-national levels shared a common responsibility and clarified each other functions. The Ministry of Education, the State Food and Drug Administration (SFDA), the Ministry of Finance, the National Committee of Development and Reform were also involved.

Initially, GAVI only procured vaccine and injection equipment. However, this was identified as a bottleneck for implementation. Hence, from 2007 onwards, GAVI China savings were assigned to support operational cost in low performing areas with flexibility given for expenditure so that human resources could also be covered. After 8 years of implementation, 193,000 health care workers in 118,316 health care facilities participated the project, mostly at the township hospitals level (55,051) and in community centres (104547). In each county of the western region, as a result of Government co-investment human resources increased from 29 in 2002 to 66 in 2009. Today, all project counties use auto-disable syringes. Hepatitis B vaccine coverage increased from 56% in 2002 to 95% in 2009. The HBsAg prevalence declined from 9.67% in 1992 to 0.96% in 2006 among children under 5 years of age. Eighty million of infection and 19 million of carriers have been averted since 1992 because hepatitis B vaccination in China.
Lessons learned from the China GAVI project include:

(1) Global cooperation allowed leveraging government's investment. Hence, national government invested much more than promised and local government provided co-funding for implementation. The government's investment was 50% in 2002, 55% in 2005 and 100% in 2008 for hepatitis B vaccination.

(2) Inequities were reduced across gender and regions because of free vaccination. Universal health care initiative to all infants has been achieved.

(3) Health system has been strengthened, through health care workers assigned and trained, who will be available as future resource.

RUAIRÍ BRUGHA

CHAIR OF DEPARTMENT OF EPIDEMIOLOGY AND PUBLIC HEALTH MEDICINE
ROYAL COLLEGE OF SURGEONS
IRELAND

Ruairí Brugha is a medical doctor, public health specialist and Professor and Head of the Department of Epidemiology and Public Health Medicine at the Royal College of Surgeons in Ireland (RCSI). He has 25 years experience in international and national health policy and systems research. This has included six years in Africa in the 1980s and 1990s as a clinician, public health specialist and researcher at the district level in Ghana and Zimbabwe. He later spent ten years at the London School of Hygiene and Tropical Medicine (LSHTM), where he was Head of the Health Policy Unit 2003-05 and co-editor of Health Policy and Planning. He has an Honorary Professorship at LSHTM. He has been Principle Investigator on several six and seven figure research grants from the European Union, Wellcome Trust, bilateral donor agencies and Irish health services research funders, over the last 10 years and has published extensively in journals, reports and policy briefs.

His research interest is primarily in health policy and systems research in Africa, where is coordinating two multi-country research networks: The Global HIV Initiative Research Network (GHIN - www.ghinet.org) and Connecting Health Research Africa Ireland Consortium (CHRAIC - http://www.chraic.org/). Through GHIN he has collaborated with other research networks and in other research initiatives, such as the WHO Maximizing Positive Synergies. Research on human resources for health, mainly in Africa, has been a main theme in GHIN and CHRAIC. At the Second Global Forum in Bangkok, he will present GHIN findings on the effects of Global Health Initiatives on staff distribution and workload in Zambia and Malawi.

In 2010, he completed a study on foreign (non-EU) nurse migration to Ireland and in 2011 started a similar study on foreign doctors working in Ireland. He was a member of the Health Worker Migration Global Policy Advisory Council that drafted the global code of practice on health worker migration. His research approach spans quantitative research methods (epidemiological study design), qualitative research (especially for policy analysis) and mixed methods studies.

In March 2011, he is starting a 5 year randomised controlled trial which will evaluate the impact and cost-effectiveness of surgical training of clinical officers in Malawi and Zambia, working with country partners and the College of Surgeons of East, Central and Southern Africa (COSECSA). This represents a revisiting of his roots, as he worked as a medical officer doing major surgery at the district hospital level for six years from the early 1980s to the early 1990s. He believes that surgically trained non physician clinicians (clinical officers) could become the cornerstone of African countries' health systems, if this cadre can be given the training and a retention package to keep them working productively at the district hospital level.

FUQIANG CUI

DIRECTOR OF HEPATITIS DIVISION
MINISTRY OF HEALTH
CHINA

Dr Cui Fuqiang, MD, MPH, Director of Hepatitis Division, National Immunization Program, Chinese Center for Disease Control and Prevention, Member of Experts committee of Chinese Foundation for Hepatitis B Prevention and Control. He is also a secretary of National Advisory Committee on Immunization Practice in China.

Dr Cui has been worked in epidemiology field for 15 years in China, during past years, he involved the response to SARS outbreak in 2003, led a national serosurvey of hepatitis B in 2006, managed a measles outbreak in Tibet in 2006, investigated a cluster of deaths following vaccination in 2008, participated the vaccination campaign of H1N1 vaccine in 2009, and measles supplement immunization activities in 2010.

As the national project manager of China/Global Alliance on Vaccine and Immunization (GAVI), he manages the project in collaboration with an international co-manager. As part of these activities, he conducted the midterm review and developed the protocol for management. Result from the serosurvey he conducted provided evidence for the Ministry to strengthen hepatitis B control in China. And the GAVI project he runs has set an example in developing country to prevent the hepatitis B virus infection through improving universal infant hepatitis B vaccination programme. Furthermore, he contributed substantially to eliminate discrimination against hepatitis B carriers in China. As a result of his work, a national regulation to protect HBsAg carriers was issued last year by three Ministries.

Dr Cui attended many conferences organized by WHO, UNICEF, GAVI, and other international partners, and contributed the public health policy making process. He published 40 papers in the last 5 years.

MARY ANN D. LANSANG

DIRECTOR OF KNOWLEDGE MANAGEMENT UNIT

THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA
SWITZERLAND

Dr Mary Ann Lansang is Director of the Knowledge Management Unit at the Global Fund to Fight AIDS, Tuberculosis and Malaria. Her work at the Global Fund involves her engagement in a range of technical issues including health systems strengthening. She is currently an alternate board member of the Global Health Workforce Alliance, representing the Global Fund. Prior to joining the Global Fund in 2008, Dr Lansang was a Professor of Medicine (Infectious Diseases) and Clinical Epidemiology at the University of the Philippines. She was also the Executive Director of the International Clinical Epidemiology Network from 2000-2004. She was involved in health research covering a broad range of issues including health policy and systems research, tropical diseases and vaccine research. Her work spans many aspects of disease control, prevention and care--most notably tuberculosis, malaria, vaccine-preventable diseases, and other tropical and infectious diseases. She was co-editor of the fifth edition of the Oxford Textbook of Public Health, which was released last year.

MASATO MUGITANI

CHAIR-ELECT GLOBAL HEALTH WORKFORCE ALLIANCE AND ASSISTANT MINISTER FOR GLOBAL HEALTH MINISTRY OF HEALTH LABOUR AND WELFARE JAPAN

Dr Masato MUGITANI, Assistant Minister for Global Health, Ministry of Health, Labour and Welfare, Japan, is currently a Board Member for the Global Health Workforce Alliance. Dr Mugitani is a medical doctor with professional and profound engagement in the global health, pandemic Influenza response, cancer policies, medical system and public health policies at global, regional and national level.

Dr Mugitani has demonstrated strong and committed leadership in global health, including Chair of the Committee A at the 63rd World Health Assembly in 2010, Chair of the 2010 APEC Health Working Group (1st and 2nd meeting), and Vice-chair of the Open-Ended working group of Member States on Pandemic Influenza Preparedness from 2010. He has also been serving as a board member of the International Agency for Research on Cancer (IARC) and a senior official member of Global Health Security Action Group (GHSAG).

He has been keenly interested in Health System Strengthening with special emphasis on Health Workforces, demonstrating his capacity to liaise with global health partners and achieve consensus on difficult public health issues through his strong public speaking and health diplomacy skills. He has an excellent management ability and strategic visions to ensure effective functioning and performance-focused decision making to find solutions to health workforce crises.

DAVID SANDERS

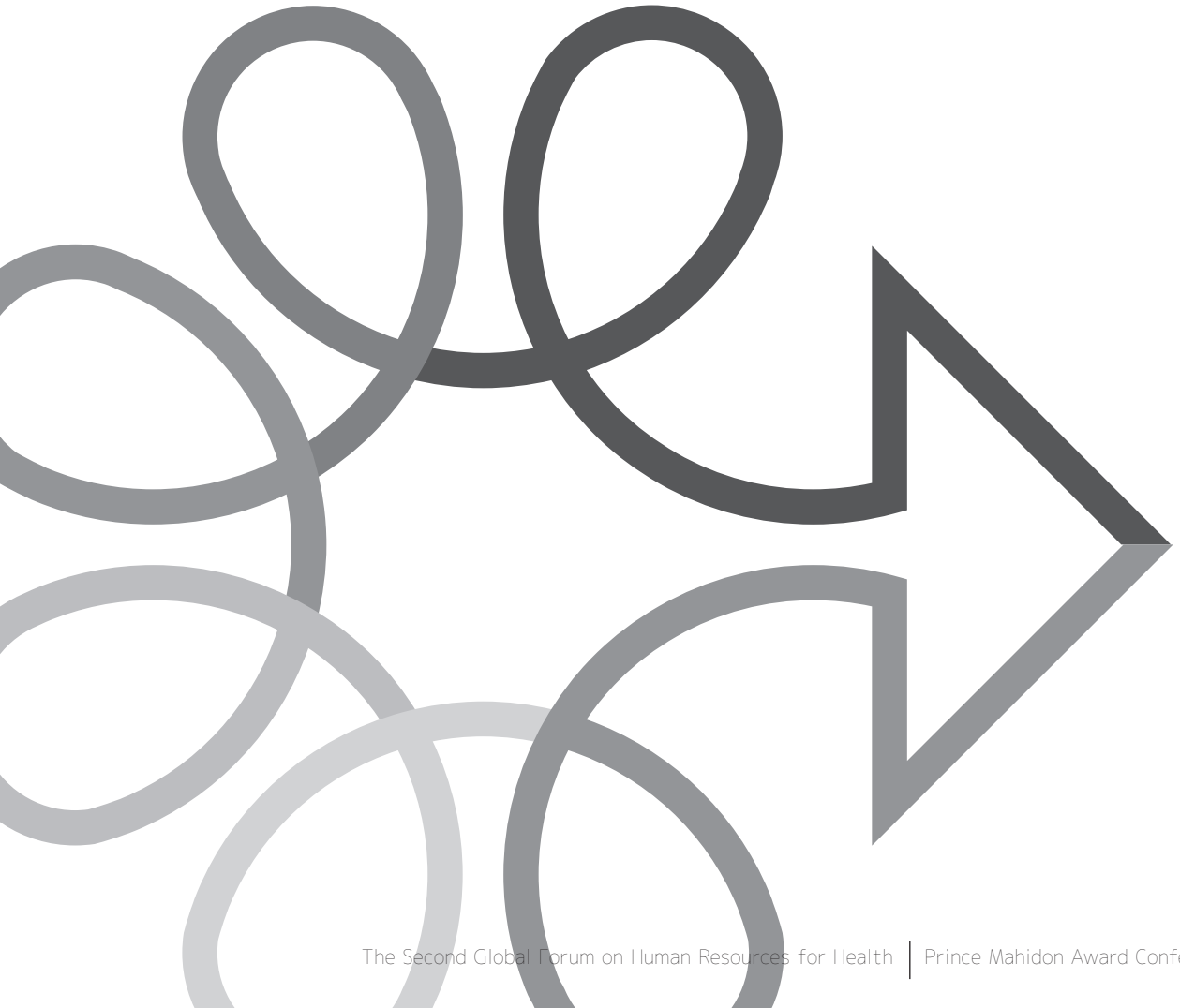
DIRECTOR OF SCHOOL OF PUBLIC HEALTH
UNIVERSITY OF THE WESTERN CAPE
SOUTH AFRICA

David Sanders, Professor and founding Director of the School of Public Health at the University of the Western Cape, (U.W.C.), South Africa, is a specialist paediatrician with postgraduate qualifications in Public Health. He has almost 30 years experience of health policy and program development in Zimbabwe and South Africa, having advised both governments as well as OXFAM,WHO,UNICEF and FAO in the areas of primary health care, child health and nutrition, and health human resources as part of health systems development. He has published extensively in these fields as well as on the political economy of health, including on structural adjustment and development aid, having authored or co-authored three books: "The Struggle for Health: Medicine and the Politics of Underdevelopment", "Questioning the Solution: the Politics of Primary Health Care and Child Survival" and "Fatal Indifference: the G8, Africa and Global Health", as well as over 30 chapters and monographs and approximately 100 articles in peer-reviewed journals. In 2004/5 he was Heath Clark visiting lecturer at the London School of Hygiene and Tropical Medicine where he was also an Honorary Professor. He is also an Adjunct Professor at the Centre for International Health at the University of Bergen, and was a Visiting Fellow at the Globalization/Management Department, Institute of Population Health, University of Ottawa, Canada in 2005.

He was on the Steering Committee of the United Nations Standing Committee on Nutrition from 2002 – 2006 and was actively involved in the Joint Learning Initiative on Human Resources for Health. He is on the editorial boards of and is a reviewer for several international journals. He was a member of the Knowledge Network of the WHO Commission on Social Determinants of Health. He is on the Global Steering Council of the Peoples Health Movement and was a managing editor of the recently published Global Health Watch 2. He is recipient of the Nutrition Society of South Africa award in 2002

PARALLEL SESSION 5 :

Economic fluctuations, universal health coverage and the health workforce



HANNES DANILOV

CHAIRMAN OF THE MANAGEMENT BOARD
ESTONIAN HEALTH INSURANCE FUND
ESTONIA

I have been working as a chairman of the management board of Estonian Health Insurance Fund since 2002.

Estonian Health Insurance Fund is an independent legal entity and acts as a single purchaser of health care services for Estonian population. Coverage with health insurance is 95% in Estonia, children up to age 19 and retired people are equalized with insured people.

Fund doesn´t cover health care expenditures of long term unemployed people, this is obligation of local municipalities. Health Insurance Fund finances 2/3 of total health expenditures of Estonian population.

Prior to the present position I used to be a general secretary of the Estonian Ministry of Social Affairs from 1999 to 2002 and governor of West–Estonian County from 1994 to 1999.

I graduated from University of Tartu in 1977 as a chemistry teacher and have taught almost 20 years in several high schools.

Additionally I finished Estonian Business School in 1990 and obtained diploma in business administration.

I have attended several advanced professional trainings at World Bank, at Harvard University in USA and at Dalhousie University in Canada.

I am married, my wife Ingrid is a principal of West-Estonian Occupational Education Centre. We have three children - two daughters, a son and four grandchildren.

My hobby is sailing at summertime and skiing at wintertime.
I am 56 years old.

DAVID EVANS

DIRECTOR OF THE DEPARTMENT OF HEALTH SYSTEMS FINANCING
WORLD HEALTH ORGANIZATION
SWITZERLAND

David Evans is Director of the Department of Health Systems Financing in the Cluster on Health Systems and Services at the World Health Organization. He has a PhD in economics and worked as an academic in Australia and Singapore before joining WHO in 1990, initially working on social and economic aspects of tropical disease transmission and control. Subsequently his work has covered a variety of areas including the assessment of health system performance and the generation, analysis and application of evidence for health policy. This work now focuses specifically on the development of effective, efficient and equitable health financing systems. He has published widely in these areas.

SUPON LIMWATTANANON
ASSOCIATE PROFESSOR
KHON KAEN UNIVERSITY
THAILAND

Supon Limwattananon is an Associate Professor at Khon Kaen University. He is also a part-time senior researcher at the Ministry of Public Health International Health Policy Program (IHPP), Thailand. He earned Bachelor of Pharmacy from Chulalongkorn University in 1982, Master in Primary Health Care Management from ASEAN Institute for Health Development in 1991, and Doctor of Philosophy in Social and Administrative Pharmacy from University of Minnesota in 2000. He was a Fulbright Scholar during 1993-1996 and received the US Health Care Financing Administration Dissertation Award in 2000. In 2008, he was seconded to the World Bank head office in Washington, DC as a Senior Health Specialist in the Human Development Network. His expertise is in the areas of health economics and micro-econometrics.

ANN PHOYA
HEAD OF THE SWAP SECRETARIAT
MINISTRY OF HEALTH
MALAWI

1. Professional Preparation

1: BSc: Registered Public Health Nurse Midwife: Medical University of Southern Africa, Pretoria South Africa, 1983
2: MSc: Family Community Health with a Role in Nursing Education : Howard University, Washington D.C., USA, 1986
3: PhD: Health Policy and Strategic Planning with a Clinical and Research Role in Maternal and Infant Health: Catholic University of America, Washington D.C, 1993

2.Work Experience

1. Current Responsibilities

• Director & Member of Senior Management team of the Ministry of Health responsible for coordinating implementation of Sector Wide Approach (SWAP) for the health sector;
• Acting Head of Planning and Policy Development responsible for Development and monitoring f national health plans, policies and guidelines and the health budget.
• : Adjunct Faculty Dept of Maternal and Child health; University of Malawi, Kamuzu College of Nursing (Master of Midwifery Program);
• Chair: Malawi Partners Forum for HIV & AIDS responsible for guiding implementation of the National Response to HIV and AIDs
• Deputy Chair, board of Partners in Hope Medical Center

2. 3. Other Positions held

• FulBright Scholar in Residence : 2009: Winston-Salem State University, North Carolina, USA: Associate Professor maternal and Child health & Community Health Nursing,
• Director of Nursing Services/Chief Nursing Officer, Ministry of Health, 2003- 2005
• Head Of planning (2002): Ministry of health
• Program Manager (1999-2001) World Bank funder population & Family Planning Project, Ministry of Health
• Program Manager: UNFPA funded Safe Mother project (1995-1980, Ministry of Health
• Community Health Nursing & Research officer, Ministry of health
• Lecturer, Community Health, Malawi college of health Sciences
• Head Nurse, Kamuzu central Hospital

Research Interest:

HIV/AIDS, Maternal heath and Quality of care

Civil Status: Married to Ambassador Professor Richard Phoya; and has two children

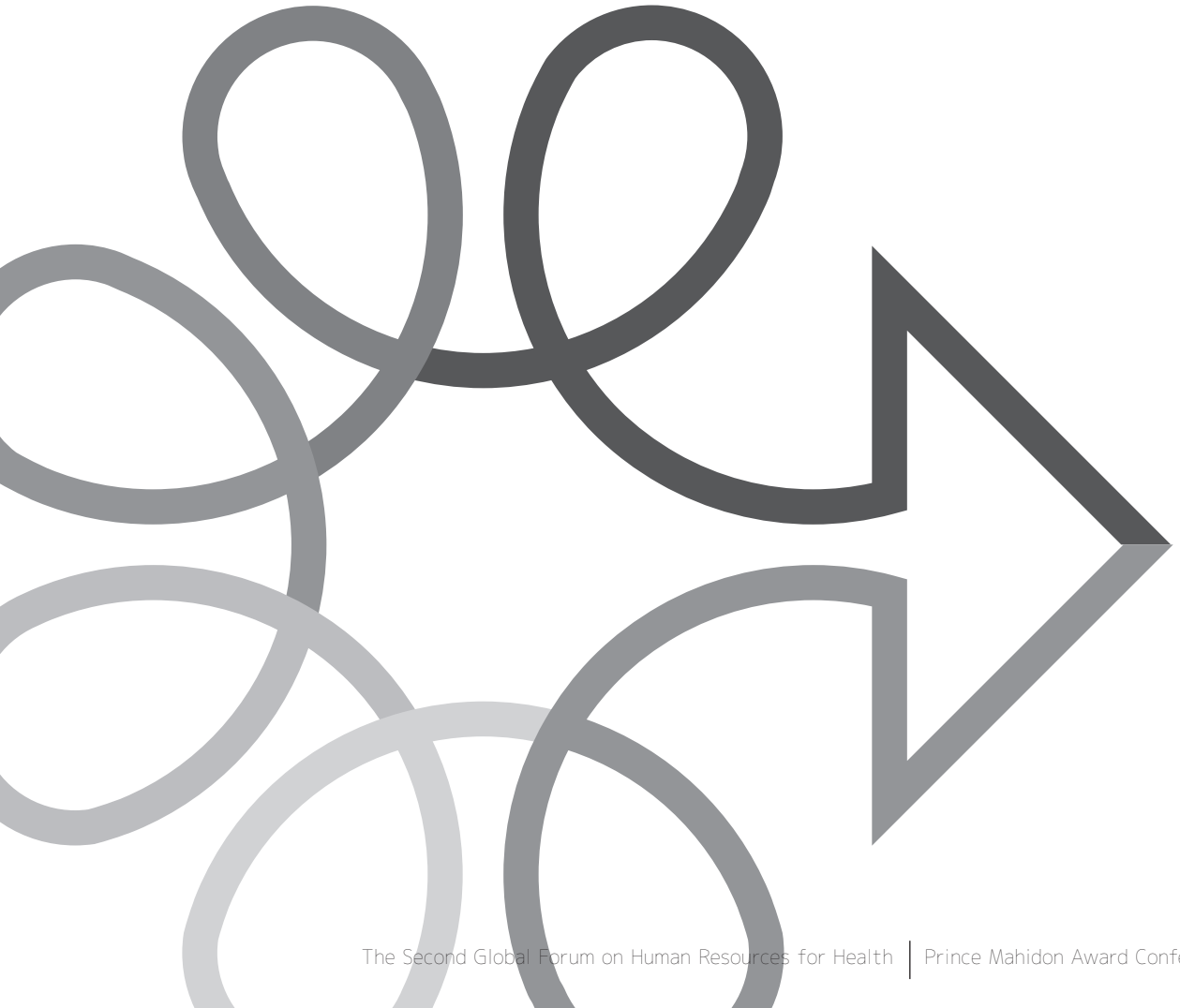
JUAN PABLO URIBE

SECTOR MANAGER
HEALTH, NUTRITION AND POPULATION
WORLD BANK
UNITED STATES

Juan Pablo Uribe, a Colombian medical doctor, joined in 2009 the East Asia and Pacific Region of the World Bank as it's Health, Nutrition and Population Manager. With master degrees in both public health and public administration, he has held various health positions in the public and private sectors, nationally and internationally. He is a former Vice Minister of Health for Colombia (1998–1999) and former National Director of Public Health (1994). He was also the CEO of one of the leading private (not for profit) health institutions in Colombia, directly involved with high complexity hospital care, medical education, health research and community health. Between 2000 and 2004 he was senior health specialist for the World Bank in the Latin America region. He has been a board member of various public and private organizations in Colombia and abroad and an invited speaker at numerous conferences.

PARALLEL SESSION 6 :

Overcoming HRH crises in conflict and post-conflict situations



Human resources development in post conflict countries: with specific reference to nursing and midwifery

Fariba Al Darazi
World Health Organization Regional office for the Eastern Mediterranean

Human resources development is a vital component of any health system, building the health system in countries during the post conflict phase of recovery is complex and requires a special attention.

This paper describes experiences from selected countries of the Eastern Mediterranean Region in human resources development with specific reference to nursing and midwifery. In some of the selected countries, the socio-economic and the political situation has had its impact on the entire infrastructure including health facilities and human resources; whereby the delivery of health care services in the country in terms of availability, accessibility, and quality is undermined.

Key issues and challenges with regard to the three components of human resources development: planning, production, and management in post conflict environments will be discussed.

The paper also presents the lessons learnt in addressing human resources development and rebuilding the health workforce in crisis situations.

Key words: Health workforce rebuilding, human resources development, post conflict.

Roles of national and international health workforces in response to an acute crisis in Haiti

Fiona M Campbell, Merlin

The impact of the disaster

In January 2010 Haiti experienced a huge earthquake of 7.0 magnitude which affected the capital, Port-au-Prince, as well as the surrounding areas of West Department and South East Jacmel in particular. Government of Haiti figures put the death toll at approximately 225,000 people with many thousands more injured or permanently disabled, and 1.5 million left homeless[1].

Responding to such acute emergency situations requires health and other personnel on the scene as soon as possible and able to function effectively with the necessary guidelines and equipment. These personnel will be a combination of those already in situ or in the vicinity and those recruited and arriving from external contexts. In these circumstances, there is need to ensure that both local and international staff are deployed in the most effective way and that any gaps in local capacity are matched with the external recruitment. This is critical both for the immediate response as well as the longer term functioning of the systems in the post- emergency context.

Following the Haiti earthquake, a massive international response was launched; the health human resource aspect of which was considerable. Large numbers of specialist doctors, nurses and other health staff were recruited, and large numbers also arrived unofficially, from a host of countries.

Six months after the earthquake, Merlin undertook a study to look at how the international response had complemented national health workforce capacity at the time of the quake and the implications for this engagement in supporting the longer term recovery and capacity of the health system.

The research assessed to what extent the international recruitment of health staff (as well as the unofficial arrival of international staff) matched the needs in the immediate term in-country and complimented the available local capacity; how this changed over time and to what extent it supported the overall functioning of the provision of health care, and the longer term post-disaster recovery and revitalisation of the health workforce.
This paper is based on the report of the study.

Before the earthquake - a health workforce already struggling.
Even before the earthquake the health system, including the health workforce, in Haiti was already challenged. The overall system was made up of a wide variety of public and private health providers working alongside each other though not necessarily coordinated, and with only loose oversight or monitoring by the Ministry of Public Health and Population (MSPP) .

At the time of the earthquake, Haiti had the lowest number of health workers per population (2.5/1000 population) and the lowest ratio of nurses to physicians (1 to 1.4) of any country of the Americas. Conditions for training and employment of health workers had also been inadequate for a long period, contributing to poor work satisfaction and a poor fit between education/training and practice. Many staff prior to January 2010 working in public facilities had not received their salary for several months.

These conditions resulted in a workforce with low motivation and morale; gaps in supplies and equipment and little or no supervision practice. There was wide application of user fees both formal and informal to supplement or replace other resources. Poor management and low motivation also contributed to a significant problem of absenteeism with many staff drawing salary without turning up for work or taking on multiple jobs and attending to their public duties infrequently.

It is unclear how big or how significant the private for profit sector was up to 2010 and it is likely that staff employed in the public sector were supplementing their earnings in this sector. The private- not-for profit sector was also a large contributor to the health system and a major employer of health professionals.

Pre-2010, coverage of health services was estimated to be approximately 40% nationally and many rural areas had very little coverage.

The national and international responses to the disaster
Merlin's research has provided an insight into both the national and international health human resource responses to the disaster and how they were inter-related.

Existing Haitian health workforce capacity was severely impacted by the earthquake with staff killed and many more losing family members, homes, colleagues and businesses[2]. Even so, the local response to the disaster was immediate. Due to the timing of the earthquake, many health workers were at home. Many provided care in their immediate

localities. Some had access to medical supplies, though these generally ran out very quickly. In the succeeding days, many health professionals with access to some equipment and supplies set up ad hoc facilities providing emergency care and trying to refer patients. The best equipped at the time were facilities run by established INGOs and some private facilities.

Many health staff worked voluntarily and unpaid for several weeks until their personal resources ran out. This included those who reported back to their usual place of employment - one INGO reported that 95% of the Ministry nurses at one hospital were back at work within one week.

The international response was essential in bringing much needed clinical expertise and human resources to tackle the overwhelming immediate needs. However for many international teams arriving in Haiti after 12 January, local health human resource capacity was not necessarily known, and there is evidence that they assumed it was negligible, making little attempt to find out what was there - at least initially. This had implications for the international response.

In many cases international medical teams moved in and set up within existing institutions without much consultation or permission or negotiation with those in charge. International organisations carried out assessments but these tended to be localised and focused on needs rather than capacities. In some cases a poor understanding of the needs also meant that there was insufficient matching of skills, for example too many surgeons in some locations meant that there was friction between incoming teams over territory and patients.

The working conditions were also a challenge and had implications for some surgical outcomes. First hand evidence from doctors working at the time (as well as evidence from doctors who treated patients at a later stage), suggests that some of the techniques used were probably not appropriate to the conditions especially given the situation into which patients were discharged post-operatively. Recognised protocols for dealing with trauma in difficult conditions and disasters were not always familiar to those who were part of the response. In addition there were concerns relating to communication with patients, particularly in the early stages of the response.

Lessons from the response - key findings with respect to human resources for health

A clear message emerging from the research is the lack of coordination by the international response with local and national structures, whether public, private or voluntary and that those entering the country to assist, while very welcome, seemed unaware of the availability of capacity and structures to link and work with, even at individual facility level.

Six months after the disaster, some Haitian respondents regretted that many skilled surgeons and other specialists had been in the country but had not used this opportunity to update the knowledge and build the technical capacity of the health staff in country

There was also concern about the effect of the influx of international agencies on the already fragile mixed health system in the country, in particular the flows of health staff out of the public and private facilities towards better paid and resourced international teams which reduced the operational capacity of the national facilities. The implementation of free- at- point- of- access health care (agreed between the MSPP, WHO and INGOs) also appeared to undermine the financial viability of existing facilities which all relied to some extent on user fees.

Overall the research indicated that the international community planned on the basis that they were arriving in a context with negligible human and other resources and there was a tendency towards over-reliance on international staff in the initial critical emergency phase of the response. One recurrent underlying theme is that there was little attention given to the fact that the disaster occurred in a capital city and a densely occupied urban zone. The reality that there would be a range of health facilities (including tertiary facilities) as well as survivors who were health professionals and managers in situ did not seem to feature in the planning of the international response.

What needs to be done: Promoting national responsibility

The findings from Merlin's study resonate with the wider picture reported in the Inter- Agency Real-time evaluation at 3 months. This highlighted the limited collaboration between international actors and national institutions at both national and decentralised levels. (RTE, 2010).

Policies and inter-agency guidelines supporting international engagement contain clear commitments to supporting and building on national capacity, e.g. the Global Humanitarian Platform's principles of partnership. However the practice often falls short of the commitment and international relief efforts have been criticised in the past for ignoring,

sidelining and undermining local capacities (ALNAP, 2010). As the Haiti response indicates, learning from previous responses has not yet been translated into action and there is clearly a need for the international community to better implement its principles and work more effectively with national efforts.

Merlin's research on the health human resource implications of the response in particular highlights the need for the international community to engage more effectively with local capacity and that this must be underpinned by a concerted effort to promote a comprehensive assessment of local capacity as well as local needs in all emergency situations.

Ensuring that humanitarian coordination and decision making processes such as the health cluster are accessible to national actors is critical and these processes should also recognise the importance of human resources for health. Local groups and associations including professional health workforce groups can make valuable contributions to discussions on the availability and use of local health capacity.

Working effectively with national institutions is vital for the immediate response but also for strengthening systems for the longer term. Responses therefore need to be grounded in the longer term impact on the health system and the health workforce. The health impact of disasters can be substantially reduced if communities in high-risk areas are prepared, and able to respond to the risks they face. The on-going engagement in Haiti offers opportunities to tackle longstanding issues within the health sector including human resources. It is therefore hoped that efforts to build a stronger health workforce for the future will be accelerated and strengthened.

In these ways the health system and communities within Haiti, together with the international community, will be better placed to respond to future hazards.

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RTE, 2010. Inter-agency real-time evaluation in Haiti: 3 months after the earthquake. François Grünewald (Groupe URD), Andrea Binder (GPPi) with the support of Yvio Georges (National Consultant),August 31, 2010

Further information is available in: Responding to a Crisis: The role of national and international health workers- lessons from Haiti available at: http://www.merlin.org.uk/userfiles/Responding%20in%20a%20Crisis%20-%20Merlin%202010.pdf

Reconstruction of human resource development system in post-conflict countries - Lessons learned from Afghanistan and DR Congo

Nariko Fujita
National Center for Global Health and Medicine

Background

Responding to the global human resource crisis requires new thinking. Systems thinking is required to promote and inform a more comprehensive approach to human resource management and development: this will differ substantially from the more traditional training and education, as well as from the personnel management approach. Such systems thinking is even more necessary in post-conflict and fragile states.

In post-conflict periods, large numbers of development partners, including UN agencies, international NGOs, and aid agencies, literally rush into the country. The situation is often characterized by a weak health system, complicated by a limited quantity and quality of human resources for health. New governments and emergent Ministries typically have limited capacity to manage all the tasks for reconstruction. Development partners have their own mandates and agendas, and their support usually focuses only on one part of the human resource system even if they are operating within a functional aid coordination mechanism. Disease-specific programs tend to receive priority, particularly given the MDG targets and disease-specific global funds, and these promote rapid expansion of service delivery through vertical management, including human resources; at times this may weaken overall system functioning.

Objective of the presentation

This presentation aims to explore measures to strengthen the health workforce and health services in post-conflict situations, by reviewing the reconstruction process of the human resource system in Afghanistan and DR Congo.

Lessons learned from Afghanistan and DR Congo

In Afghanistan, an initial assessment of national health resources was conducted in 2002 in order to map out the available health resources in the country with financial and technical support by development partners. Results revealed an extremely limited number of female health professionals (approximately 1 female doctor, 1 female nurse, and 1 midwife for 50,000 populations). Human Resource Task Force was established in 2003 by Human Resource Department of the Ministry of health (MoH) and development partners. Major activities implemented by Human Resource Department and supported by the Task Force were as follows: delineating of 17 categories of health

professionals trained and recognized by the MoH and initiating Test and Certificate system in order to integrate health workers who were trained on an ad hoc basis by NGOs during the conflict-period into the MoH system.
The high maternal mortality ratio urged the MoH to focus on midwife as a priority. A new standard curriculum was introduced and a new category of health professionals (community midwife) was created who were supposed to be based in health centers and work for the community. Education of both midwives and community midwives started at 21 re-opened or newly-established schools in 2003-2007 of which five were public and the rest was contracted to NGO. To ensure the quality of midwifery education, an accreditation system was introduced during expansion. However, the partners' support for the production of midwives in response to the critical shortage was not linked to the deployment when the program was initiated. Graduates wanted to remain in towns and the deployment rate was less than 50% in some schools. Provinces such as Bamyan, began to recruit female students from rural areas with an agreement regarding posting after the graduation, and the deployment rate increased almost 90%. Some NGOs provided scholarships for those who agreed to work in rural health centers, which positively affected deployment. In total, from 465 midwives working in the initial assessment in 2002, there had been 1337 midwives graduated until 2008, of which 991 (74%) have reportedly been deployed.

The MoH department in charge of human resources became a General Directorate in 2004 and addressed aspects such as production, personnel management, planning, and information. At the provincial level, a liaison officer addressed human resource management issues, without an accompanying organizational structure because the MoH was restructured after the provincial structure was created Contracting basic health services was used for increasing the service coverage to respond to urgent services delivery needs, but this measure required a functioning human resource management system to optimize the value of this investment. It was difficult particularly at the provincial level to grasp the human resource situation regarding deployment and retention.

Human Resource Taskforce was created for stakeholder coordination in the early stage of reconstruction, but a frequent turnover of the Director of Human Resource Department (General Directorate) affected the activities and achievements of the taskforce. Professional education in the field of allied health is under the Ministry of Health, and medical education is under the Ministry of Higher Education (MoHE). Coordination between the two Ministries was not an easy task.

In DR Congo, a national health resource survey was conducted in 2009 by GAVI-HSS funds. School surveys of mid-level health professionals

under the MoH and of higher education under the MoHE were conducted in 2009-2010 based on the basis of the accreditation standard of the MoH and MoHE. The results reveal an increased number of low-quality schools, overproduction of nurses and doctors without following any workforce plan, a shortage of certain categories (midwives, laboratory technicians), and unequal distribution of doctors and nurses between urban and rural area. Although professional categories, carrier paths, and accreditation standards existed, they were not observed during the conflict period. The MoHE began to close the schools on the basis of the results of the school survey; however, this decision is political.

Production is not linked to the deployment. One reason is that a number of health workers who reached the retirement age did not retire because the government did not provide retirement pensions during the conflict period. The preliminary results revealed that 8.9% of the MoH have already reached retirement age. The World Bank is currently supporting an Administrative Reform by the Public Service Commission to identify the staff at retirement age, and to prepare the processes concerning and establish a fund for retirement.

The annual report of the health workforce was published in 2009 after a long suspension during the conflict. The total number of government staff in the public sector was around 100,000, 40% of which were administrative staff, and 90% of the technical staff were nurses. This report was prepared by the departments responsible for Human Resources at the MoH. At the provincial level, the structure of the provincial health office is similar to that of the central Ministry, and departments in charge of human resources exist with staffs who have experiences of the health system that functioned before the conflict. The National Health Development Plan 2011-2015 was prepared with a focus on expanding the coverage of primary health care. The National Plan for Human Resource Development for Health is being prepared as a sub-plan. Its priorities are to strengthen the governance, improve the quality of education, strengthen the human resource management, and facilitate the retention. Both plans will be launched at the beginning of 2011.

During the planning process, relevant Ministries, associations, and councils offered inputs in the discussion. An appropriate coordination mechanism needs to be established when the plan is implemented.

While these forms of support to human resources development are of potential value in these two countries, where they are unbalanced or incomplete, such forms will be much less effective, and systems and the health of the community may suffer. A far more comprehensive framework is needed for assessment and analysis to formulate an appropriate human resource policy and facilitate planning: we identify the elements of a much needed Human Resource System Development initiative, and propose a model to promote this.

Salam T Ismael
Doctors for Iraq Society

ABSTRACT

The invasion of Iraq in 2003 and the ensuing civil disturbance have caused severe and long lasting damage to the whole population. Under such tragic circumstances, qualified health workers have been killed, threatened, terrorized and many have decided to migrate or are compelled to abandon their jobs. At the end of 2006, from among 34,000 Iraqi physicians registered before 2003, 2000 had been killed and 12,000 have left the country.

(The interact between physicians' migration and their possible impact(s) on human resources actions is analyzed, using what s available of quantitative data sources and qualitative data collected from five semi-structured interviews with Iraqi health workers and some international experts.)

Increased workload, a stressful work-environment and the deficiency of experienced physicians, created a vicious cycle that feed on each other and eventually affected competence, motivation and availability of the remaining medical staff, which ultimately affects the effectiveness and quality of care provided for population in need. With fewer numbers of physicians and a steadily growing young population, accessibility of services could be further compromised and health inequalities, especially in remote disadvantaged areas, could intensify.

Restrictions on freedom of movement for medical staff and students in the occupied Palestinian territory: undermining healthcare in East Jerusalem, the West Bank and Gaza Strip

Ruchama Marton
Founder & President of Physicians for Human Rights-Israel

Introduction

When we hear about limitations on access to adequate healthcare for Palestinians in East Jerusalem, the West Bank and the Gaza Strip, the focus is often on the tragic and dramatic cases of patients being stopped at checkpoints and not reaching medical treatment in time to save their lives. We know of the many patients from Gaza Strip denied permits to leave for treatment in Israel or abroad, who cannot receive the treatment they need because of the poor state of the healthcare infrastructure in Gaza.

In this paper, however, the focus will be on the less dramatic but systematic damage caused to the entire Palestinian healthcare infrastructure by the restrictions healthcare students and employees face under the Israeli occupation. In particular, the two case studies examined in this paper will be the difficulties hospital staff from the West Bank have in reaching their places of work in East Jerusalem, and the denial of permits to medical students from the West Bank to complete training in East Jerusalem. Amongst many examples of other difficulties created for the Palestinian healthcare system, aspects of the Israeli occupation such as these are integral to the denial of basic rights to healthcare experienced by Palestinians.

Background

The situation regarding healthcare facilities in East Jerusalem reflects the broader effects of Israeli occupation in East Jerusalem and the West Bank, whereby the two areas are becoming increasingly separated and populations in both areas suffer as a result. The construction of checkpoints at city entrances at the end of 2000, and of the separation barrier through and around certain areas of the city, as well as the harsh permit system imposed on Palestinians which prevent them from moving between different regions of the West bank, have caused a significant decrease in the number of patients who are able to get to hospitals in the city. These hospitals are becoming facilities for East Jerusalem Palestinians only, the same hospitals that used to be the main medical facilities for the entire West bank and Gaza Strip. Israeli health maintenance organizations (HMOs) do not refer Jews to these

hospitals, and Jews do not go to them. This development fits in well with the increasing segregation and inequality in the area of healthcare, since the best Palestinian hospitals are half empty and therefore experiencing severe economical difficulties and the population remains with no proper medical care.

Access for staff

Hospitals in East Jerusalem have always relied on employees who are residents of the West Bank or Gaza Strip – 70% of their staff members were residents of these areas as of 2005. This number has been gradually decreasing the last few years. Since the early 1990s restrictions have been placed by Israel on the movement of medical personnel into East Jerusalem. In 1996 Israel established quotas of the numbers of staff from the West Bank which East Jerusalem hospitals could employ and who would receive permits to travel to work, exploiting these hospitals' dependence on staff from the West Bank and Gaza as a mechanism of control. Permits are regularly denied to employees in the name of security, final decisions being made by the General Security Services (GSS, or 'Shabak'). Furthermore medical staff is frequently denied passage even when they do have a permit, at the discretion of Israeli soldiers at the checkpoints. Hospitals mostly avoid challenging these decisions due to the weak position they are in vis-à-vis the Israeli authorities, and they constantly have to replace staff who are denied permits, thus losing time and money and impeding the hospitals' functioning. Upon completion of sections of the separation barrier, many hospital employees without entry permits left their workplaces in Jerusalem altogether, having to make do with jobs available locally in the West Bank, because of the great difficulty and the daily risk involved in reaching their workplaces in the city. The barrier and the almost-total separation it imposes on the hospitals from the population they are supposed to serve thus pose a real threat to the very existence of these hospitals.

The most recent guidelines brought in on November 2, 2008, required Palestinian medical personnel traveling between the West Bank and East Jerusalem to use only the Qalandiya checkpoint in Ramallah, and forbid them to use other checkpoints closer to their homes. The passage via Qalandiya checkpoint adds one hour to two and a half hours to the daily journey of the staff on their way to East Jerusalem hospitals. These employees are also not allowed to use their own transport to cross the checkpoints, so must use local transport and cross on foot. These restrictions caused further delays and seriously disrupted the hospitals' work. Various parties including PHR-Israel and the Palestinian Medical relief Society, who were approached by medical personnel affected by the new guidelines, protested these new guidelines.

This resulted in a partial lifting of the restrictions – but only allowing physicians to use any checkpoint, and not other medical staff.

Restrictions for medical students

Amongst those affected by the restrictions on movement and the permit policy are Palestinian medical students from Al-Quds University in Abu-Dis, (Jerusalem) which lies on the eastern side of the separation wall. During their 5th year of study they are required to complete practical training placements, which are most appropriately carried out in hospitals in East Jerusalem, for example in Makassed, where students are able to do the rounds at hospitals with a fuller range and higher standard of treatment facilities than in West Bank medical facilities. Makassed, with 200 beds, located in the Mount of Olives in Jerusalem, is the only teaching hospital in the occupied Palestinian territory and is considered the leading one professionally. The application process for these placements requires the hospital to send names and ID numbers of students to the West Bank Civil Administration Health Coordinator, who has to approve the applications in coordination with the Israeli GSS ('Shabak'). Those students who receive permits then have to cross checkpoints from the eastern to the western side of the separation barrier, where they are sometimes stopped and required to attend interrogations by the Shabak, their permits taken away until they do so.

PHR-Israel is regularly approached by students in these cases. In recent months, for example, a medical student from Ramallah, who started his 5th year of studying medicine at Al Quds University, was granted a permit for 6 months to work in Makassed hospital. After 3 months, as he was crossing a checkpoint to get to Makassed, he was stopped by private security personnel, who took away his permit and told him he was denied access, without giving him any reason. He approached the DCO (District Coordinator's Office) in Ramallah about what had happened and they told him that on his file he was requested to attend an interrogation with the Shabak, although he had not been informed of this request until approaching the DCO on his own initiative. A few weeks later he went to this interrogation where he was requested to collaborate with the Israeli authorities in order to get his permit back, which would involve him sharing with them information about his fellow students, particularly those travelling abroad, and being in daily contact with the Shabak. When he refused to collaborate they threatened to use force against him. He approached PHR-Israel, who wrote to the Israeli authorities on his behalf in order to request the reason his permit had been removed. An answer came only two months later, which stated that the permit had been removed for security reasons, and they may reconsider the decision if the student

applies again. PHR-Israel submitted a petition to the High Court, and subsequently received an answer from the Israeli Ministry of Security which stated that students may apply for permits only once per year and denying the allegation that permits are denied to those who refuse to cooperate with the Shabak. In the meantime this student has been unable to complete his training at Makassed hospital in East Jerusalem.

Similar cases of slow and complicated application processes and arbitrary denials of permits to qualified medical staff are regularly dealt with by PHR-Israel, illustrating how the entire system of medical care in the occupied Palestinian territory is being undermined by the occupation's bureaucracy. In the case of Palestinians from Gaza Strip, permits for students or staff are simply not approved any more, meaning that it is impossible to maintain an adequate health system for the residents of Gaza and preventing East Jerusalem hospitals such as Makassed from employing staff from Gaza.

Conclusion

Outcomes of the situation described above include the establishment of many smaller medical centers or hospitals within the West Bank and Gaza Strip, replacing one good centre in East Jerusalem. No one centre is able to provide the highest standards of medical care whilst more and more smaller centers are built and the healthcare infrastructure as a whole increasingly undermined. This wastes money and human resources in an already stretched small budget. Moreover, it is inefficient and unnecessary to establish multiple medical facilities in such a small geographical territory, when one good facility in East Jerusalem could serve the whole population as it did for many years.

The state of healthcare in East Jerusalem, the West Bank and Gaza Strip is ultimately dependent on the political realities of Israel/Palestine and the way in which Israel is implementing 'facts on the ground', in particular the territorial separation of these Palestinian areas. Israel's demand to postpone negotiations on the status of Jerusalem until permanent status negotiations also commit itself not to take unilateral steps that may change the status quo in the city, until such negotiations take place. The kinds of actions that have been described in this paper constitute a violation of this obligation. Human resources for health in the occupied Palestinian territory, therefore, cannot be genuinely strengthened without pressure being put on the Israeli state to change its political actions on the ground, for example the construction of the separation barrier and restrictions placed on movement of Palestinians.

Complex emergencies and post conflict health response: Case studies on Sudan and Somalia

Annette Mwansa NKowane
World Health Organization

Complex emergencies and post conflict situations bring about the challenges of health systems rehabilitation and development and offers an opportunity to reform or strengthen existing programmes. Within the World Health Organization Eastern Mediterranean Region, there is a great demand for reforms in pre-service nursing, midwifery and allied health education as well as new programmes. Nursing and midwifery services are particularly critical in the development of health programmes. Over 65% of health care providers in the region are nurses and midwives. In response to countries' needs for WHO to support rebuilding of health programmes, EMRO has embarked on comprehensive programmes to address this need. Several countries in the region are undergoing or emerging from conflict. In order to highlight EMRO's efforts to country support in complex and post conflict situation, case studies on Somalia and South Sudan have been compiled. These case studies demonstrate among many other factors the importance of commitment and concerted efforts among international, regional and national partners, maintenance and nurturing of partners and networks for a sustained response well as the adoption of a dynamic, flexible but, comprehensive approach to health reforms, programming and development of programmes on education, service provision, policies including infrastructure development. Lessons drawn from these experiences can provide a reference point for the adoption or adaptation of future similar health response.

FARIBA AL-DARAZI

REGIONAL ADVISER
NURSING AND ALLIED HEALTH PERSONNEL
WORLD HEALTH ORGANIZATION
EGYPT

As Dr Fariba Al-Darazi is the Regional Adviser for Nursing and Allied Health Personnel at Regional Office for the Eastern Mediterranean of the World Health Organization, her responsibilities include working with Member States of the Eastern Mediterranean Region to strengthen all components of Nursing and Midwifery services {education, practice, regulation, policy development, planning} and allied health personnel's education as an integral part of the health system. As a member of the human resources development (HRD) team in the Division of Health Systems and Services Development works with countries of the Region to develop HRD processes and capacity especially in post conflict countries. She has been in this post since May 2000.

She obtained a diploma in Nursing from Bahrain School of Nursing in 1972 and she then continued her studies at the American University of Beirut (AUB) in Lebanon and got a diploma in teaching and administration of medical - surgical nursing.

Dr Al-Darazi was one of the three first Bahraini tutors who joined the School of Nursing in 1974. She was a member of the team that worked with the consultants from the American University of Beirut (AUB) to transform the School of Nursing to a College of Health Sciences in 1976. She obtained her BSc from Concordia University in Canada in 1978 and a master degree from University of Illinois at Chicago. She obtained a Doctor of Philosophy (Ph.D.) in Nursing Sciences. (areas of Concentration: Health Promotion Research and Educational Administration) from University of Illinois at Chicago in 1986.

She was the first GCC (Gulf Cooperation Council Countries) national to obtain a Ph D in nursing. She was appointed as the Chairperson of the Nursing Division at the College of Health Sciences in 1987 and in 1990 the Division was designated as a WHO Collaborating Centre for Nursing Development and thus it became the First WHO Collaborating Centre for Nursing in the Region and Dr Al-Darazi was appointed as the Director of the Centre.

Towards the end of 1990 she was appointed as the Director of Training at the Ministry of Health and she had an important role in developing the policy and plan for human resources development for health. She continued in this post until may 2000 when she joined WHO.

Dr Al-Darazi prior to joining WHO undertook several consultations in different countries in the field of Nursing and human resources development.

In the area of community service Dr Al-Darazi has been involved with the civil societies including women's societies in preparing and conducting training workshops for the members of the societies, nursery teachers, women and the public in the areas of health. She was also the first president of the Bahrain Nursing Society.

Dr Al-Darazi received three national education achievement awards, the Bahrain Nursing Society's award for voluntary work and nursing leadership, and an award for excellence from the Executive Board of the Ministers of Health of the Gulf Cooperation Council Countries

In March 2006 she was decorated by His Majesty King of Bahrain Hamad Bin Essa Al-Khalifa for Competence First Degree.

In 2009, she was recognized for excellence in health leadership by the Supreme Council for Women in Bahrain.

FIONA CAMPBELL
HEAD OF POLICY
MERLIN
UNITED KINGDOM

Fiona Campbell has a background in nutrition; public heath, and development management and has worked in the development sector in programme management and technical roles in Africa and South Asia and with government and non-governmental agencies. Fiona joined Merlin in July 2006 as Head of Policy, heading up a small policy team supporting policy analysis, research and advocacy across the organisation in the areas of health, development and humanitarian response.

MSc Nutrition (King's College, London)
MSc Public Health in Developing countries (London School of Hygiene and Tropical Medicine)
MSc Development Management (Open University, UK)

NORIKO FUJITA
SENIOR TECHNICAL OFFICER
NATIONAL CENTER FOR GLOBAL HEALTH AND MEDICINE
JAPAN

NCGM is an implementing agency of Japan's ODA, and I am working as a program manager at country and regional level. With a clinical background of obstetrician and gynecologist in Japan, I studied public health in Mahidol University in Thailand in 1997. Besides voluntary work in a refugee camp and a local NGO in Thai-Burmese border in Mae Sod Province, field experiences are JICA program manager on human resource development at National Maternal and Child Health Center in Cambodia (1998 - 2002), at Reproductive Health Directorate at MoH in Afghanistan (2003 - 2008). Now I am working with Human Resource Department in the MoH of DR Congo and in the MOH in Cambodia on a short tem basis for HR assessment, planning, and legal and regulatory framework. Entire job has been focused on the institutional capacity building of the government staff at central and provincial level. A collaborative research on human resource system development started with Prof. Anthony Zwi, School of Public Health and Community Medicine, University of New South Wales.

NCGM organizes a short-term training course on HR management for Francophone African countries, funded by JICA. During side meetings on 25 January, a skill building workshop will be arranged as a network of the training course participants, focusing on HR information system and HR observatory. NCGM team provides technical support on this network.

SALAM T ISMAEL

DIRECTOR
DOCTORS FOR IRAQ
IRAQ

Dr. Salam Ismael received is an Iraqi Medical Doctor graduated from Baghdad Medical School in 2000. Started his carerr in orthopaedic surgery then finished his master's in public health from London School of higene and tropical medicine in 2008. He has been awarded his degree with titled thesis "The Impact of Physicians' Migration on the provision of Health Care in Iraq after the 2003 US-led invasion". After the invasion, Dr. Ismael founded, together with a few of his colleagues, an Iraqi medical relief NGO called 'Doctors for Iraq'. Doctors for Iraq is a neutral medical humanitarian organisation that provide health services for people in need inside Iraq depending on the medical and surgical skills of its volunteers. Since 2006 Dr Ismael is the Director of this organisation.

Dr Ismael later engaged in International medical relief work with international organizations such as the Red Crescent and ICRC in areas of conflict and disaster zones such as Somalia , Lebanon and Haiti. Working in conflict zones led him to document, publish and speak out publicly, both nationally and internationally, about the health situation, humanitarian assistance, together with human rights abuses and breaches in medical neutrality in such sensitive environments of work, particularly in Iraq .

Dr Ismael published several articles, organised many workshops on health and humanitarian assistance and spoke in different international arenas about right to health and medical neutrality breaches.

RUCHAMA MARTON
PRESIDENT AND FOUNDER
PHYSICIANS FOR HUMAN RIGHTS
ISRAEL

March 2005

Born in Jerusalem "when it was still in Palestine", Dr. Ruchama Marton learned about human rights first hand as a young woman fulfilling her military duty in the Israeli army. In 1956, she watched as Israeli soldiers executed unarmed Egyptian soldiers who had surrendered. At 19, she was discharged for refusing to obey an order that she deemed sexist. Psychiatrist, peace activist and feminist, she has written and lectured extensively on human rights, women's rights, the struggle for peace and democracy, and mental health theory and practice connected to those issues. She also edited and contributed to the book 'Torture: Human Rights, Medical Ethics and the Case of Israel', (Zed Books, London and New Jersey, 1955) and written screenplays for three films. Dr. Marton has spoken extensively during tours of Europe and North America, has been interviewed by major American and British media.

Dr. Matron's activism over 4 decades has focused on exposing, analyzing and challenging the systematic and individual acts and policies of Israeli occupation and repression towards Palestinians including the employment of torture, house demolition, denial of access to basic services, and political exclusion. After accusing Israeli psychiatrists for intentional and systematic malpractice toward psychotic Palestinian prisoners, Marton was brought before the Israeli Medical Association disciplinary court and was harassed by them for three years.

In 1998-99, Dr. Marton was chosen for the peace Fellowship at the Radcliffe Bunting Institute at Harvard and the Jeanne and Joseph Sullivan fellowship for Middle East activism.

Dr. Marton was the founder and the driving force within the Association of Israeli and Palestinian Physicians for Human Rights (AIPPHR). The Association which was established during the Palestinian Uprising of 1987 has worked since to document and mobilize public and professional opinion in Israel and abroad against Israel's use of live ammunition against unarmed protesters, and its use of torture, abuse and other modes of violence in its efforts to suppress the first Uprising. AIPPHR has struggled for prisoners' health rights and for free passages of medical personnel and patients in the Occupied Territory, as well as for health rights of Palestinian residents of East Jerusalem. Special efforts were made to accommodate Palestinian children's health.

Currently Dr. Marton is the president of the association's successor, Physicians for Human Rights-Israel, which has continued its human rights activities over the years.

Marton is the recipient of several peace and human rights awards, including the Emil Grunzweig Award for Human Rights, presented by the Association for Civil Rights, Israel, and the Jonathan Mann Award for Global Health and Human Rights, 2002. She is one of 1000 women nominated for the 1000women Nobel Peace Prize 2005.

JIHAD MASHAL

DIRECTOR OF HEALTH
THE PALESTINIAN HEALTH SECTOR REFORM & DEVELOPMENT PROJECT
PALESTINE

Dr. Mashal is a Medical Doctor and Public Health Specialist with over 25 years of experience in an extensive range of health and development related activities and their fields of practice. His work experience covers: direct clinical work; project planning and implementation, management of health programs ,with a focus on health systems development to improve quality of healthcare in both the NGO's and public sectors.

From the year 2000 till 2009, as The Director General of PMRS, Dr Mashal was successfully able under difficult and hostile environment, to lead the organization to be able to respond effectively to serious emergency needs, while maintaining the ongoing developmental programs.

As the Director of Clinical and Community Based Health since May 2009 till now (Part of Palestinian Health Sector Reform & Development Project "The Flagship Project" team) , he worked closely with the Palestinian Ministry of Health to strengthen the institutional capacity of the public sector to deliver high quality health-care services ,he used his experience and approach in strengthening health systems at all levels .

Using His strong communication skills and long standing professional experience, he participated in and led several health thematic groups that effectively influenced the national health policies of this country, in an effort to harmonize and standardize healthcare issues. In addition, Dr Jihad has been a key speaker and presenter in a selected number of local, regional and International conferences and workshops.

Dr. Mashal is currently an active member in the Jordanian Medical Association, also the Global Steering Committee and the Coordination Council of the People's Health Movement (global health advocacy group); PHM Coordinator of the Middle East/North Africa Region .

EDWARD MILLS
PROFESSOR
UNIVERSITY OF OTTAWA
CANADA

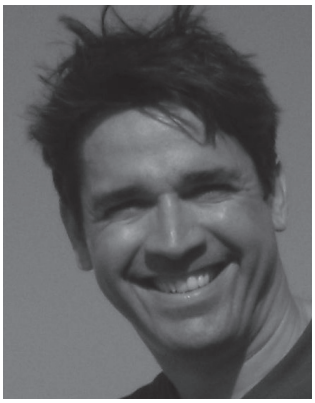
Edward Mills is Canada Research Chair in Global Health at University of Ottawa.

He is trained in both Clinical Epidemiology and International Law. He works predominantly in Uganda with The AIDS Support Organization (TASO), Joint Clinical Research Centre and Mildmay in developing a nationwide cohort of HIV+ individuals. He currently leads several large randomized trials in East Africa to evaluate improvement of care among low resourced patients. He is the Editor-in-Chief of the journal Conflict and Health and is on the advisory council of large NGOs in Africa and South Asia.

ANNETTE MWANSA NKOWANE

TECHNICAL OFFICER
WORLD HEALTH ORGANIZATION
SWITZERLAND

Is a Technical Officer, World Health Organization, Department of Human Resources for Health with focus on nursing and midwifery profession and serves as member of the WHO Ethical Research Committee. Prior to this, worked in other WHO Departments; Mental Health and Substance Dependence (1998-2003) and Gender and Women's Health (2003-2005). Scope of work has involved generation of advocacy and technical documents related to the nursing and midwifery workforce, training, training material development, programme development, monitoring and evaluation and operational research. Before this, served at World Wide Young Women's Christian Association(1992), International Federation of the Red Cross (1993-1995), Geneva and as an independent consultant (1996-1998). She is a registered nurse/ midwife and holds Bachelor a of Science degree in nursing with a major in Community Health Nursing, post graduate training in Management Development and a Masters Degree in Human Resources Development. Has worked as a practicing nurse-midwife both in the USA and Zambia.



MARIVAND PINTO
NATIONAL PROFESSIONAL
PAN AMERICAN HEALTH ORGANIZATION
BRAZIL

Mr. Marivand Pinto holds a title of Specialist in Global Health and Diplomacy in Health from the National School of Public Health (ENSP/FIOCRUZ), in Brazil, holds a Masters degree in Business Administration with a concentration in International Business, from Lewis University, in the United States, and for the last 6 years he has been directly involved in the development of policies on Human Resources for Health in Brazil, as part of a continuous effort to improve the National Health System, by strengthening of the capacity of the country in establishing international cooperation in the RHR field.

Mr Pinto has worked for the Federal House of Representatives, the United Nations Educational, Scientific and Cultural Organization (UNESCO) and for the General Coordination on Environmental Health Surveillance, within Brazil's Ministry of Health, when he was responsible for the design and implementation of better mechanisms for monitoring the projects related to that area.

Currently working for the office of the Pan American Health Organization in Brazil, under the guidance and supervision of the Manager of PAHO's Human Resources for Health Policies Division, Mr. Pinto has been directly involved in the development of PAHO's International Cooperation Program, playing a very important role in the process of strengthening the capacity of the country to engage in international cooperation in the field of HRH, as the program is completely aligned with the Brazilian Ministry of Health's Secretary of Labor and Education Management for Health. Mr. Pinto is responsible for the supervision and development of an array of work plans that are part of the Technical Cooperation agreements between the Brazilian Government and PAHO/WHO.

MIRIAM K. WERE

CHAIRPERSON
NATIONAL AIDS CONTROL COUNCIL
(Laureate, HIDEYO NOGUCHI AFRICA PRIZE)
KENYA

Born in 1940 in Western Province in Colonial Kenya, Miriam has lived through tremendous changes in her life. The first 8 years of education were in schools sponsored by the Church since colonial Kenya did not provide education for the "natives". Following High School she studied in USA from 1961 under Friends Church sponsorship. She graduated in 1964 with a Composite Major in Natural Sciences: Biology, Chemistry and Physics. She got admission to Medical school in USA but not having been home at all since 1961, she returned to Kenya in 1965. The newly Independent Kenya Government was keen to get science teachers and sponsored her to Makerere in Uganda for the Postgraduate Diploma in Education. She qualified as High School teacher in Biology, Chemistry and Physical Education in June 1966 and got married that same year to Humphreys R. Were.

Teaching at High school was fun but not teaching sick children. While a wife and mother and with the support of her husband, Miriam enrolled in the five year Medical Course in the Medical School at the University of Nairobi. Miriam completed the 5-year course in 1973 followed by a year of internship and a year as a Medical Office in the Ministry of Health, Kenya. In late 1974 she was recruited to teach in the Department of Community Health in the University of Nairobi Faculty of Medicine.

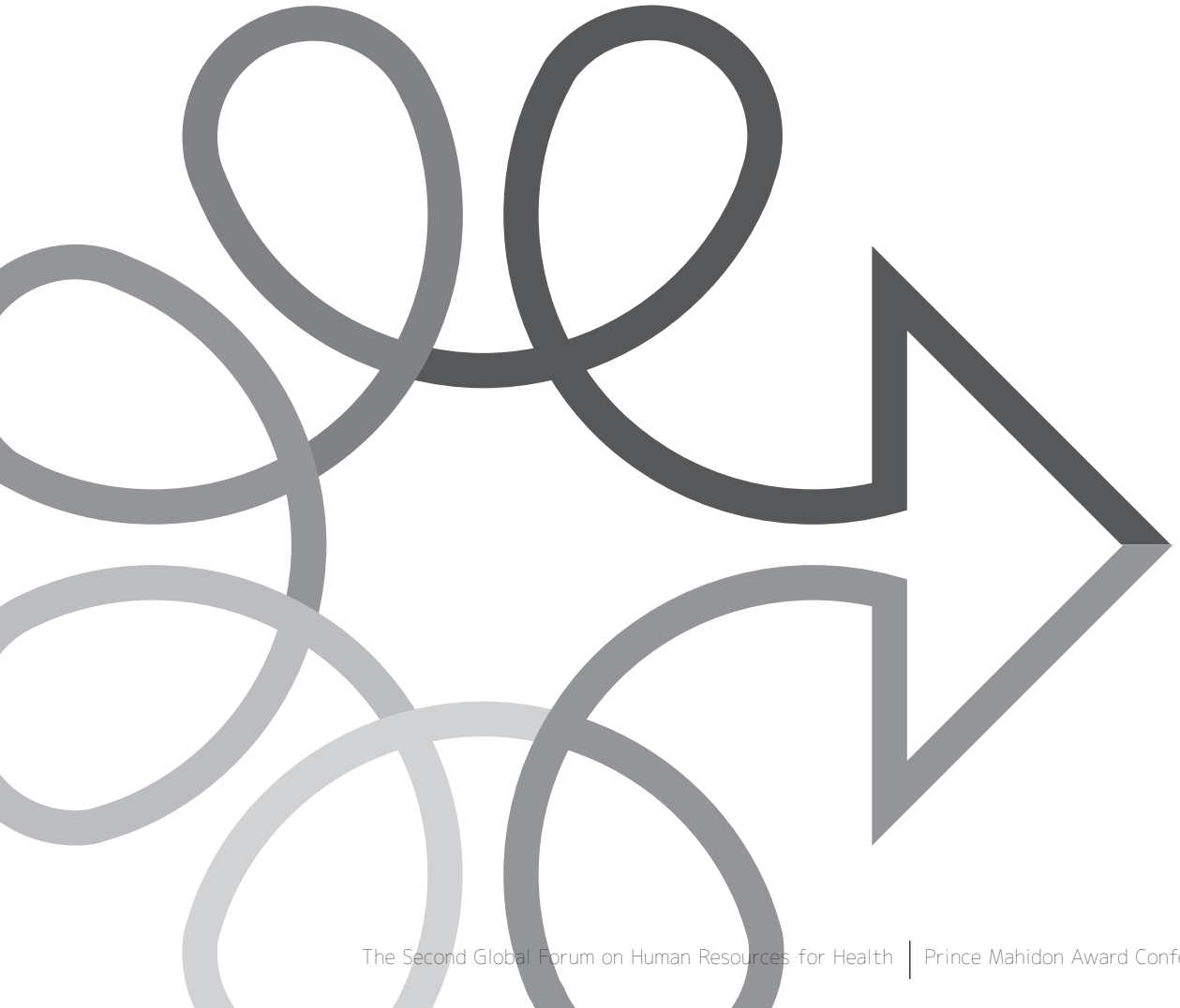
While in this Department, she got opportunity to study at the Johns Hopkins University for the Masters and then Doctorate of Public Health degrees. She subsequently became the Chairman of this department and established the first Master of Public Health program in Kenya in 1983. In 1985, she was recruited by UNICEF to work in Ethiopia in an even more challenging health environment. In 1990-1993 she was appointed Representative of the World Health Organisation in Ethiopia. Between 1993 & 2000 when she retired from the UN, she was the Director of UNFPA Country Support Team based in Addis Ababa. Miriam headed a team of Technical Advisors in Population and Reproductive Health to countries in East, Central and Anglophone West Africa. Therefore, her experiences are across the African continent.

Since 1995, Miriam and her husband, Humphreys, are Co-Sponsors of UZIMA Foundation focused on Youth Empowerment. More recently, Miriam has held the various responsibilities including Chairman of the Kenya National AIDS Control Council(2003-2009), Chairman of the African Medical and Research Foundation, Member of the Boards of MAP International, Global Health Workforce Alliance,(GHWA), Champions for HIV-Free Generation and the Global Commission on HIV and the Law by UNDP. Miriam has received major awards including the UNICEF

Maurice Pate Award, (1978), World YWCA Trail Blazer Award (2007), The Queen Elizabeth II Gold Medal for Public Health (2007), KNIGHT in the Legion of Honour in the French National Order for distinguished services in health, and the HIDEYO NOGUCHI AFRICA PRIZE by Japan (2008). In 2010, Miriam was one of six national scholars given the title of HERO (SHUJAA) for putting Kenya on the international map.

PARALLEL SESSION 7 :

High Level Roundtable: Working together for health workers



CARISSA ETIENNE

ASSISTANT DIRECTOR-GENERAL
WORLD HEALTH ORGANIZATION
SWITZERLAND

Carissa F. Etienne assumed the role of Assistant Director-General for Health Systems and Services in February 2008. Prior to that, she was the Assistant Director of the Pan American Health Organization. As Assistant Director in PAHO from July 2003, she directed five technical areas - health systems and services; technology and health services delivery; health surveillance and disease management; family and community health; and sustainable development and environmental health.

A national of Dominica, Dr Etienne began her career as a medical officer at the Princess Margaret Hospital in her country, where she eventually became the Chief Medical Officer. Other high-level posts she has held include the Coordinator of Dominica's National AIDS Programme, Disaster Coordinator for the Ministry of Health of Dominica, Chairperson for the National Advisory Council for HIV/AIDS and the Director of Primary Health Care for Dominica.

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

MICHEL D. KAZATCHKINE

EXECUTIVE DIRECTOR
THE GLOBAL FUND TO FIGHT AIDS, TB AND MALARIA
SWITZERLAND

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

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

Dr Kazatchkine has spent the past 25 years fighting AIDS as a leading physician, researcher, administrator, advocate, policy maker, and diplomat. He attended medical school at Necker-Enfants-Malades in Paris, studied immunology at the Pasteur Institute, and has completed postdoctoral fellowships at St Mary's hospital in London and Harvard Medical School. His involvement with HIV began in 1983, when, as a young clinical immunologist, he treated a French couple who had returned from Africa with unexplained fever and severe immune deficiency. By 1985, he had started a clinic in Paris specializing in AIDS - which now treats over 1,600 people - and later opened the first night clinic for people with HIV in Paris, enabling them to obtain confidential health care outside working hours.

Prior to joining the Global Fund, Dr Kazatchkine was Professor of Immunology at Université René Descartes and Head of the Immunology Unit of the Georges Pompidou Hospital in Paris. He has authored or co-authored of over 500 articles in peer reviewed journals, focusing on auto-immunity, immuno-intervention and pathogenesis of HIV/AIDS. In addition to his clinical teaching and research activities, Dr. Kazatchkine has played key roles in various organizations, serving as Director of the National Agency for Research on AIDS (ANRS) in France (1998-2005), Chair of the World Health Organization's Strategic and Technical Advisory Committee on HIV/AIDS (2004-2007), member of the WHO's Scientific and Technical Advisory Group on tuberculosis (2004-2007), and French Ambassador on HIV/AIDS and communicable diseases (2005-2007).

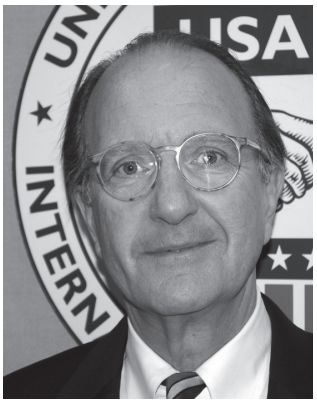
Dr Kazatchkine's involvement with the Global Fund to Fight AIDS, Tuberculosis and Malaria began when the organization was established in 2001. He was the first Chair of the Global Fund's Technical Review Panel (2002-2005) and has served as a Board member and Vice-Chair of the Board (2005-2006).

While recognizing the enormous challenges of tackling AIDS, tuberculosis and malaria globally, Dr Kazatchkine believes that the progress made in recent years - particularly through programs supported by the Global Fund - has been extraordinary. "The mission and mandate of the Global Fund developed seven years ago were visionary and aspirational", he says. "Since then, an additional 5 million people have been treated for TB with Global Fund support. More than 70 million bed nets have been distributed to protect families against malaria. And the Fund has contributed to a major scale up of AIDS treatment and prevention". Dr Kazatchkine notes that, by 2009, the Global Fund's objective of making a sustainable and significant contribution to the achievement of the Millennium Development Goals is actually being accomplished. He also emphasizes that the Fund's focus on results and performance is key to its success. "The unprecedented mobilization for the health of the poor in the past few years is producing results which can actually be measured in terms of lives saved", he says.

SIGRUN MØGEDAL

CHAIR OF THE BOARD FOR THE GLOBAL HEALTH WORKFORCE ALLIANCE
NORWAY

Sigrun Møgedal, [MD, DTM&H] is the Chair of the Board for the Global Health Workforce Alliance and serves as a Special Adviser to the Executive Director of UNAIDS. A former Norwegian Ambassador for HIV/AIDS and Global Health Initiatives, Dr. Møgedal's main areas of professional involvement are in the interface between development, health and foreign policy, with a focus on governance for health at global and national level. She has a long time involvement in human resources for health, and in working with civil society and community responses. From 2000-2001 she was a State Secretary in the Ministry of Foreign Affairs in Norway.



GARY NEWTON

UNITED STATES GOVERNMENT SPECIAL ADVISER ON ORPHANS AND VULNERABLE CHILDREN
UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
UNITED STATES

Gary Newton is a Senior Foreign Service Officer with the United States Agency for International Development (USAID). He began his current appointment as the U.S. Government Special Advisor for Orphans and Vulnerable Children in July 2008. The position is mandated by U.S. Public Law 109-95, the Assistance for Orphans and Other Vulnerable Children in Developing Countries Act of 2005. The law calls for the U.S. Government (USG) response to orphans and vulnerable children to be comprehensive, coordinated and effective. Mr. Newton is based at USAID headquarters in Washington D.C. and from this base works with colleagues from across seven USG departments, the UN and NGO community.

Mr. Newton has worked on a variety of human resource strengthening initiatives, among them, a bilateral assistance program which enabled Malawi to significantly expand its cadre of village health workers; a partnership to strengthen the education system's capacity to meet the human resource needs of Egypt's private sector; a project to help countries develop the human capacity required to scale-up national HIV/AIDS programs; and, an initiative to raise awareness of the human resource needs of the social welfare sector, especially the critical need to invest more in those who care for and protect children.

Mr. Newton has thirty years of international development experience, twenty-one of which have been spent outside the United States. As a USAID Foreign Service Officer, Mr. Newton served in Malawi (1988-1992) and Kenya (1992-1996), where he was in charge of USAID assistance to the health sector; Egypt (1996-2000), where he was an Associate Mission Director in charge of assistance for health, education and democracy and governance; and Namibia (2004-2008), where he was the USAID Mission Director.

Mr. Newton spent four years (2000-2004) at USAID headquarters in Washington in the Bureau for Global Health where he helped establish the HIV/AIDS Office and was then the first Director of the Office of Regional and Country Support.

Before joining USAID as a career officer, Mr. Newton spent four years in Bangladesh (1983-1987), first, as Assistant Director of Engender Health's Asia Regional Office, and then as an advisor in the USAID/Bangladesh Population and Health Office. Mr. Newton served as a Peace Corps volunteer in Agadez, Niger (1974-75).

Mr. Newton is a graduate of Colby College in the State of Maine in the U.S. and has a Master's Degree in Teaching from Smith College in Northampton, Massachusetts and a Master's Degree in Public Health from Columbia University in New York City.

MUBASHAR SHEIKH
EXECUTIVE DIRECTOR
GLOBAL HEALTH WORKFORCE ALLIANCE
SWITZERLAND

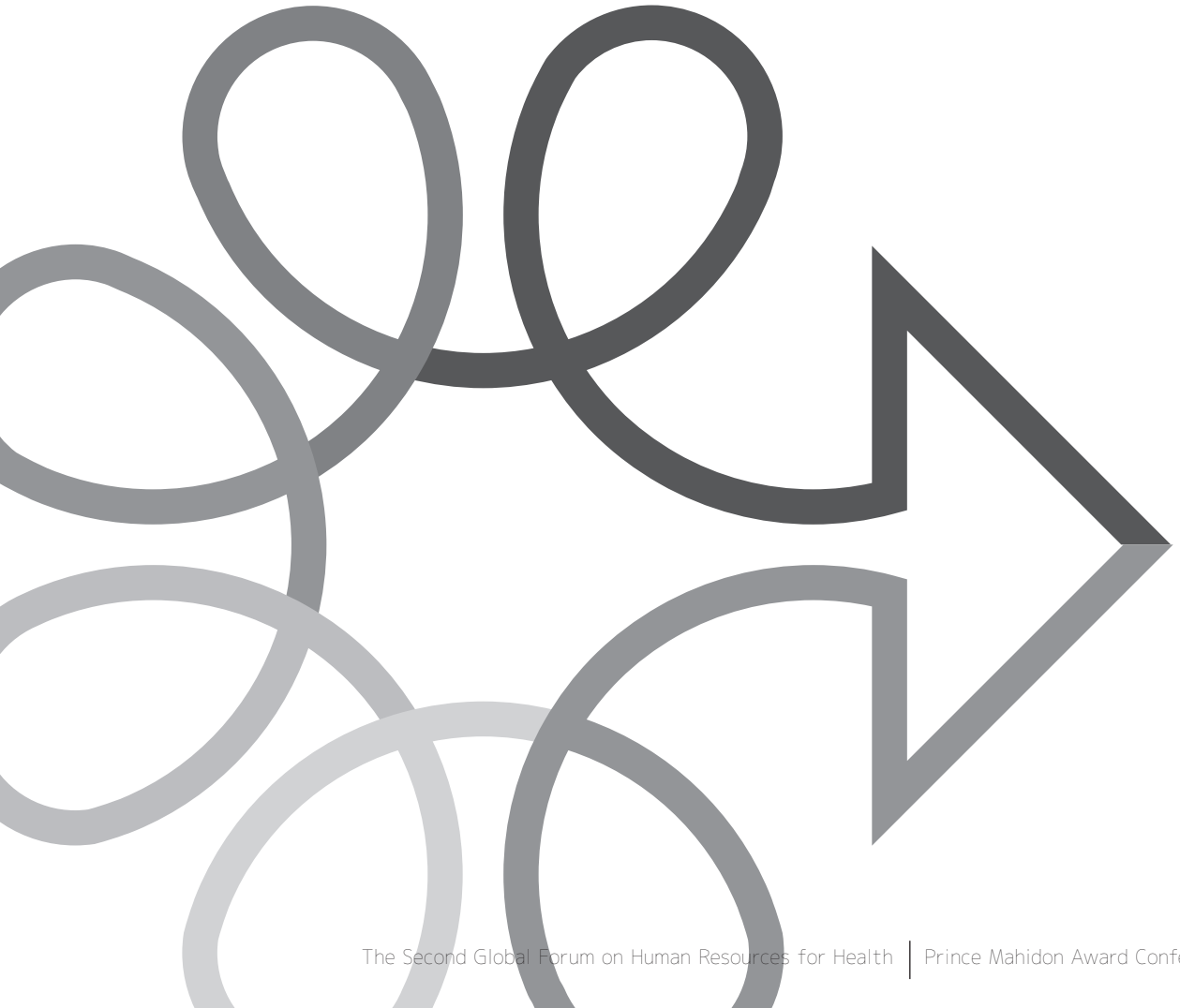
Mubashar Sheikh, is a medical doctor and a specialist in health system policy and planning. Dr. Sheikh started his public health career in 1987 with the Ministry of Health in Pakistan. During this period he managed different departments and spearheaded various projects including the flagship National Primary Health Care program (also known as the Lady Health Workers program). This initiative, the largest in social sectors, was introduced in 1994 to ensure universal access to essential health care at the grass roots and underserved areas for the provision of essential services including integrated management of childhood illnesses, maternal health, water and sanitation, nutrition and promotion of healthy lifestyles. The program is recognized by WHO as the 'best practice' among its 192 member states and has so far been replicated by many countries in Asia and Africa.

In 1998, Dr Sheikh joined the Eastern Mediterranean Office of World Health Organization as Regional Adviser in the department of Health Systems. On this position, Dr. Sheikh also developed strategies for the advocacy and implementation of Community and Sustainable Development initiatives aimed at reducing poverty and social inequalities. In 2004 Dr. Sheikh was assigned to WHO office in Iran as Country Representative, where he also served as Resident Coordinator of the UN system as well as Representative for Food and Agricultural Association.

At present, Dr Sheikh is holding the post of the Executive Director of the Global Health Workforce Alliance based at the WHO Headquarters in Geneva. In this capacity, he is playing the lead role for the development of national policies and plans in 57 countries in Asia, Africa and Latin America aimed at ensuring that all people, everywhere, have access to skilled, motivated and supported health workers within a robust health system...Dr Sheikh is chairing and also acting as member of various expert committees and task forces at the international and regional levels. He is the author and co-author of numerous policy documents, training manuals and guidelines. He is also writing regularly in well reputed journals on various aspects of health systems and human development.

PLENARY SESSION 3 :

Professional Leadership and Education for 21st Century



ZULFIQAR A. BHUTTA
PROFESSOR
AGA KHAN UNIVERSITY
PAKISTAN

Dr Zulfiqar A. Bhutta is Husein Laljee Dewraj Professor and the Founding Chair of the Division of Women and Child Health, Aga Khan University, Karachi, Pakistan. He also holds adjunct professorships in International Health & Family and Community Medicine at the departments of International Health at the Boston University and Tufts University (Boston) respectively. He was designated a Distinguished National Professor of the Government of Pakistan in 2007. He is also the Dean of the faculty of Paediatrics of the College of Physicians & Surgeons, Pakistan and the Chairman of the National Research Ethics Committee of the Government of Pakistan.

Professor Bhutta was educated at the University of Peshawar (MBBS) and obtained his PhD from the Karolinska Institute, Sweden. He is a Fellow of the Royal College of Physicians (Edinburgh), the Royal College of Paediatrics and Child Health (London) and the Pakistan Academy of Sciences. He has been associated with the Aga Khan University since 1986 and heads a large research team working on issues of maternal, newborn and child survival and nutrition globally and regionally. Dr Bhutta has served as a member of the Global Advisory Committee for Health Research for the World Health Organization, the Board of Child & Health and Nutrition Initiative of Global Forum for Health Research, and the steering committees of the International Zinc and Vitamin A Nutrition Consultative Groups. He is an executive committee member of the International Paediatric Association and on the Board of the Global Partnership for Maternal, Newborn and Child Health (PMNCH). He is a Foundation Council member of the Global Forum for Health Research, a council member for the International Society for Infectious diseases (ISID) and serves on the governing council for the World Alliance for Patient Safety Research. Dr Bhutta is currently the Chair of the Health Sciences Group of the Biotechnology Commission of Pakistan, a member of the WHO Strategic Advisory Committee for Vaccines (SAGE), the Quantitative Vaccine Research (QUIVER) group of WHO, the Advisory Committee for Health Research of WHO EMRO, and its apex Regional Consultative Committee. He is the immediate past-President of the Commonwealth Association of Paediatric Gastroenterology and Nutrition (CAPGAN) and the Federation of Asia-Oceania Perinatal Societies (FAOPS).

Dr. Bhutta is on several international editorial advisory boards including the Lancet, BMJ, PLoS Medicine, PLoS ONE and the Cochrane ARI group. He has published four books, 55 book chapters, and over 320 indexed publications to date. He has been a leading member of recent major Lancet series on Child Survival (2003), Newborn Survival (2005), Undernutrition (2008), Primary Care (2008) and the forthcoming series on Stillbirths (2010). He has won several awards, including the Tamgha-i-Imtiaz (Medal of Excellence) by the President of Pakistan for contributions towards education and research (2000), the President of Pakistan Gold Medal for contributions to Child Health in Pakistan (2004) and the Outstanding Paediatrician of Asia award by the Asia Pacific Pediatric Association (2006). He is also the first recipient of the Aga Khan University Distinguished Faculty Award for Research (2005). Dr Bhutta was awarded the inaugural Global Child Health award (2009) by the Program for Global Pediatric Research for outstanding contributions to Global Child Health and Research and has recently been elected an honorary Fellow of the American Academy of Pediatrics for contributions to international child health. He was the Windermere Lecturer at the Annual Meeting of the Royal College of Paediatrics and Child Health UK (2010).

Dr Bhutta's research interests include newborn and child survival, maternal and child undernutrition and micronutrient deficiencies. He leads a large research group based in Pakistan with a special interest in research synthesis, scaling up evidence based interventions in community settings and health systems research

LINCOLN C. CHEN

PRESIDENT
CHINA MEDICAL BOARD
UNITED STATES

Lincoln C. Chen is President of CMB (China Medical Board). Started in 1914, the CMB was endowed by John D. Rockefeller as an independent American foundation to advance health in China and Asia by strengthening medical education, research, and policies.

Dr. Chen was the Founding Director of the Harvard Global Equity Initiative (2001-2006) and in an earlier decade (1987-1996), the Taro Takemi Professor of International Health and Director of the University-wide Harvard Center for Population and Development Studies. In 1997-2001, Dr. Chen served as Executive Vice-President of the Rockefeller Foundation, and for 14 years earlier, he represented the Ford Foundation in India and Bangladesh.

Dr. Chen serves on the board of many organizations - including BRAC USA, FXB Center on Health and Human Rights at Harvard, Social Science Research Council, the Institute of Metrics and Evaluation at the University of Washington, and the Public Health Foundation of India. Dr. Chen, a member of various scientific academies, graduated from Princeton University (BA), Harvard Medical School (MD), and the Johns Hopkins School of Hygiene and Public Health (MPH).

THOMAS L. HALL
EXECUTIVE DIRECTOR
GLOBAL HEALTH EDUCATION CONSORTIUM
UNITED STATES

Thomas L. Hall, MD, DrPH, is lecturer in the UCSF Dept. of Epidemiology and Biostatistics and Executive Director of the Global Health Education Consortium. He received undergraduate, MD and MPH degrees from Harvard and his DrPH degree in international health from Johns Hopkins. He has held faculty appointments in the schools of public health of the Univ. of Puerto Rico, Johns Hopkins, Univ. of NC at Chapel Hill, and the Univ. of Washington (Seattle). At UNC he was director of the Carolina Population Center. Non-academic positions have included medical director of a rural hospital, director of a regional health planning agency, and Chief Medical Officer (Research) in the New Zealand Dept. of Health (1985-86). He joined UCSF in 1988, directed a postdoctoral training program in HIV research (1989-96) and since then has taught and mentored students in global health, and has served as Executive Director of the Global Health Education Consortium. He has consulted extensively with WHO, the World Bank and many countries on strategic health workforce planning. He was: the lead author and editor of Health manpower planning: Principles, methods and issues, WHO, Geneva, 1978, primary author of the WHO ToolKit for Human Resources Development, and; developer of the WHO planning simulation models that can be used in workforce planning.

Thomas L. Hall, UCSF Dept. of Epidemiology and Biostatistics, San Francisco, CA; 415/731-7944; 415-731-3132 (fax); thall@epi.ucsf.edu

RICHARD HORTON
EDITOR-IN-CHIEF
THE LANCET
UNITED KINGDOM

Richard Horton is Editor-in-Chief of The Lancet. He was born in London and is half Norwegian. He qualified in physiology and medicine from the University of Birmingham in 1986. He joined The Lancet in 1990, moving to New York as North American Editor in 1993. He was the first President of the World Association of Medical Editors and is a Past-President of the US Council of Science Editors. He is an honorary professor at the London School of Hygiene and Tropical Medicine, University College London, and the University of Edinburgh. He is a Council member of the UK's Academy of Medical Sciences and the University of Birmingham, and he chairs the Board of the Health Metrics Network. He has a strong interest in issues of global health and medicine's contribution to wider culture.

VICHARN PANICH

CHAIRMAN OF THE INTERNATIONAL AWARD COMMITTEE
PRINCE MAHIDOL AWARD FOUNDATION
CHAIRMAN OF UNIVERSITY COUNCIL
MAHIDOL UNIVERSITY
THAILAND

Professor Vicharn Panich received his M.D. from the Faculty of Medicine Siriraj Hospital, University of Medical Science in 1966 and M.Sc. in Human Genetics from the Department of Human Genetics, University of Michigan Medical School, Ann Arbor, Michigan, USA in 1968.

Career: Lecturer at Siriraj Hospital from 1968-1974; Dean of Faculty of Medicine, Prince of Songkla University, 1981-1983 and 1985-1989; Vice President, Prince of Songkla University, 1975-1978 and 1991-1993; Founding Director of the Thailand Research Fund for 1993-2001; Founding Director of the Knowledge Management Institute 2003-2008.

His research interests include medical cytogenetics, thalassemia and G6PD deficiency. He is also very interested in Knowledge Management and was the driving force the establishment of the Knowledge Management Institute in 2003. He has worked extensively on training, and capacity building especially human resource development. The institute is recognized by many national and international agencies. He continues to serve as committee member of numerous academic institutions as well as serving as a director of Siam Commercial Bank.

Presently, he serves as the Chairman of University Council, Mahidol University and also Chairman of the International Award Committee, and Chairman of Youth Program Steering Committee, Prince Mahidol Award Foundation.

ARIEL PABLOS-MÉNDEZ
MANAGING DIRECTOR
THE ROCKEFELLER FOUNDATION
UNITED STATES

Dr. Pablos-Méndez began his public health career at Columbia University working on the emergence of multi-drug resistant tuberculosis in New York City in 1991; in 1997 he led the Global Surveillance Project on Anti-Tuberculosis Drug Resistance at the World Health Organization (WHO). In both instances, his research and publications brought about significant and successful policy changes in the field.

His affiliation with The Rockefeller Foundation started in 1998, when Dr. Pablos-Méndez spearheaded the program "Harnessing the New Sciences" on product development for diseases of poverty through public-private partnerships. In 2000, his vision and leadership drove the creation of the Global Alliance for TB Drug Development (New York). He also led the Rockefeller Foundation's efforts in AIDS and a program for the treatment of mothers with AIDS and their families (MTCT-Plus) in 2001. Later, he managed the Joint Learning Initiative on Human Resources for Health. Ariel served as Deputy and interim Director of the Health Program until 2004.

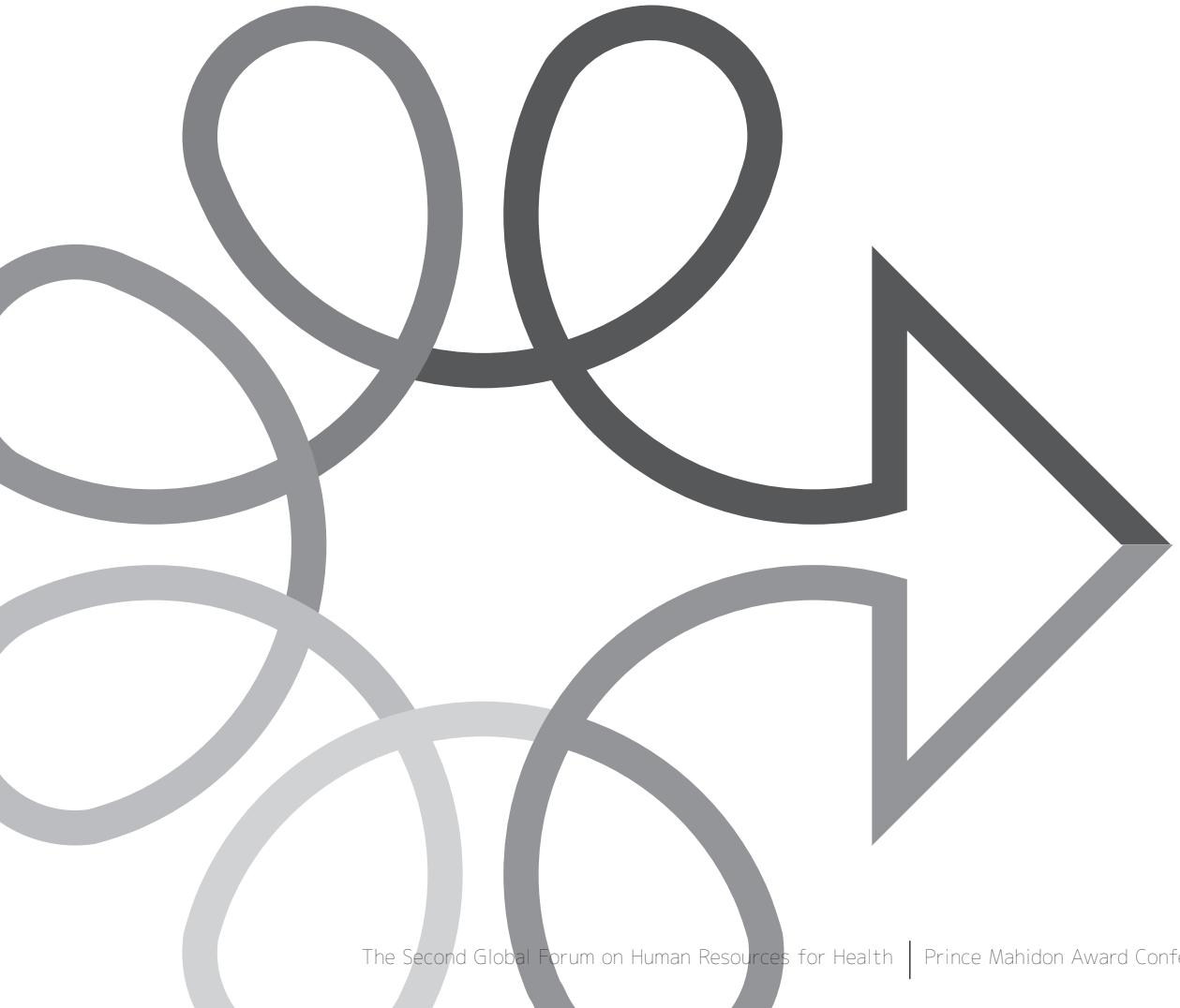
As Director of Knowledge Management & Sharing at WHO from 2004 to 2007, Dr. Pablos-Méndez worked to establish the principles and practice of KM as a core competence of public health, fostering shared learning and social entrepreneurship to help bridge the know-do gap in global health. He advanced the agenda on Knowledge Translation, established WHO Press, launched a Global Health Histories initiative and WHO's e-Health unit, which produced the first global e-Health report in 2006.

In 2007, Dr. Pablos-Méndez returned as Managing Director to The Rockefeller Foundation in New York, where he led the Disease Surveilance Network initiative. He currently works on various strategies to address the Global Challenge of Health Systems, including eHealth and the role of the private sector in mixed health systems, and universal health coverage in the developing world.

Dr. Pablos-Méndez is Professor of Clinical Medicine and Epidemiology at Columbia University in New York. He received his M.D. from the University of Guadalajara's School of Medicine (Mexico) and his M.P.H. from Columbia University's School of Public Health. He was elected to the American Society of Clinical Investigation in 2003, and serves in several international health advisory committees and boards.

PARALLEL SESSION 8 :

Building Capacity to Translate HRH Evidence into Action to Sustain HRH Policy, Decisions and System Strengthening



IRENE AKUA AGYEPONG
REGIONAL HEALTH DIRECTOR
GHANA HEALTH SERVICE
GHANA

Irene Akua Agyepong is a public health physician from Ghana. She has an MBChB (1986) from the University of Ghana Medical School; an MCommH (1991) from the University of Liverpool School of Tropical Medicine, and a DRPH (2000) from the University of North Carolina at Chapel Hill, School of Public Health (Health Policy and Administration /Public Health Leadership). She is a Foundation Fellow of the Ghana College of Physicians and Surgeons. She is currently Regional Director of Health Services in the Ghana Health Service and also teaches part time in the School of Public Health of the University of Ghana. She was Professor to the Prince Claus Chair in Development and Equity for the period 2008 - 2010 in the University of Utrecht in the Netherlands. She is a member of the Scientific and Technical Advisory Committee (STAC) of the Alliance for Health Policy and Systems Research. Her research and publications are in the area of Health Policy and Systems research.

JAMES BUCHAN
PROFESSOR
QUEEN MARGARET UNIVERSITY
UNITED KINGDOM

Professor Buchan has more than twenty years experience of policy advice, consultancy and research on human resource for health (HRH) issues, specializing in supporting the development of national HRH policies and strategies; skill mix; pay and reward strategies and incentives; workforce planning; and health worker migration .

His other current appointments include Adjunct Professor at the WHO Collaborating Centre at the University of Technology; Policy Associate at the WHO Observatory on Health Systems and Policies, Europe; and Professional Adviser to the Centre for Workforce Intelligence, NHS England.

Prof Buchan has directed health workforce policy and consultancy projects for a broad range of clients internationally including the World Health Organisation, the World Bank, International Council of Nurses, the Commonwealth Secretariat and OECD. Recent projects have focused on health worker incentives, skill mix, national HRH strategies, and migration of health workers. In addition to work in the UK, he has recently worked in Australia, Brazil, Cambodia, Lao PDR, Portugal, the Solomon Islands, and Vanuatu .

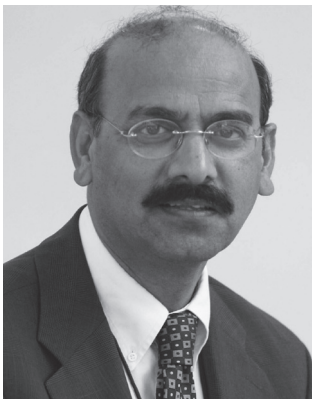
His background includes periods working as a senior HR manager at national level in the National Health Service (NHS) in the UK, and as a HRH specialist at the World Health Organisation (WHO).

FADI EL-JARDALI

ASSISTANT PROFESSOR OF HEALTH POLICY
AMERICAN UNIVERSITY OF BEIRUT
LEBANON

Fadi El-Jardali, MPH, PhD. is an Assistant Professor of Health Policy at the American University of Beirut (AUB), an Evidence-to-Policy Fellow for Evidence-Informed Policy and an affiliated member of the Program in Policy and Decision Making at McMaster University, Canada. He is also a research program director of the Research, Advocacy and Public Policy (RAPP) program in the Arab World at Issam Fares Institute for Public Policy and International Affairs.

His principal research interests and publications are focused on health systems and policy research including human resources for health, health policy making analysis and knowledge translation. He held a number of senior positions at several policy analysis organizations such as the Ontario Ministry of Health and Long-Term Care, Health Canada and the Health Council of Canada. He is the founding member of the Middle East and North Africa Health Policy Forum and a member of its board of trustees. He holds a PhD in Public Policy from Carleton University and an MPH from the American University of Beirut.



ABDUL GHAFFAR
EXECUTIVE DIRECTOR
ALLIANCE FOR HEALTH POLICY AND SYSTEMS RESEARCH
SWITZERLAND

The Alliance for Health Policy and Systems Research welcomes its new Executive Director, Dr Abdul Ghaffar.

Dr Abdul Ghaffar has worked for over 25 years in low-and middle-income countries managing research for health; planning, designing and evaluating national health systems; and teaching health policy and management. He is a physician by training with a PhD in International Health from Johns Hopkins University.

Before joining the Alliance, Dr Ghaffar served as Regional Advisor for Research, in the Eastern Mediterranean Office of the World Health Organization. Earlier, he worked as a Health Policy and Systems Specialist at the Global Forum for Health Research in Geneva. In his country (Pakistan) he started his career as a public health physician, and later worked at different leadership positions as Assistant Director General of Policy and Planning; Deputy Director General of International Health; and Deputy Director and Director of the Health Services Academy, a national school of public health.

He has played a leading role in establishing and managing policy and research for a involving civil society, policy makers and development partners, both at the national and international levels. His desire and interest is to trigger a global movement to generate and use research evidence for improved policy and management decisions at the country level.

SAMUEL MWENDA
GENERAL SECRETARY
CHRISTIAN HEALTH
ASSOCIATION OF KENYA
KENYA

Dr Samuel Mwenda is the General Secretary of Christian Health Association of Kenya (CHAK) and the Coordinator for the Africa Christian Health Associations Platform. He provides strategic leadership to CHAK which has a membership of 527 health facilities and programs of the Protestant Churches in Kenya. CHAK's core mandate is in advocacy, health systems strengthening including HRH, capacity building, networking and HIV programmes. The responsibilities for this position include policy advocacy, partnerships building, programs design, resource mobilization, communication and networking. He participates in various policy and planning committees and technical working groups of the health sector in Kenya. He is currently coordinating advocacy, HRH policy & capacity building and networking of the Christian Health Associations in Africa through the secretariat hosted by CHAK. He is also the Secretary for a Technical Working Group between Government and Faith Based Health Service Providers in Kenya which has developed a partnership framework/MoU that has been adopted to guide partnership between Government and FBOs in the Health Sector. Before joining CHAK, he was the CEO of a 250 bed capacity Mission Hospital in rural Kenya which had a training college for Registered Nurses, for a period of six years. Samuel Mwenda is a medical doctor specialized in health systems management (MSc).

JAMES MCCAFFERY

DEPUTY DIRECTOR FOR THE USAID TRG AND CAPACITYPLUS
UNITED STATES

Dr. James McCaffery, is a Deputy Director for the USAID-funded CapacityPlus project and a member of the project leadership team. Dr. McCaffery is a founding member of TRG-one of the partners on the CapacityPlus project-and has over 30 years' experience helping to build the capacity of ministry planners, human resources management units, private sector groups, nongovernmental organizations, and community groups in a broad range of countries. For CapacityPlus, he oversees and guides all health systems strengthening activities, with particular responsibility for partnership, policy, planning and human resources management system strengthening initiatives. He was instrumental in helping to develop the Human Resources for Health Action Framework (HAF) adopted by the Global Health Workforce Alliance and a broad range of global and country level partners.

Dr. McCaffery has a special expertise in human resource system strengthening, especially in the area of linking evidence to help guide decisions that lead to policy decisions, plan implementation and action. As part of this work, he is currently engaged in writing and testing evidence based stakeholder leadership guidelines that can be used by diverse and cross-sectoral HRH leaders to agree on key policy decisions and sustainable interventions.

Since 1981, Dr. McCaffery has played a major role in growing TRG into a well-respected HR consulting organization that has worked in 100 countries. His international work spans 18 countries in North and sub-Saharan Africa, Asia/Near East, and Central America, and includes and includes a special emphasis on strategic planning and system strengthening work aimed at sustaining HRH change and innovation. He has a PhD in education from the University of Wisconsin.

SANIA NISHTAR
FOUNDER AND PRESIDENT
HEARTFILE
PAKISTAN

Sania Nishtar is the founder and president of the NGO think tank, Heartfile, which today is the most powerful health policy voice in Pakistan and is recognized as a model for replication in other developing countries. Her areas of interests are health systems, global health, broader issues of governance and public-private relationships.

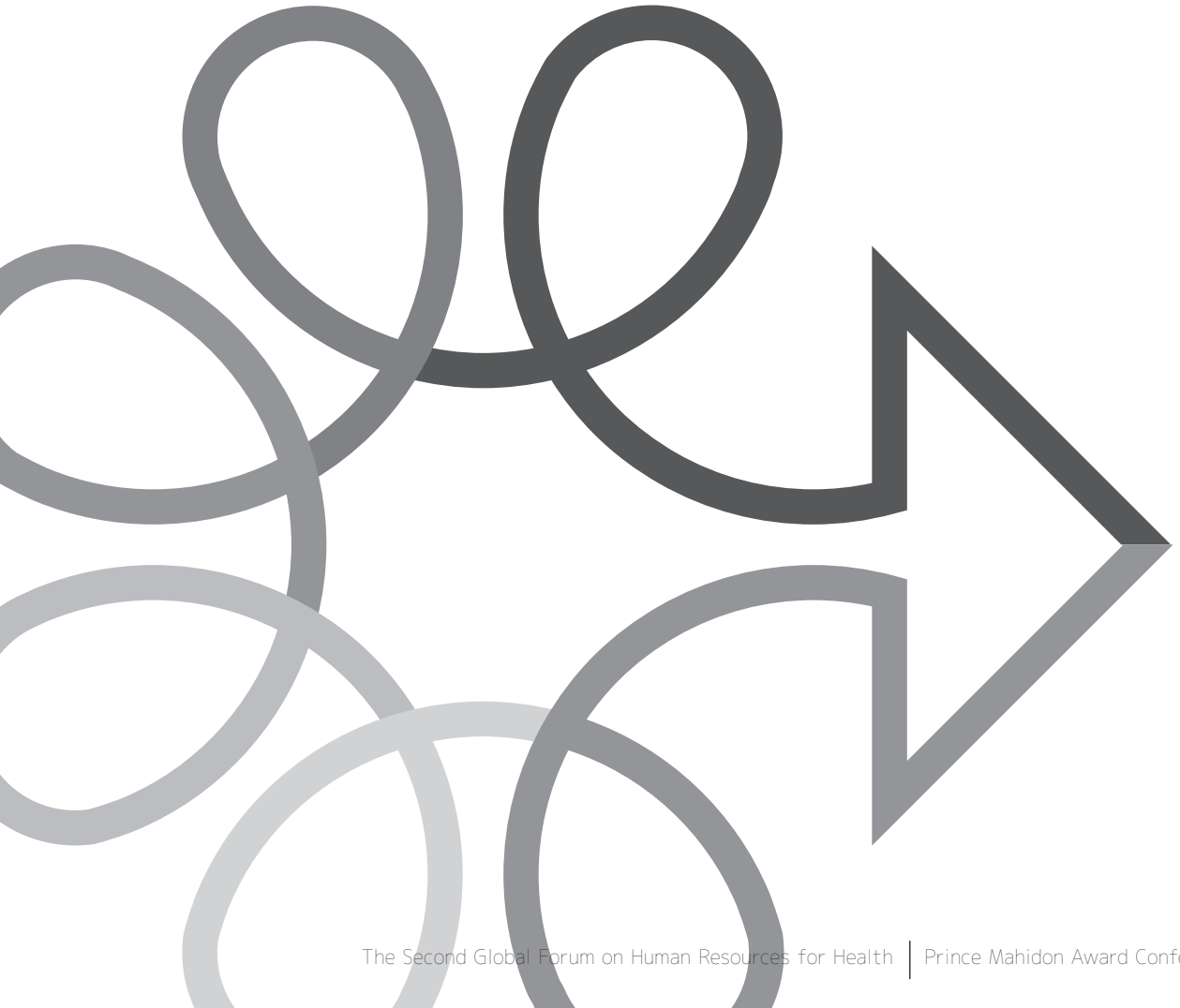
In Pakistan her pioneering work in the health sector has inspired new initiatives and has shaped policies on health reform and non-communicable diseases. She is also the founder of Pakistan's Health Policy Forum and provides support to many agencies in an advisory role. She additionally sits on many governing boards and is a visiting faculty to many educational institutions. Within Pakistan, she is also a voice to catalyze change at the broader governance level as an op-ed columnist in Pakistan's largest English newspaper.

Internationally, Sania Nishtar's scope of work has several dimensions. She is a member of many Expert Working Groups and Task Forces of the World Health Organization and is currently a member of the board of the International Union for Health Promotion and the Alliance for Health Policy and Systems Research. She is also a member of the World Economic Forum's Global Agenda Council, the Clinton Global Initiative, the Ministerial Leadership Initiative for Global Health and many other international initiatives. She has formerly been on several international Boards, and has chaired several global campaigns and programs. She has also been an advisor to WHO on numerous occasions, has published over 100 journal articles and is the author of 6 books. Her book on Health Reform entitled 'Choked Pipes' will be released by Oxford University Press in February 2010.

She speaks to audiences around the world and has been extensively published in and quoted in the media. Sania Nishtar is the recipient of Pakistan's Sitara-e-Imtiaz (presidential honour), the European Societies Population Science Award, 16 gold medals and many accolades of the International Biographical Centre, Cambridge and the American Biographical Center. Sania Nishtar holds a Fellowship of the Royal College of Physicians and a Ph.D from Kings College, London.

PARALLEL SESSION 9 :

Innovative solutions for strengthening HRH information systems



PARTNERSHIPS FOR STRENGTHENING HUMAN RESOURCE FOR HEALTH INFORMATION SYSTEM FOR PLANNING AND MANAGEMENT

A case study from Tanzania

EXECUTIVE SUMMARY

Tanzania is an East African country with a population of about 40,000 million people and an area size close to one million square kilometers. Human Resource for Health Information System (HRHIS) in the country was established basing on Information Communication Technology (ICT) in July 2009. Its objective is to improve health service delivery as it aides informed decision making and planning in the aspects of placement, management and development of the health workforce. It was developed by the Ministry of Health and Social Welfare (MOHSW) through joint technical collaborative efforts with the Department of Computer Science of the University of Dar es salaam and supported by Japan International Cooperation Agency (JICA).Through a multi-sectoral HRH Working Group, Government Ministries, Development Partners, Faith-Based Organizations and Private Sector were consulted and updated on the progress at each stage.

Major problems and challenges that led to the development of the System include the absence of a well established comprehensive and reliable ICT-based human resource system for tracking HRH information in the country; existence of multiple ,uncoordinated and unharmonized data sources; and difficulty experienced in making intelligent forecasts on demand and supply of HRH due to analyzing deficient data.
The process of establishing HRHIS comprised:-

i. Assessment of the existing human resource databases and information systems within and outside the Ministry;

ii. Analysis of the existing paper based HRH system at various levels in the health sector to identity key data fields and information required by various stakeholders including MOHSW and Prime Minister's Office, Regional Administrative and Local Government;

iii. Designing data collection tools and procedures, and system specifications;

iv. Software development and testing;

v. Training of personnel to operate the System;

vi. Installation of the System at working stations;

vii. Carrying out remote user support (through phone calls) and onsite supportive supervision missions (on monthly basis, 2 months consecutively) after the installation;

viii. Further improvement and refinement of the System based on feedback obtained in (v) and (vii) above, and

ix. Linking HRHIS with other systems including Training Institutions Information system (TIIS) and District Health Information System (DHIS) and Health Management Information System (HMIS)

So far, the System has been successfully rolled out in 7 out of 25 Regions and to 7 out of 8 Consultant Hospitals. Since its establishment, the HRHIS is proving to be an effective and reliable management tool for use at various levels in the health sector. Periodic evaluation is undertaken for refinement and upgrading to ensure continued usefulness.

BACKGROUND

The Ministry of Health and Social Welfare has developed the Human Resource for Health Information System in collaboration with the University of Dar es Salaam, Department of Computer Science. The rationale behind developing it was to address limitations related to the availability of timely and accurate human resource data for various needs such as retention rates, retirement trends, educational levels and the like. Some specific problems were:

i. Lack of well established, comprehensive and reliable ICT based system for tracking HRH information in the country;

ii. Gaps and limitations on available information on health cadres in all sources such as Health Management Information System, Professional Councils Data Bases and other sources, for the purposes of proper planning and decision making;

iii. Difficulties in coordination and ascertaining accuracy and reliability of information collected from multiple sources ; and

iv. Challenge in analyzing the then available HRH information to forecast demands and supply.

The need for the establishment a functional and compressive HRH information system was advocated as a priority area in a number of policy documents within the Ministry i.e. HRH Monitoring Guideline, 2003. It is in this document that HRHIS was planned and monitoring framework highlighted .Other documents are National Health Policy, 2007; Heath Sector Strategic Plan III,2009; Council Comprehensive Health Plan Guideline, 2010; and the Five-Year Human Resource Strategic Plan, 2008.Its necessity was reiterated at the Joint Annual Health Sector Review Meeting held in 2008, which assessed the performance of the sector. It was at this meeting where a milestone decision was made requiring that "A functional Human Resource for Health Information System be established by September 2008". However, it was not until 2009 that the system became operational. So far, the system has been successfully rolled out to seven (7) regions out of twenty five (25) in the country and seven (7) Consultant Hospitals out of eight (8). A reliable data flow has been established (down from health facilities all the way to the national level).

EVOLVEMENT OF HRHIS

HRHIS has evolved through various development stages based on inputs obtained from users, stakeholders and from sharing the progress made at different meetings and fora. HRHIS is a part a larger and integrated system of the Ministry known as Health Management Information System. HRHIS is one among several modules that collectively make up the HMIS. Different levels of health service delivery are involved with different roles and functions of HRHIS as follows:-

i. Health facilities which are responsible for HRH data collection and onwards forwarding the data to Council Health Management Team (CHMT) located in Districts.

ii. District level where CHMT is responsible for routine data gathering, entry and analysis using HRHIS software for utilization purposes at the District level and below. Data collected and analyzed are then electronically forwarded to Regional Management Team (RHMT) where the HRHIS system is installed.

iii. Regional level where the RHMT is responsible for analysis of HRH data using HRHIS software from all Districts for utilization and thereafter electronically forwarded to the Ministry Headquarters.

iv. Ministry Headquarters where the compilation of data from all regions is done and analyzed using HRHIS software to generate various reports including status of health workforce.

The system has been designed and configured in such a way that it can communicate and share data with other existing systems. So far, the HRHIS is linked with HMIS software called DHIS. Work is underway linking HRHIS to the following Information Systems and data bases:-

i. Human Capital Management Information System (HCMIS);

ii. iHRIS used by Christian Social Service Commission;

iii. Data base owned by Association of Private Health Facilities in Tanzania,

iv. Health Training Institutions Information System (TIIS); and

v. Other Data Bases operated by Professional Councils.

The importance of human resource in the health sector is unique in the sense that health service delivery is next to impossible without human resource; even where a machine is available, it must be operated by a human being. This circumstance explains the labor intensive nature of the health service delivery, thus calling for proper and secure HRH information system.

Positive comments made by system operators at different levels are:

i. It is easy to identify HRH gaps and maldistribution;

ii. Attrition rates is known to justify proper HRH management;

iv. It assists planning training programme;

v. It shows investment on salaries;

vii. It provides a solid base for decision making.

METHODOLOGY USED IN INTRODUCING THE SYSTEM

Its introduction included evolutionary software development which is an interactive and incremental approach to software development. The initial requirements and architecture envisioning was obtained. Instead of creating comprehensive software initially, the development of software has evolved in an interactive manner and delivered incrementally over time to obtain different feedback from user and stakeholders.

Training sessions were carried out to the targeted persons chosen strategically to obtain feedback based on the nature of their role and function in handling human resource issues.The rationale of providing the training was to impart knowledge and orient participants on how to operate the system. Another approach applied was self-learning and practice whereby participants are given manuals for them to read and follow the instructions enabling them to operate the system. The justification for self guiding is the fact that "practice makes it perfect".

Onsite supportive supervision is adopted to determine the progress made on data entry and to get feedback from users experience with the system was undertaken.Most important is that through supportive supervision, trouble shooting associated with limited computer skills are dealt with and also clarifications on unclear issues are resolved. Data are collected from the health facilities by using forms which comprise of identified fields agreed by health providers, managers and policy makers. These forms are forwarded to District Medical Officer Office's for entry into the system by a trained person. Whenever, the system is updated, IT specialists from University of Dar es Salaam visit the site and provide instructions and clarification to system users. Telephone consultation is also done by in providing quick solutions when needs arise.

The chosen methodology has some challenges, however, since the country is relatively large which makes it costly to conduct supportive supervision missions in every district, and since most health workers are not computer literate and hence, require induction.

SALIENT FEATURES OF THE HUMAN RESOURCE FOR HEALTH INFORMATION SYSTEM

HRHIS Software has been built using free and open source technologies (such as Linux OS, PHP, and PostgeSQL). Its design is based on flexible and open ended architecture which allows system administrators to configure the system from its requirements mostly without entering into the system codes. The system comprises the following key fields for capturing data of employees working in public and private health facilities:

S/N	FIELDS	S/N	FIELDS
1	Employee Name	14	Basic Monthly Salary
2	Date of Birth	15	Date of First Appointment
3	Sex	16	Date of confirmation
4	Marital Status	17	Date of Last Promotion
5	Nationality	18	Employer
6	Education Level	19	Employment status
7	Number of Children	20	Next of Kin
8	District of Domicile	21	Relation to Next of Kin
9	Check No	22	Registered Disability {visual impaired, physical disability, other}
10	File No.	23	Contacts
11	Registration No.	24	Superlative substantive position
12	Terms of Employment	25	Department
13	Profession	26	Salary Scale
		27	Contacts

Fields such as retirement date and duration of stay at a facility are calculated fields, computed automatically by the system.

The System is flexible to allow additional fields if need be. General and specific reports in different formats can be generated automatically including graphic reports. The innovative aspects that have gone into the system have made it user friendly as it offers web self guide instructions. The system is versatile and has the potential to work elsewhere.

Since HRH information/data are personal and confidential, the HRHIS system has been designed and developed taking into account high security measures for protecting the data that has been entered. Log-in mechanism is such that only allowed individuals can enter the

system. The system has Users Administration functionality which allows the system administrator to limit system users on the available functions of the system. A user only has access to some of functionalities and data privileged to him/her.

MONITORING AND EVALUATION

Monitoring and evaluation of the HRHIS development and progress, is regularly done through generating reports and presentations in relevant fora. Such fora include MOHSW Management Meetings as well as HRH Working Group, Technical Committee for Sector Wide Approach (TC-SWAP) and the Joint Annual Health Sector Review Meetings. To-date, the system has received a positive acknowledgement from different stakeholders.

Furthermore, Ministry of Health and Social Welfare officials have been visiting the sites periodically to monitor actual usage of the system. To sensitize health managers to ensure that the system is functioning, the availability of "Functional HRHIS" at each working station and its usage are one among the checklist items of the National Supportive Supervision.

OBSERVATIONS

1. The analysis of the existing human resource information systems within and outside the Ministry reveals that HRHIS has its own uniqueness aspects which are:-
   i. Its local embedded nature which guided the system and software development processes driven by Tanzanian System Experts from a local university;
   ii. Continuous involvement of all levels of health service delivery in a bottom up approach; and
   iii. In-built security measures given the sensitivity of the personnel information.

2. The envisaged challenges are those associated with system sustainability particularly:-
   i. Continual System maintenance;
   ii. Continual capacity building for the system operators at all levels given that there will be system updates when need arises;
   iii. Need for seriousness and commitment from all stakeholders; and
   iv. Financial and partnership consolidation.

CONCLUSION

The HRHIS has proved to be a useful tool given the progress made in a short time since its inception. It has been developed through partnership and getting feedback from various stakeholders. Capacity building in data utilization, system maintenance and linkage are important areas for partnership.

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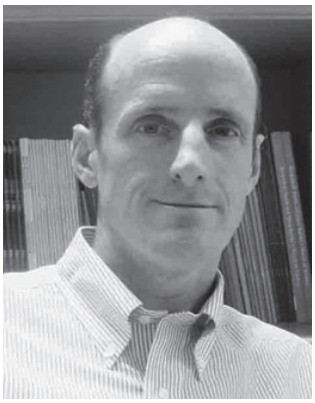


TIMOTHY GRANT EVANS

DEAN
JAMES P GRANT SCHOOL OF PUBLIC HEALTH, BRAC UNIVERSITY
BANGLADESH

Tim Evans is a dual national of Canada and the United States. Following under-graduate training in social sciences at University of Ottawa, he obtained a D.Phil in Agricultural Economics at University of Oxford on a Rhodes Scholarship. He subsequently trained in medicine at McMaster University in Hamilton and completed a research-residency in Internal Medicine at the Brigham and Women's Hospital in Boston with a joint appointment as a MacArthur post-doctoral fellow at the Harvard Center for Population and Development Studies. From 1995 through to 1997, he was an Assistant Professor, International Health Economics, at Harvard School of Public Health as well as an Attending Physician, General Internal Medicine, at the Brigham and Women's Hospital. In 1997, he was appointed the Director, Health Equity at the Rockefeller Foundation in New York. There he led the development of a programs related to new drugs and vaccines for neglected diseases, tobacco control, access to HIV treatment, disease surveillance, enhancing information systems capacity for vital statistics, disease surveillance and the monitoring of inequities in health, and a global learning initiative on human resources for health. During his tenure, he was a co-founding Board member of the Global Alliance on Vaccines and Immunization (GAVI) and the Global Forum for Health

Research. In 2003, he joined the World Health Organization as an Assistant Director General with responsibility for Evidence, Information, Research and Policy. During his tenure, he pioneered institution-wide strategies for health systems, knowledge management and research and oversaw the annual production of the World Health Report. He led the global Commission on Social Determinants of Health and was a co-founder of various partnerships for strengthening health systems including the Health Metrics Network; the Global Health Workforce Alliance; the World Alliance for Patient Safety and the Providing for Health Partnership. In July 2010, he took up the post of Dean at the James P. Grant School of Public Health at BRAC University and ICDDR,B in Bangladesh. Dr. Evans has written numerous journal articles, chapters and books on a wide array of topics in global health and development with a particular focus on health equity, health systems and health research policy. He is currently a Commissioner on the Commission on Health Professional Leadership in the 21st Century, a member of the Board of the Public Health Foundation of India and serves as a scientific advisor to the Institute of Population and Public Health of the Canadian Institutes for Health Research. He previously served as Chair of the Board of Trustees of ICDDR,B and on the Board of BRAC.

MICHAEL FRIEDMAN

MEDICAL OFFICER/ PEPFAR HRH CO-CHAIR
US CENTERS FOR DISEASE CONTROL
UNITED STATES

Captain Michael Friedman is a US Public Health Service medical officer with CDC's new Center for Global Health. For the past 1 1/2 years, Dr. Friedman has been spearheading CDC's effort to broaden its global work in health systems strengthening and human resources for health. He also directs 2 public health evaluations examining the impact of PEPFAR on non-HIV health services and systems and serves on a US government interagency steering committees to address health systems within PEPFAR, human resources for health, and the President's new Global Health Initiative.

Dr. Friedman was CDC's Associate Director in India from 2004-8 and the director of a 7 year community asthma initiative in 7 US cities prior to that. Dr. Friedman received his medical degree from the University of Miami School of Medicine and completed his internal medicine and pediatrics residencies at the University of Chicago hospitals. He began his public health career as a physician for a small NGO in Bihar, India in 1994-5 and later worked with the Indian Health Service in Zuni, New Mexico as a physician and public health advisor to the Zuni tribe.

Dr. Friedman is a active father of 3-a 12 yr old boy and 10 year old boy/girl twins and tried to squeeze in any and all sports when he has the chance.

PIYA HANVORAVONGCHAI

LECTURER IN HEALTH POLICY
THE LONDON SCHOOL OF HYGIENE & TROPICAL MEDICINE
THAILAND

Piya Hanvoravongchai is a Lecturer in Health Policy at the London School of Hygiene & Tropical Medicine (LSHTM) based in Bangkok. He is also the Southeast Asia Program Advisor for the CMB Foundation. Piya has strong interest in health policy and health systems research including issues relating to health financing, health care resource allocation, and health workforce policy. He has over 12 years of work experience in the public health sector, starting his career as a clinician and a hospital administrator at a rural hospital in Thailand. Prior to joining LSHTM, Piya worked at the World Health Organization (Switzerland), Harvard University (USA), Health Systems Research Institute (Thailand) and International Health Policy Programme (Thailand). He was the Co-ordinator of the Asia-Pacific Action Alliance on Human Resources for Health (AAAH) between 2006-2008 and a member of the secretariat and the research & writing team of the Joint Learning Initiative on Human Resources for Health between 2003-2005. Piya graduated from Mahidol University (MD), London School of Economics and Political Science (MSc), and Harvard University (ScD).

ELIKAANAN MWAKALUKWA

ASSISTANT DIRECTOR
MINISTRY OF HEALTH AND SOCIAL WELFARE
TANZANIA

Elikaanan Mwakalukwa has 24 years working experience in human resource planning. She was appointed to the position of Assistant Director in 2006.She is responsible for the development of human resource policies and strategic plans and for monitoring and evaluation of the implementation. Since 2008, she is a chair to a Multi - Sectoral Human Resource for Health Working Group. Furthermore, she has been the focal point and coordinator for the establishment of Human Resource for Health Information System at the Ministry of Health and Social Welfare.

She is a holder of a Masters Degree in Human Resource Development from University of Manchester (UK) and a Bachelor of Arts in Sociology from University of Dar es salaam, Tanzania. She has also undertaken short-term courses, amongst others, the Projection Models for Human Resources at University of Western Cape, South Africa and Computer Assisted Human Resource Data Base Design and Management at the Eastern and Southern Management Institute, Arusha ,Tanzania. Health Economics, Trans Africa Management Institute, Kampala Uganda, Human Resource Planning, Institute of Development Policy and Management, UK.

MARIO ROBERTO DAL POZ

COORDINATOR, DEPARTMENT OF HUMAN RESOURCES FOR HEALTH
WORLD HEALTH ORGANIZATION

Mario Roberto Dal Poz: Brazilian, a paediatrician with a passion for Public Health, has been working in the area of health systems for over 25 years, gaining vast experience in the development of human resources at regional, national and international levels. He has a Master of Sciences in Social Medicine with a focus on health delivery models in the context of the growing urbanization in Brazil, and a Doctorate in Public Health with the elaboration of a new methodology for policy analysis of human resources for health development.

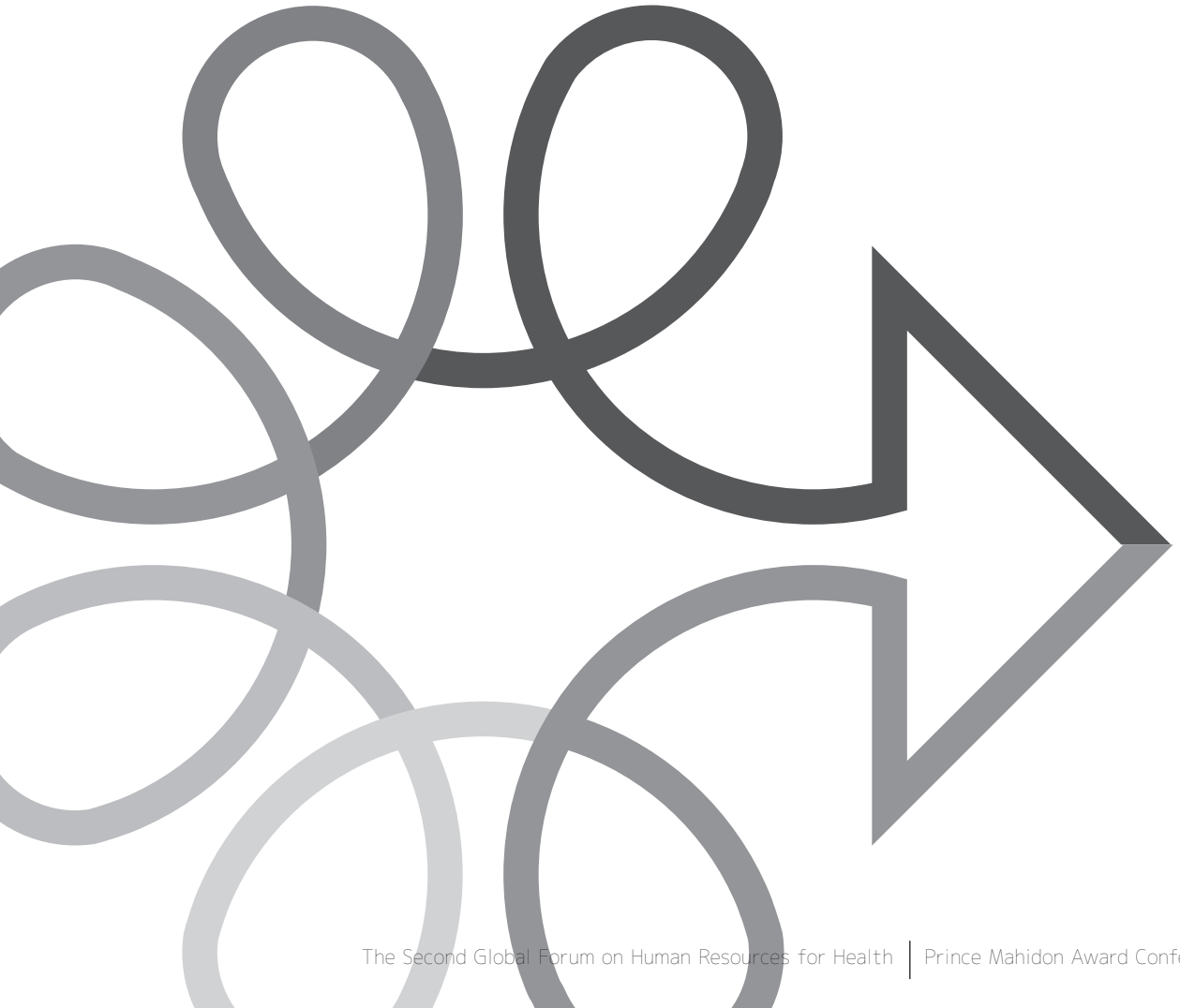
Associated professor and former deputy director of the Social Medicine Institute at the University of the Rio de Janeiro State (UERJ), he worked extensively in the Brazilian Health System (SUS). At the World Health Organization (WHO), has been working on human resources for health development and policies initially as a scientist and then coordinating the Health Workforce Information and Governance Unit within Department of Human Resources for Health.

He worked in several countries in Latin America, Africa, Middle East, Europe and Asia, mostly assisting countries on human resources for health (HRH) development, health workforce information system and health system performance. He also works on technical cooperation on HRH policy and planning implementation at national and sub-national level.

Published more than 60 articles in peer-review and specialized journals, 6 books and contributed for more than 10 book chapters in the área of human resources for health. Additionally he is the current Editor-in-Chief of the Human Resources for Health electronic journal [http://human-resources-health.com/].

PARALLEL SESSION 10 :

Scaling up HRH towards equity



"Innovative HRH Management for Rural Health Workers in Cambodia"

Keat Phoung
Ministry of Health, Cambodia

According to the Ministry of Health (MoH) staffing standards that required to having at least 6 to 10 staffs working per health facility to provide MPA services at the periphery level. The current workforce situation showed clearly a great shortfall of staff, especially nurse/midwife, along with the geo-demographic situation of Cambodia, especially in the Nord East (NE) Region that could not allow health staff to provide adequate service delivery to the community. Major problem of getting staff to the "unattractive" post and keeping them to stay could not be addressed. The Second Biennial Review of the National Health Workforce Development Plan 1996-2005 (HWDP) in August 2001, identified two strategies to assist the scaling up of health workers to fulfill the vacant post at the rural health facilities:

1. Recruitment of rural entrants, and trained them away from large cities.

2. Assuring young staff that a posting is definitely time-limited-say two-year contract

There are very few qualified staffs are willing to serve at the rural and remote areas, especially those of NE Region. In addition, the growing fast of the private sectors, increasing of basic needs and better career development, could not stop staff moving from remote working place to the capital cities. In the other hand, the disparity of the population, led to the heavy workload to the staff in providing the health care to the remote mountainous community. Most deliveries are at home and not done by trained staff. Overload of work at HC can not allow midwifery staff to provide delivery at home (maximum 2 trained midwives per HC). The establishment of health post (HP) as alternative health facility when people seek for health care has been put in place in the North East provinces. In this connection, the need of staff is much greater. Therefore, the selection of local community candidates to MoH course and recruitment them to MoH post was recommended to keep them working for their own community. Because the low educational background of the people in the community could not be met the MoH entry requirement, a situation analysis of the NE Region, was conducted to identify appropriate intervention to meet the needs. In this regards, a MoH comprehensive interventions which link student recruitment, education, and deployment were elaborated. This intervention started from 2003 in one school covering 4 remote provinces and expanded to all other public schools from 2005, resulted in solving the problems of shortage and mal-distribution of nurse-midwife at remote health centers. Because the production strategy could not address the shortfall of staff on time, in 2009, the new initiative of the Minister of Health the so-called Fast Track Strategy with the

involvementfrom the 24 Provincial Health Directors (PHDs) and Health Development Partners toward resource mobilization, re allocation of staff to meet the service need at remote and rural areas across the country.

Interventions

A. Innovative training to scaling up health workers:

As mentioned above, efforts have been made to produce staff to fulfill vacant post at the front line of health services through a situation analysis to access the situation of the NE provinces. The study team was composed of:

- Director and Deputy Director of HRD Department
- Director of Regional Training Center
- Representatives of Provincial Health Department in the region
- Representatives of local health facilities
- Representative of Provincial Education Department
- Representative of Local Authorities

Several activities were conducted as the following:

1. Job analysis of nurse/midwife at remote health centers and educational background of local communities:

Not every district has secondary school. The distance from home to the school led to difficulty for accessibility. Referring to the statistic of the Provincial Education Department, has shown that at the district level of the four provinces, there were students who have mostly grade 5 - 9 year schooling, grade 5 (30%) , grade 7 (5%) and grades 8-9 (3%). Among those, few female students have grade 7. In addition, MoH employment was not guaranteed for graduates. Therefore, very few students apply to the regular MoH courses (secondary nurse or midwifery training programs).

To promote the local community children more to the course and based on the number of students with the acceptable educational level, the revitalization of the primary nurse midwife with the educational entry requirement is only grade 7, was recommended. The implementation of the course aims at equips graduates with basic skills and knowledge to serve the front line services. They will play a management role for basic service delivery and will replacing the role of TBA and traditional healer when their competency will be recognized. Therefore, a study of service package of those remote facilities that link to the knowledge and skills of nurses and midwives working at the remote health facilities is a pre requisite to provide background for further appropriate interventions.

The objective of the study is to identify what the low level of staff have done and could do to provide access to health services and safe life of people.

2. Adapt the role and responsibilities of nurse/midwife at local context referring to the national standard

After identification of the service package of the remote those health facilities, a matching of MoH roles and responsibility of nurse and midwife and the identified roles and responsibility of the front line staff have been done to secure the ability of staff providing services at those facilities.

3. Review the Primary Nurse/Midwife curriculum

According to the study, the HRD Department in collaboration with relevant partners has adjust the curriculum based on the level of education of local community and their role and responsibilities. Basic nursing care, safe delivery and refer patients when identified of danger signs were integrated into the curriculum. Curriculum guidelines, handouts, lesson plans were developed to facilitate the teaching and learning activities.

4. Set up the selection criteria for recruiting students for primary level nurse/midwife course

Four teams have been appointed to identify vacant posts and interview the potential candidates. The interview focused on their motivation to the course as well as their willingness to apply to the course. The distance from the vacant post (HC or HP) to the district varies from 20 kilometers to 80 kilometers. The time for traveling varies from 2 hours to two days.

To appropriately select the right people to the course, establishment of selection committee was set up with the involvement from representatives of MoH Departments (HRD and Personnel Departments), MoH Regional Training Institutions, Provincial Health Departments, Provincial School Department, Local Authorities, Local Communities, and NGOs. Priority has been given to potential candidates who have minimum educational background of grade 7 that came from:

- HC where has no staff
- HC where staff is nearing retire
- HC where staff has potential to leave
- HC with limited number of staff for the population
- HC where staff are non technical staff

Eligible candidates must be recognized by local authority from the target places selected/identified as vacant post.

To facilitate the accommodation and encourage more female students

from local community to the course, training sites were placed in each of the 4 Provinces. Contracting arrangement with the provision of small incentives for students during education has been made between Provincial Health Departments (PHDs) and the students regarding the deployment after graduation. There were collaboration between Human Resource Development and Personnel Departments to convince and ensure all graduates will be recruited for MoH employment and posted them at their original communities.

Resulting from the mentioned activities, several achievements have shown as the following:

1. Students of primary level nurse/midwife were recruited from the needy area under the contract for deployment
2. After graduation, 100% of the students applied to the MoH posts, not to the private sector, and obtained the posts at contracted health centers of their origin
3. PHDs follow the Fast Track Strategy for ensuring staff management and retention
4. From 2003 to 2010, 580 primary nurses and 1,060 primary midwives graduated and posted to remote health centers.

B. Fast Tract Initiatives Road Map for Reducing Maternal and New-born Mortality

1. Purpose of the Initiatives

It is a political commitment from the Minister of Health aims at elaborating critical areas of interventions and resources needed that would effectively contribute to the reduction of maternal and new born mortality as stipulated in the Cambodian Millennium Goals and specific activities to be implemented as a regular basis at the national and sub national levels.

2. Overall Goal of the Fast Track

"To contribute to the achievement of Cambodia's Millennium Goals 5 target of less than 250 maternal deaths per 10,000 live births by 2015".

3. Keys Objectives

a. To scale up as fast as possible to achieve universal coverage with the most essential maternal, new born and reproductive health services
b. To improve accessibility and affordability of maternal and reproductive health services by removing financial barriers to care
c. To improve individual, family , and community care practices before and during pregnancy, childbirth and post partum, including appropriate care seeking and increased demand for priority RMNH

The first key objective mentioned clearly the MoH order goes to all

PHDs and key MoH Departments to find ways to allocate staff to the vacant post. While waiting the graduates to be posted at vacant post, a Committee has been established to monitor and feed back the following strategies have been identified and supported to meet the need:

- Each PHD has to identify vacant post and send to MoH as priority area of intervention
- Resource mobilization strategy is worked out with involvement from all stake holders to have at least one midwife placed at those facilities. Several mobile teams were set up to send senior midwives assist junior midwives and stay for a while to fill the gap
- Each PHD to report as a regular basis to MoH for specific assistance
- Key Departments, HRD and Personnel, play a critical role in monitoring the allocation of graduates and resource mobilization to ensure staff coverage

In parallel to the fast track initiatives, convincing the top government to secure 100% of post for allocation of new graduates, especially the primary nurses and midwives are very challenging for MoH. Monitoring on the placement of new staff to vacant post is priority action with participation from all stakeholders.

Lesson learned from the innovative training strategy

- The innovative training can meet the need of staff in term of quantity only but the quality for service delivery remain problem because they can serve only the basic health services but not the severe health problems of the community due to limitation of knowledge and skills stipulated in the curriculum which is based on level of education of local communities
- Because most of students are from ethnic groups, quality of teaching and learning request to have detailed and simple training materials with close monitoring and evaluation for maintaining the quality of graduates

Recommendations

- The strategy of innovative training for rural health workers could be implemented as temporary solution only because the educational background of the students could not allow them for their career path way development. Furthermore, the quality of training should be paid more attention to meet the safety and the quality of health services for the rural and remote areas

- The fast track strategy should be continue with regular feed back and monitoring system to ensure vacant post are fulfilled as required in the MoH staffing standards and further meeting the recommendations of the Global Trend.

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BARBARA ARANDA-NARANJO

HIV/AIDS BUREAU DIRECTOR
HRSA/DHHS
UNITED STATES

Dr. Barbara Aranda-Naranjo, PhD, RN, FAAN has been a community health researcher and public health nurse with over twenty-five years experience in the promotion of health and the prevention of disease in underserved, resilient communities at both the local, state, national and international level. She has extensive "front-line" experience in planning, developing and coordinating research investigation and program evaluation related to health care delivery with African-American and Hispanic-American populations especially women and children living with HIV disease. She has an effective record establishing collaboration among federal, state and local stakeholders related to people living with co-morbidities such as substance abuse, mental illness and STD's, primarily HIV/AIDS.

Currently, Dr. Aranda-Naranjo is the Director of the Global HIV/AIDS Program at the Health Resources and Services Agency (HRSA). In this capacity she oversees a budget of over 240 million, through funding from the President's Emergency Program for AIDS Relief (PEPFAR), and manages a portfolio of care and treatment cooperative agreements that include clinics, provider training and quality improvement programs.

Prior to this position she was the first Robert and Kathleen Scanlon Endowed Chair in Values Based Health Care at the School of Nursing & Health Studies (NHS) at Georgetown University in Washington D.C. In this role, she provided leadership in integrating the core values of excellence and social justice in the research, teaching and service activities for faculty at NHS. During her tenure at Georgetown, she was also the Director of a new project she co-founded with her nursing students entitled "Nurses for America". This innovative program was funded in August, 2005 by AmeriCorp and the focus is on placing professional nurses for a two year commitment to serve in community health clinics and public health departments that serve vulnerable, resilient populations. The nurses receive mentoring from Georgetown Nursing faculty and an educational stipend of over 9 thousand dollars to pay off their student loans or start graduate school.

Prior to coming to Georgetown, Dr. Aranda-Naranjo spent five years working at HRSA in the HIV/AIDS bureau and served in the following positions: the Branch Chief for Special Projects of National Significance, the Deputy Director for the Division of Community Based programs and the Acting Director of the Division of Science and Policy.

In these roles, she was both innovative and tenacious in ensuring that the funding of new projects was sensitized by not only the voices of the health care providers, but the people living with HIV/AIDS.

Dr. Aranda-Naranjo is best known for her leadership in developing the South Texas AIDS Center for children and families with her colleagues at the University of Texas Health Science Center in San Antonio in 1988, which was funded by HRSA. This Center continues to exist today as the South Texas Family AIDS Network (STFAN) housed at the University Health System. The goal of STFAN is to provide culturally competent quality care and coordinate support services to individuals and families living with HIV/AIDS to improve physical, spiritual and emotional well-being.

ZULFIQAR A. BHUTTA
PROFESSOR
AGA AKHAN UNIVERSITY
PAKISTAN

Dr Zulfiqar A. Bhutta is Husein Laljee Dewraj Professor and the Founding Chair of the Division of Women and Child Health, Aga Khan University, Karachi, Pakistan. He also holds adjunct professorships in International Health & Family and Community Medicine at the departments of International Health at the Boston University and Tufts University (Boston) respectively. He was designated a Distinguished National Professor of the Government of Pakistan in 2007. He is also the Dean of the faculty of Paediatrics of the College of Physicians & Surgeons, Pakistan and the Chairman of the National Research Ethics Committee of the Government of Pakistan.

Professor Bhutta was educated at the University of Peshawar (MBBS) and obtained his PhD from the Karolinska Institute, Sweden. He is a Fellow of the Royal College of Physicians (Edinburgh), the Royal College of Paediatrics and Child Health (London) and the Pakistan Academy of Sciences. He has been associated with the Aga Khan University since 1986 and heads a large research team working on issues of maternal, newborn and child survival and nutrition globally and regionally. Dr Bhutta has served as a member of the Global Advisory Committee for Health Research for the World Health Organization, the Board of Child & Health and Nutrition Initiative of Global Forum for Health Research, and the steering committees of the International Zinc and Vitamin A Nutrition Consultative Groups. He is an executive committee member of the International Paediatric Association and on the Board of the Global Partnership for Maternal, Newborn and Child Health (PMNCH). He is a Foundation Council member of the Global Forum for Health Research, a council member for the International Society for Infectious diseases (ISID) and serves on the governing council for the World Alliance for Patient Safety Research. Dr Bhutta is currently the Chair of the Health Sciences Group of the Biotechnology Commission of Pakistan, a member of the WHO Strategic Advisory Committee for Vaccines (SAGE), the Quantitative Vaccine Research (QUIVER) group of WHO, the Advisory Committee for Health Research of WHO EMRO, and its apex Regional Consultative Committee. He is the immediate past-President of the Commonwealth Association of Paediatric Gastroenterology and Nutrition (CAPGAN) and the Federation of Asia-Oceania Perinatal Societies (FAOPS).

Dr. Bhutta is on several international editorial advisory boards including the Lancet, BMJ, PLoS Medicine, PLoS ONE and the Cochrane ARI group. He has published four books, 55 book chapters, and over 320 indexed publications to date. He has been a leading member of recent major

Lancet series on Child Survival (2003), Newborn Survival (2005), Undernutrition (2008), Primary Care (2008) and the forthcoming series on Stillbirths (2010). He has won several awards, including the Tamgha-i-Imtiaz (Medal of Excellence) by the President of Pakistan for contributions towards education and research (2000), the President of Pakistan Gold Medal for contributions to Child Health in Pakistan (2004) and the Outstanding Paediatrician of Asia award by the Asia Pacific Pediatric Association (2006). He is also the first recipient of the Aga Khan University Distinguished Faculty Award for Research (2005). Dr Bhutta was awarded the inaugural Global Child Health award (2009) by the Program for Global Pediatric Research for outstanding contributions to Global Child Health and Research and has recently been elected an honorary Fellow of the American Academy of Pediatrics for contributions to international child health. He was the Windermere Lecturer at the Annual Meeting of the Royal College of Paediatrics and Child Health UK (2010).

Dr Bhutta's research interests include newborn and child survival, maternal and child undernutrition and micronutrient deficiencies. He leads a large research group based in Pakistan with a special interest in research synthesis, scaling up evidence based interventions in community settings and health systems research

LINCOLN C. CHEN

PRESIDENT
CHINA MEDICAL BOARD
UNITED STATES

Lincoln C. Chen is President of CMB (China Medical Board). Started in 1914, the CMB was endowed by John D. Rockefeller as an independent American foundation to advance health in China and Asia by strengthening medical education, research, and policies.

Dr. Chen was the Founding Director of the Harvard Global Equity Initiative (2001-2006) and in an earlier decade (1987-1996), the Taro Takemi Professor of International Health and Director of the University-wide Harvard Center for Population and Development Studies. In 1997-2001, Dr. Chen served as Executive Vice-President of the Rockefeller Foundation, and for 14 years earlier, he represented the Ford Foundation in India and Bangladesh.

Dr. Chen serves on the board of many organizations - including BRAC USA, FXB Center on Health and Human Rights at Harvard, Social Science Research Council, the Institute of Metrics and Evaluation at the University of Washington, and the Public Health Foundation of India. Dr. Chen, a member of various scientific academies, graduated from Princeton University (BA), Harvard Medical School (MD), and the Johns Hopkins School of Hygiene and Public Health (MPH).

MARC DANZON
FORMER REGIONAL DIRECTOR
WHO/EURO

Born in 1947 in Toulouse, France, Marc Danzon was not sure if he was going be a doctor or journalist until the last minute. Aged 18, however, he enrolled in medicine at Université Paul Sabatier in his hometown, staying for 7 years, studying and becoming involved in politics (the events of May 1968 and a stint on the student council). In 1974, two years after graduating, he joined the Comité français d'éducation pour la santé (French Health Education Committee – FHEC), a public body charged with defining and implementing policies and programmes for health promotion and education. At the same time he began his postgraduate studies, eventually finishing with a "certificate of special studies" in preventive medicine, public health and hygiene, a diploma in advanced specialized studies in health economics and, finally, in 1984, a specialization in psychiatry.

The following year, Dr Jo E. Asvall, then WHO Regional Director for Europe, offered Dr Danzon the job of head of public information. The chance to combine his longstanding love of journalism and his medical qualifications proved irresistible and Dr Danzon moved to Copenhagen. He stayed until 1989, when he returned to FHEC. Inspired by the huge upheavals in the wake of the political changes in the eastern half of the Region, he returned to the Regional Office in 1992 as director of the newly created Department for Country Health Development. Thus, he became responsible for the implementation of the EUROHEALTH programme. He later became head of a newly created department of public health.

In 1997, Dr Danzon again returned to his native country, this time to head up the Public Health Department of the Fédération nationale de la mutualité française (National Federation of Mutual Insurance Companies), a body representing non-profit-making health insurance companies. In parallel, he prepared to campaign for election as WHO Regional Director for Europe. He called for a streamlined Regional Office that would better serve Member States. With this vision, he was nominated as Regional Director by the WHO Regional Committee for Europe in September 1999.

On taking up his post in February 2000, Dr Danzon started work to make the Regional Office a better partner to countries, tailoring its services to their needs. This came to be known as the country strategy and, following his re-election in 2004, it concentrated the Regional Office's mission on strengthening health systems in ways adapted to countries' particular needs.

In February 2010, Dr Danzon left the post of Regional Director. He handed over a strong and focused Regional Office that concentrates on Member States' needs, and is engaged with WHO headquarters and key international organizations.

FELY MARILYN E. LORENZO
PROFESSOR
UNIVERSITY OF THE PHILIPPINES
PHILIPPINES

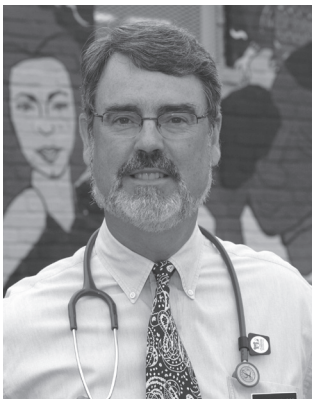
Dr. Fely Marilyn E. Lorenzo is a professor at the University of the Philippines, Manila. She was the founding chair of the MA Health Policy Studies (MAHPS) program committee and continues to participate the teaching of the MAHPS courses (1998-present) in the College of Public Health. She also teaches in the Masters in Hospital Administration and Masters in Public Health Programs (1989-present). She was founding Director of the Institute of Health Policy and Development Studies of the National Institutes of Health and directed the research and policy development work there from 1999-2006. She continues to do research at the National Institutes of Health - Institute of Health Policy and Development Studies.

Academic and Professional Background
Dr. Lorenzo graduated from the University of the Philippines College of Nursing obtaining her BSN degree in 1973. She proceeded to earn her Masters degree in Public Health at the Institute of Public Health UP Manila in 1981. Dr. Lorenzo then pursued her post graduate education and was awarded her DrPH from the School of Public Health of the University of California at Berkeley in 1996 majoring in Health Policy and Administration. She is registered nurse in the Philippines, California and Massachusetts.

After graduating from nursing school, she went on to take on a hospital-clinic nurse job at a remote post in Brooke's Point Medical Care in Brooke's Point , Palawan, a 10 bed hospital where she was the only professional nurse who assisted in major surgeries, managed the outpatient and inpatient care and supervised all other nursing assistants. She then became an Instructor for Public Health at the UP College of Nursing from 1974 to 1977. After that she was invited to be one of the pioneer faculty of the UP Institute of Health Sciences in Tacloban, Leyte in 1977 as Assistant Professor in the Midwifery, Nursing and BS Community Health (Nursing Practitioner) programs up to 1981 implementing her masters thesis results. After taking leave from the UP to raise a family, she worked as a nurse in the Harvard University Health Services from 1986-1987. In 1989, Dr. Lorenzo was invited again to join the University this time as an Assistant Professor in Public Health at the College of Public Health in UP Manila. She was promoted to Associate professorship in 1992 and to full professorship after earning her DrPH in 1996. She was awarded the Professorial Centennial Chair by UP Manila in April 2008.

Research, Publication and Consultancies

Dr. Lorenzo is active in research, consultancies and policy development aiming to link all these three areas together. Among her recent national and international research projects which she has mostly led as principal investigator are in the areas of Health Human Resource development specifically in Nursing Development and Health worker migration, Climate Change and Health; Health Care Reform and Financing, Health Systems Strengthening ; Tobacco Control ; and Burden of Disease determination.



FITZHUGH MULLAN

PROFESSOR
MEDICINE AND HEALTH POLICY
GEORGE WASHIINGTON UNIVERSITY
UNITED STATES

Fitzhugh Mullan, M.D. is the Murdock Head Professor of Medicine and Health Policy at the George Washington University School of Public Health and a Professor of Pediatrics at the George Washington University School of Medicine. Dr. Mullan graduated from Harvard University with a degree in history and from the University of Chicago Medical School. He is board certified in pediatrics. As a member of the United States Public Health Service he served in many capacities including director of the National Health Service Corps, director of the Bureau of Health Professions, and as an Assistant Surgeon General.

He has been a faculty member at George Washington University since 1998 where his work has focused on human resources for health. He has a long record of research and publication on the issues of US and global health workforce including recent studies ranking the social mission of US medical schools, strategies to promote primary care, and the metrics of global physician migration. He is the Principal Investigator of the Sub-Saharan African Medical School Study (SAMSS) funded by the Bill and Melinda Gates Foundation and the just announced Coordinating Center for the NIH's Africa project entitled the Medical Education Partnership Initiative (MEPI).

Dr. Mullan has written widely for both professional and general audiences on medical and health policy topics. His books include Plagues and Politics: The Story of the United States Public Health Service and Healers Abroad: Americans Responding to Human Resource Crisis in the HIV/AIDS (editor.) He is a member of the Institute of Medicine of the National Academy of Sciences.

FRANCIS GERVASE OMASWA

CHAIRMAN
HEALTH WORKER MIGRATION GLOBAL POLICY ADVISORY COUNCIL
UGANDA

Professor Francis Omaswa is the Executive Director of the African Centre for Global Health and Social Transformation (CHEST), an initiative incorporated in Uganda and promoted by a network of African and International leaders in health and development. It is an independent "Think Tank and Network" that works stimulate the growth of African rooted capacity for leadership and excellence in health and to make Africa a stronger player in international health.

Until May 2008, he was Special Adviser to the WHO Director General and founding Executive Director of the Global Health Workforce Alliance (GHWA) a partnership that is dedicated to identifying and providing solutions to the global health workforce crisis. This work culminated in the first ever global forum on human resources for health, organized by Professor Omaswa and adopted the "Kampala Declaration and Agenda for Global Action" that now guides the global response on health workforce development.

Between 1999 - 2005, he was the Director General of Health Services in the Ministry of Health in Uganda during which time he was responsible for coordinating and implementing major reforms in the health sector in Uganda which included the introduction of the Swaps, quality assurance and decentralization. He has a keen interest in cost-effective approaches for increasing access of the poor to quality health care and spent five years at the remote Ngora mission hospital testing various models and innovations for this between 1982 and 1987.

His academic career includes serving as Head of Cardiothoracic Surgery at the University of Nairobi and Kenyatta National Hospital in Kenya and founding Director of the Uganda Heart Institute and Associate Professor of Surgery at Makerere University, Kampala Uganda. He has also taught at Liverpool University in England. He is the founding President of the College of Surgeons of East, Central and Southern Africa whose head office is in Arusha, Tanzania. He has published in the areas of surgery, infectious diseases, and health system reform and health services management including human resources for health. He is the lead editor of the Manual for Quality Assurance of Health Care and has contributed to chapters in other books. His current research interests are in Leadership Capacity of Ministers and Ministries of Health, Health Systems Governance, Capacity Needs of African Medical Schools and Health Worker migration, retention and distribution.

In the community, he has served on many boards in schools and universities, civil society, the private sector and parastatals in several cases as the Chair of these boards. For this, he has received multiple meritorious awards and in his home town of Soroti, a street has been named after him.

At the global level is the current chair of the GAVI Independent Review Committee, Senior Advisor to the Ministerial Leadership Initiative for Global Health, Co Chair of the Health Worker Migration Policy Council and the Sub-Saharan African Medical Schools Study. He has also served as founding Chair of the Global Stop TB Partnership, Chair of the Portfolio and Procurement Committee of the Global Fund Board. He was a member of the steering committee of the High Level Forum on health-related MDGs. At the African level, he has served on many committees and expert panels: he was the lead consultant who developed the African Union HIV Policy, was on a panel of experts who developed guidelines for monitoring of implementation of the African Union Abuja Declaration on HIV, a member of WHO Afro Task Force on Poverty and Health He has served as an adviser to governments on health policy and strategy in developing and developed countries and has access to a wide network of contacts in international health.

Professor Omaswa is a graduate of Makerere Medical School, Kampala, Uganda, a Fellow of the Royal College of Surgeons of Edinburgh, founding President of the College of Surgeons of East, Central and Southern Africa and is a Senior Associate at the Johns Hopkins Bloomberg School of Public Health. He has several qualifications in health services management and medical education.

ANN PHOYA
HEAD OF THE SWAP SECRETARIAT
MINISTRY OF HEALTH
MALAWI

Professional Preparation

1: BSc: Registered Public Health Nurse Midwife: Medical University of Southern Africa, Pretoria South Africa, 1983
2: MSc: Family Community Health with a Role in Nursing Education : Howard University, Washington D.C., USA, 1986
3: PhD: Health Policy and Strategic Planning with a Clinical and Research Role in Maternal and Infant Health: Catholic University of America, Washington D.C, 1993

2.Work Experience

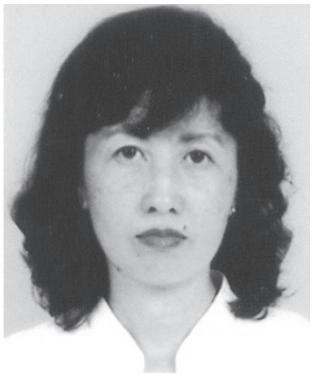
1. Current Responsibilities

- **Director & Member of Senior Management team of the Ministry of Health** responsible for coordinating implementation of Sector Wide Approach (SWAP) for the health sector;
- **Acting Head of Planning and Policy Development responsible for Development and monitoring f national health plans, policies and guidelines and the health budget.**
- **: Adjunct Faculty** Dept of Maternal and Child health; University of Malawi, Kamuzu College of Nursing (Master of Midwifery Program);
- **Chair:** Malawi Partners Forum for HIV & AIDS responsible for guiding implementation of the National Response to HIV and AIDs
- **Deputy Chair,** board of Partners in Hope Medical Center

2. 3. Other Positions held

- **FulBright Scholar in Residence : 2009:** Winston-Salem State University, North Carolina, USA: Associate Professor maternal and Child health & Community Health Nursing,
- **Director of Nursing Services/Chief Nursing Officer,** Ministry of Health, **2003- 2005**
- **Head Of planning (2002):** Ministry of health
- **Program Manager (1999-2001)** World Bank funder population & Family Planning Project, Ministry of Health
- **Program Manager: UNFPA funded Safe Mother project (1995-1980),** Ministry of Health
- **Community Health Nursing & Research officer,** Ministry of health
- **Lecturer, Community Health,** Malawi college of health Sciences
- **Head Nurse, Kamuzu** central Hospital

Research Interest:
HIV/AIDS, Maternal heath and Quality of care
Civil Status: Married to Ambassador Professor Richard Phoya; and has two children



KEAT PHUONG

DIRECTOR OF HUMAN RESOURCE DEVELOPMENT DEPARTMENT
MINISTRY OF HEALTH
CAMBODIA

Madame Keat Phuong is currently the Director of Human Resource Development at the Ministry of Health. She received her Diploma of Pharmacy from the University of Health Sciences in 1983 and her Master of Public Health degree from Boston University in the USA in 1998. In addition Madame Phuong has attended many other international educational programs. Madame Phuong has been in a variety of positions at the Ministry of Health including Staff at the Department of Drug, Head of Technical Bureau of the National TB Center, and Director of the Human Resource Development Department. She has been in her current role as the Director of Human Resource Development at the Ministry of Health since 1998. Beside, she was also worked as the ADB/MoH Project Manager for capacity building of staff and also as focal person for the Health Supported Project for HRD activities using Loan and Pooled fund money. Her vision in the Director position includes promoting gender and human rights and supporting capacity building and organizational development for health care in Cambodia. She tried her best to get the alignment and harmonization from relevant Health Development Partners for resources sharing and resources mobilization for effectively improve HRH and HRM situation.

She has been involved in many activities during her time at the Ministry of Health in working with relevant technical working groups, mainly key staffs from training institutions for health, for policy development and dissemination including the Ten-Year Health Workforce Development Plan, a midwifery project, establishment of standards for training including curricula for higher and co-medicals educations to be issued as the Joint Prakas of the Ministry of Health and Ministry of Education Youth and Sports, development of an educational Quality Assurance Program for the use of MoH internal evaluation.

With the empowerment from the Government to the MoH in managing and controlling the quality of education for health, she was appointed as the Secretariat of the National Exam Committee chaired by the Councils of Ministers. In this position she plays as a focal person to implement the National Entry Exam to select the best students for applying to both public and private Medical Universities and also the National Exit Exam to ensure the quality of those graduates. The National Exit Exam will serve as the Licensing Exam for professional practice that in her current position, she tries to work with relevant institutions to put the Licensing and Registration system in place in the near future.
To limit the number of intakes, recommendations of the Global

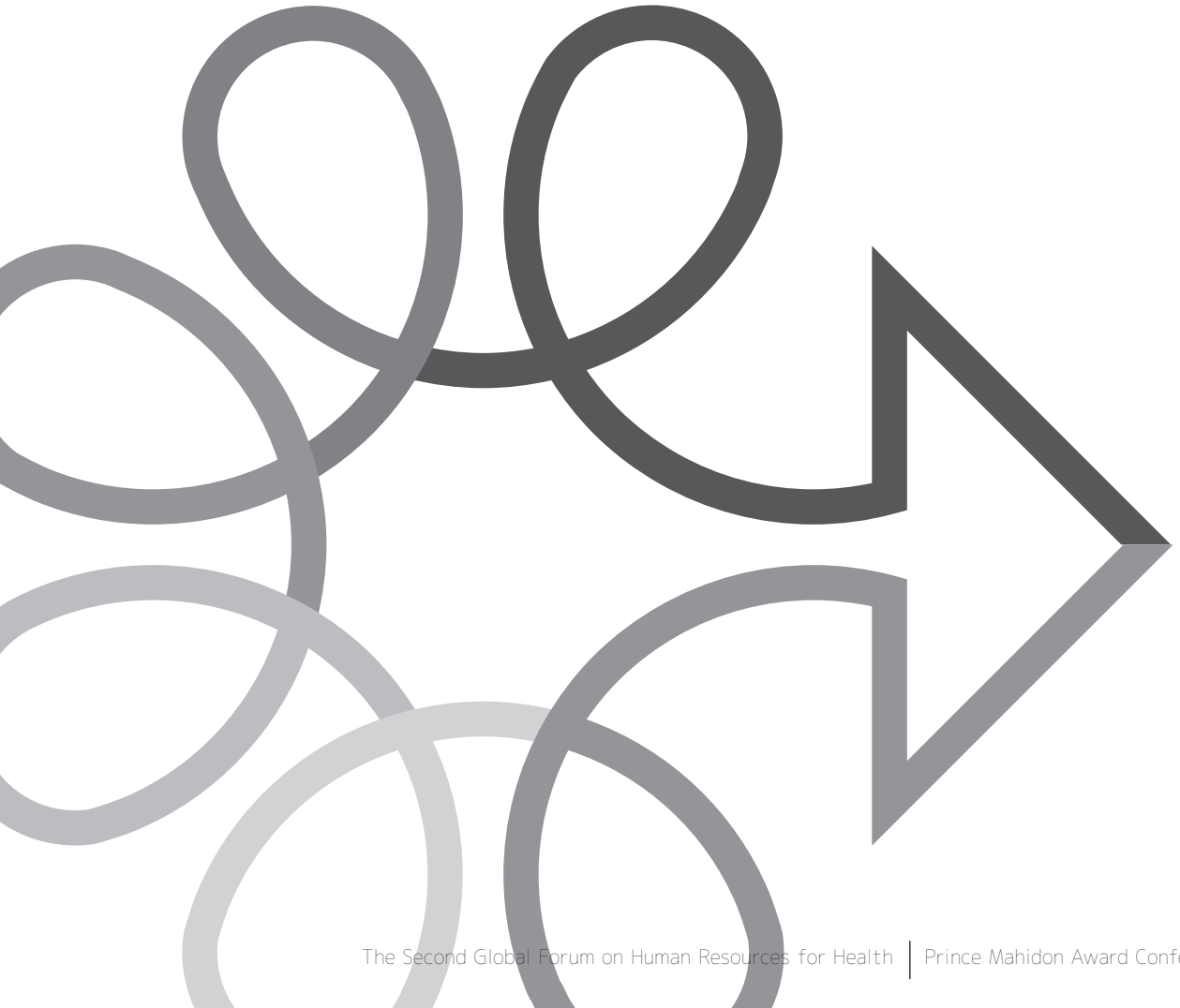
Alliances for HRH and staff projection of the Cambodian Health Workforce Development Plan are keys that she used to relies on to convince the decision makers.

Madame Phuong's professional interest is communication and advocacy for the purpose of social mobilization, development and promotion of responsive and accountable government. She has a strong desire to contribute to building civil society, including advancing democratic, gender and human rights values.

Building of capacity and organizational development are her strong commitment. She supports the nursing and midwifery professions a great deal.

PARALLEL SESSION 11 :

Seeking the stamp of good quality? Imperatives of HRH regulation and accreditation



Human Resource for Health Coordination Mechanism country cases studies /Iraq HRH

Professor Thamer Kadum Yousif WHO/ ME and HRH consultant

Background:

The health workforce status in the EMRO varies immensely as its 22 Member states represent a combination of low, middle and high income countries. The health workforce challenges in most of the countries include absolute shortage, underemployement, geographic and skills, maldistribution, non supportive working environment, uncontrolled migration of health professionals and inadequate HRH policies, planning and management.

Reflecting the health workforce status in the region.

- Iraq is among the countries that characterize by central system to a large extent. More than 1/3rd of total beds and doctors are located in Baghdad.
- About 50% of those doctors are working in Baghdad complex hospital.
- Iraq had a therapeutic Health system that depends on Hospitals and related PHC services, whether it is preventive in nature or general health activities that cover all over Iraq.
- High % of Iraqi community is urban Population with high % of education.
- There is an easy access to doctors and public health services hospitals and PHCC).
- In such system that is reforming itself Human resources can be utilized to determine health needs and community in general toward preventive aspects and toward empowering PHC services. Putting into consideration that 2/3rd of MOH Budget is invested in Human Resources. .
- Health services in IRAQ were presented through network of PHCCS which have amounted to about 2053 centers, and hospitals which have reached to (214) hospitals (80 Hospitals of them are private hospitals) all over the country
- In spite of the fact that the number of PHCCS and hospitals were not consistent with the usual standards, the human resources suffer from problems hindered the chances of improving and developing health issues for more than three decades, due to circumstances incurred on IRAQ

Human Resources.

- the following points demonstrate these domains within the development indicators in the strategic work plan for the next 5 years:-

1. Mean population within the catchments area of main PHCC at the time being is more or less than (20000), where as it is targeted to be 10000 for each main PHCC.

2. This means that the number of current main PHCCS ought to be duplicated at least to cover the needed health services, but that was difficult to be achieved.
3. The available capabilities were not the main issue, but it was the shortage in human resources.
   Simultaneously there were a mean of (4) doctors General Practioners) in Each main PHCCS / 10000 of population
4. This needs to be increased to (10) doctors which seems also to be difficult and needs an elaborated partnership with MOHE within a strategic work plan for that ministry.
5. Same will apply for specialized doctors who ought to be increased in parallel to the increase in the non-specialized doctors.
6. Other health personnel will have the same problem as such:-
   - Nursing staff ought to be triplicate (mostly female staff).
   - Health staff ought to be duplicated.
   - Dentists and pharmacists also to be increased and distributed evenly.

There is a clear shortage in some of the medicals specialities, mainly: Anesthesia, Forensic medicine, Emergency Medicine, Psychiatry and Family Medicine.

The following table compares Human Resources between IRAQ and neighboring countries /10000 of population and as follow:

Nursing staff	Pharmacists	Dentists	Total doctors	Year	Country
12.6	1.9	1.4	6	2008	IRAQ
11.9	2	1.9	8.7	2004	IRAN
19.4	5.2	7.2	14	2001	SYRIA
19.8	1	1.4	5.4	2003	EGYPT
29.7	2.2	1.7	13.7	2004	SAUDIA ARABIA
39.1	3.1	2.9	15.3	2001	KUWAIT
29.4	31.4	12.9	20.3	2004	JORDAN
17	3.2	2.4	13.5	2003	TURKEY

- In Iraq there is an average increase in the number of health workers through the last 3 decades.
- The number of health staff doubled through 1993-2003 when previous military health workers, that were working in previous military hospitals were combined to Civilian public health workers.
- But there was an increase in externally migrated population with continuous Brain drain process since 2003.

- Rapid increase in the population growth did decrease or at least limited the coverage improvement rate.
- There was already less % of nursing females in comparison to male (4/1), with 2 nursing staff/doctor.
- in year 1999 the % of health workers /total population were 11/10000,while this % did increase to 50.52/10000 population in Year 2007.
- The number of registered doctors in Iraq were 10832 (excluding Kurdistan Region).
- The % of doctors were 1/1926 population or 5.3/10000.
- In year 2005 the % increased to 6.5/10000.
- In year 2007 the % became 6.2/1000 or 1/1612 population.
- This represents a very low % in comparison to ideal rate (3-4 Nurses/Doctor-WHO).
- This will decrease the productivity of Nursing and medical staff and create imbalance in geographical distribution of health staff.
- Which made Iraq among the countries of low coverage rate/ population and this % is a characteristic of poor and low income developing countries.
- Iraq has health workers and specialists much than that of neighboring countries or when compared to Eastern Mediterranean region.
- The rate is less than half as that in other neighboring countries and there is a big gap regarding nursing staff and Dentists.

Community-Based Training in competences for all health professionals including community health workers: how to accredit such programmes?

Prof. Jan De Maeseneer
Secretary General The Network: Towards Unity for Health.
Primafamed-centre Ghent University.
WHO Collaborating Centre on Primary Health Care.

Kaat De Backer, MA.
Executive Director, The Network: Towards Unity for Health
Department of Family Medicine and Primary Health Care – Ghent University.

Correspondence: Jan.DeMaeseneer@Ugent.be

Introduction.

Any intervention in relation to training health professionals should start from an in-depth analysis of the actual health workforce crisis. The most striking phenomena are the multiple forms of "brain-drain". Most developing countries are confronted with different types of "brain drain": an "internal" brain-drain, shifting health care providers from primary care to secondary care and specialty care, from comprehensive horizontal health care settings towards vertical disease-oriented programs and from rural to urban areas[1]. Moreover, there is an externational brain-drain, moving health care providers from countries that face huge difficulties and insecurity to countries where there are more opportunities to function as a health care provider (e.g. from central Africa to Southern Africa), and finally there is the intercontinental brain-drain, bringing nurses and physicians from developing countries towards countries like Canada, United States, United Kingdom, Australia,··· The answer to the health workforce crisis is both a question of training sufficient numbers and assuring that the needed quality is present in the health workforce. Nowadays, in Asia, Latin-America, Africa,··· an increasing number of medical faculties are established. A lot of those are private initiatives, only accessible for those who can afford to pay high tuition fees or those who can get a bursary that enables them to study. Some of these faculties offer merely theoretical programs, because they are not able to provide clinical bedside training in hospitals at community based settings.

The last three decades have demonstrated a clear need to integrate sufficient amounts of community-based training into the undergraduate curriculum, in order to expose students sufficiently to the reality of primary health care and the needs of local communities. The World

Health Report 2008: "Primary health care: Now more than ever!"[2] and the Resolution WHA62.12: "Primary health care: Including health systems strengthening"[3] urge member states to "train and retain adequate numbers of health workers with appropriate skill mix, including primary health care nurses, midwifes, allied health professionals and family physicians, able to work in a multidisciplinary context, in cooperation with non-professional community health workers in order to respond effectively to people's health needs".

Nowadays, there are a lot of examples of good practices in undergraduate exposure to community-based education and service: in regions and institutions as varied as B.P. Koirala Institute in Dharan (Nepal), Moi University in Eldoret (Kenya), Walter Sisulu University in South-Africa, Universidade Estadual de Londrina (Brazil), Northern Ontario School of Medicine (Canada), Ghent University (Belgium)[4], students experience the confrontation with the health needs of the community[5]. By doing so they learn to appreciate, not only the role of professionals, but also the important role of volunteers who give informal contributions to health promotion, disease prevention and care and the importance of participation of the local population in health care delivery[6].

Principles and standards to asses the training of health care providers and their competences.

Any assessment of a training programme of health care providers should look carefully to what extent the competences acquired by the students, contribute to the following principles:

Relevance of care: care that really answers the needs (and not only the demands) of the local population, taking into account priorities.

Equity: care that is responsive to the variation in needs of different social, ethnic,··· groups in society, contributing to "social justice";

Quality: extent to which the health care provider is able to deal with the "structure, process and outcome"-components of quality of care.
Cost-effectiveness: in order to make optimal use of the resources, reconciling individual aspirations of patients with community requirements.

Sustainability: looking at the long-term perspective and assessing how measures in health care may influence other sectors (e.g. work, education,···) and to what extent measures in other sectors (environment, transport,···) may affect the health system.

Person- and people-centred care: putting the people at the centre of the process.

Innovation: competences that enable graduates to continuously reflect on their actual performance and implement continuous innovation.

These principles all refer to the concept of "social accountability" of the training programme and the institution.

At a recent conference (October 10-13, East-London South-Africa), the Global Consensus on Social Accountability of Medical Schools was formulated, inspired by an international reference group of 135 organisations and individuals seen as leaders in medical education, accreditation and social accountability. The Global Consensus on Social Accountability Initiative identified 10 areas that should be reflected in medical education standards, evaluation, accreditation and quality improvement.

Table 1: Social accountability and medical education standards[7].

Area 1. Anticipation of society's health needs and vision & mission of the medical school
Area 2. Partnerships with the health system and stakeholders
Area 3. Evolving roles of doctors and other health professionals
Area 4. Outcome-based education
Area 5. Governance of the Medical School
Area 6. Scope of Standards
Area 7. Quality improvement in education, research and service delivery
Area 8. Mandated mechanism for accreditation
Area 9. Global principles with context specificity
Area 10. Role of Society

The need for Community-Based Training and the strengthening of primary health care.

All over the world the health workforce crisis is most apparent in the ambulatory setting, primary health care and community-based settings. So, community-based training is an essential strategy in the recruitment of health care providers for the primary health care system. Nowadays, it is clear that if we want to achieve the Millennium Development Goals, an emphasis should be put on primary health care and on the integration of person-oriented and community-oriented care[8 9].

The members of The Network: Towards Unity for Health (www.thenetworktufh.org) have clearly demonstrated how important it is to have all stakeholders on board in order to create synergies between education and health care: cooperation of academics, communities, man-

agers, providers,··· is needed in order to make a difference. Moreover, community-based training[10], illustrates the important role of volunteers and community health workers in the health system.

The Primafamed-network (www.primafamed.ugent.be) has demonstrated in more than 15 countries in Sub-Saharan Africa, how important it is to create a specific post-graduate training for primary health care physicians, that work as family physicians in multidisciplinary primary health care teams. Nowadays, a clear profile for the African family physicians" has been defined and training programmes are developed accordingly[11 12]. The Primafamed-network uses the strategy of South-South cooperation in order to enhance capacity-building.

Strategy for implementation of standards in order to assess and accredit programs for Community-Based Training and competences for all health professionals including community health workers.

Although it is important to define international standards, a process of implementation of standards to assess community-based training requires a bottom-up strategy. Ten steps can be defined:

Involve all stakeholders in the process of operationalising the standards: not only health care providers and academics, but also representatives of the population, health managers, representatives of other sectors in relation to welfare,··· should be involved.

Include a timeframe to create a sufficient amount of "ownership" through a participatory process, so that training institutions "internalise" the standards as being relevant for their educational processes.

Communicate clearly about the standards and the way they are operationalised.

Define the legislative framework wherein the process of assessment and accreditation will take place. Indicate clearly what will be the consequences for the institutions (e.g. in terms of financial and other resources).

Establish and recognise independent accreditation bodies that will be in charge of the accreditation-procedures.

Assess whether accreditation bodies should be national or supranational. Sometimes, a supranational approach is worthwhile, as it may strengthen independency, provided local governments accept the authority of those international bodies.

Take advantage of existing structures. An example: the Interuniversity Council for Eastern Africa could be an appropriate environment wherein one or more accreditation bodies may function.

Start with the try-out on voluntary basis, so that institutions see the advantage of participation in an accreditation process.

Make the procedure as transparent as possible with emphasis on the self-study report, the SWOT-analysis by the institution, the proposals for improvement by the institution and the report of the study visit by the experts. Foresee an appeal-procedure for the institution.

Communicate the conclusions clearly and make sure that the consequences are put into practice.

What makes a strategy towards Community-Based Training into a success?

The assessment of community-based training programmes is very often complex, as it is a multi-centre endeavour by the faculty. Therefore, site visits are of utmost importance. Moreover, as it is impossible to visit all training sites, the assessment of the "Quality Assurance System" that the faculty puts forward in order to guarantee the quality of the training at the different training sites could be worthwhile.

An important indicator is the "output", e.g. the number of graduates that opt for a career in primary health care. When looking at the output, we should be very careful about absolute figures, as, very often, the result will be determined by the context. So, contextualisation of data is of utmost importance when assessing community-based teaching.

It will be important to assess strategies that are actually used in order to increase the workforce in rural and remote areas. In a lot of countries, a "compulsory" community service obliges the graduates to work 1 or 2 years after graduation, in rural or remote areas. The impact of this experience should carefully be assessed, as sometimes the working conditions in those areas are so poor, that providers never want to return to these areas.

Finally, a Health Systems Approach will be needed in order to understand the contribution the programme makes e.g. in addressing the health workforce crisis. International measures are needed to limit the brain-drain. An example could be that countries that integrate health care providers coming from developing countries in their health system are obliged to refund the actual cost of the training of that health care provider in the receiving country to the country of origin.

The assessment and accreditation of Community-Based Training and competences.

The assessment and accreditation of Community-Based Training and competences for all health professionals including community health workers, is an important challenge. Apart from the need for a clear conceptual framework (and there is a lot of expertise and good practices), the overarching concept of "social accountability" of training programs has to be taken into account. Moreover, a clear strategic approach is needed, in order to avoid a disruptive impact of accreditation procedures. Finally, these accreditation procedures have to be linked to the health workforce crisis. Therefore, there is a need for more research on the determinants of the health workforce crisis and how this crisis can be addressed. In the framework of the EU-FP7-project: "Human Resources for African Primary Care", Ghent University, together with Oxford University, the Medical University of Vienna, University of Botswana, University of Witwatersrand, Ahfad University for Women (Sudan), Université de Bamako in Mali and Mbarara University of Science and Technology in Uganda will start a four-years research project that may contribute to the analysis of community-based training and competences for all health professionals in order to address to the health workforce crisis.

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The way forward to accredit informal health professionals and their training programme that will protect both the public and the profession

This presentation will discuss the way forward to accredit informal health professionals and their training by using the accreditation of Traditional Chinese Medical Practitioners in Hong Kong as an example. In Hong Kong, the role of Traditional Chinese Medical doctors in the Hong Kong healthcare system was officially recognized in 1997 after Hong Kong's handover to China.

The accreditation of TCM practitioners in Hong Kong aimed to 1) clarify qualification status of existing TCMP; 2) protect the public from unsafe practice and 3) promote professional and ethical conduct among TCMP. In 1998, the first full time five year undergraduate TCM degree programme was established in public university followed by two other programmes in 1999 and 2022. In 2002, the first group of TCM doctors was registered. In 2003, the first licensing examination for TCM doctors was held and the first batch of locally trained TCM students graduated. In 2005, the Continuing Chinese Medicine Education programme was launched with the requirements of all registered TCM doctors to earn 60 CME credits in three years to revalidate their licenses.

Since the start of the accreditation process in 1999, there has been an increase in TCM service utilization. Moreover, further amendments in laws and regulations have granted TCM doctors the rights to issue legally recognized medical certificate and the recognition of treatment, examination and certification given by registered TCM doctors in the case of medical expenses reimbursement for work injuries.

On the other hand, the existing lack of integration between TCM and Western Medicine doctors in the delivery of care has not improved with the accreditation of TCM doctors which suggests that the parallel systems of WM and TCM regulation do not promote service coordination and integration. Other ways on regulation or accreditation of health professionals that can promote inter-professional team working may be needed if the ultimate aim of accreditation is to ensure improved quality and coordination of care for patients with more patient choices.

The way forward to accredit informal health professionals and their training programme that will protect both the public and the profession

Samuel Wong

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THAMER KADUM YOUSIF AL HILFI

DIRECTOR
THE ACCREDITATION AND QA UNIT
BAGHDAD UNIVERSITY
IRAQ

Dr Al Hilfy is the Director of the Accreditation and QA Unit in the main educational institution in Iraq, Al Kindy College of Medicine, and Baghdad University where he sets standards, systems, protocols and benchmarks for quality assured continuing medical education and continuing professional development. He was the first ever Iraqi with a higher degree in medical education.

He also represents his country in national, regional and international projects and conferences and is the Vice President of the leading committee for Iraqi CCM's (Country Coordinated Mechanism) steering committee for implementing the global fund program for Iraqi activities related to Malaria, AIDs and Tuberculosis).

The majority of his research papers have been related to HIV/TB and Tuberculosis. quality processes in family medicine, and HIV,HIV/AIDS in educational programs of Iraqi schools.

Current positions:

- Executive Director of Iraqi Anti TB society and Lung Disease./2010
- Vice President of Iraqi CCM(Community Coordinated Mechanism)/2010
- Member and organizer of Iraqi National Committee for setting standards of Hospitals and PHCC./2010
- Technical consultant /Medical education for the WHO/Iraq/2009.
- Senior Project manager for setting projects and programs/MOH-MOHE Director of Department of Family and Community Medicine, Al kindy College of Medicine/MOHE /2007.
- Director of Accreditation and QA unit, Al Kindy College of Medicine, University of Baghdad since 2006.
- Reporter of Iraqi Deans of Medical Colleges Committee/2008
- Reporter of Iraqi national accreditation committee/2008
- Member of leading committee for CCM (Country Coordinated Mechanism)/2009
- Iraqi steering committee for implementing the global fund program about Iraqi activities related to (Malaria, Aids and Tuberculosis)./2009
- Director of Health for all Centers and Supervisor in civil society affairs related to medical aspects and women rights.
- Member of scientific committee of CME/CPD-Iraqi MOH.

GENEVIEVE HOWSE

ADJUNCT ASSOIATE PROFESSOR
PUBLIC HEALTH LAW
LA TROBE UNVERSITY
AUSTRALIA

Genevieve Howse is an internationally recognised lawyer and specialist consultant, working in the area of public health law and legislation development. She is also the Principal Investigator on a two year AusAID funded project to develop a Model Public Health Law for the Pacific. Her work as a legal consultant has seen her undertake reviews of legislation, including health practitioner registration legislation, in Australia, Papua New Guinea, Fiji, the Solomon Islands, Vanuatu, the United Arab Emirates, Yemen and the Sultanate of Oman for governments, the World Health Organisation and the UNDP. She has been called upon to develop legislation policy, and to draft legislation, including creating and delivering the change management strategies which support its implementation. This has included communication, stakeholder and risk management. She also teaches and publishes in the area and is an Adjunct Professor of Public Health Law at La Trobe University in Australia.

Genevieve Howse has also served as the Legal Member of the Chiropractors Registration Board and the Deputy President of the Chinese Medicine Registration Board in Victoria, Australia.

JAN DE MAESENEER

HEAD OF DEPARTMENT OF FAMILY MEDICINE AND PRIMARY HEALTH CARE
GHENT UNIVERSITY
BELGIUM

Jan De Maeseneer (°1952, Ghent) graduated as a Medical Doctor in 1977 at Ghent University (Belgium). Since 1978, he has been working part-time as a family physician in the community health centre Botermarkt in Ledeberg. Since 1991, he chairs the department of Family Medicine and Primary Health Care at Ghent University. Since 1.10.2008 he is the vice-dean for strategic planning at the Faculty of Medicine and Health Sciences.

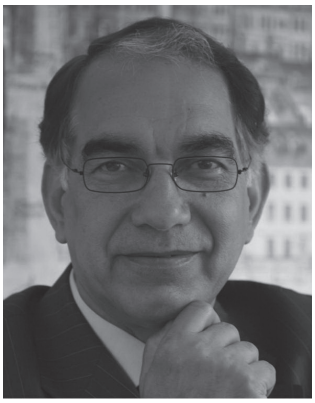
His research activities are focused on: epidemiology of general practice, functioning of GPs, prescription behaviour, medical decision making, medical education, health systems research, equity in health care, menpowerplanning, health outcome and health and poverty.

Prof. De Maeseneer is chairman of the European Forum for Primary Care since 2005 (ww.euprimarycare.org)

In 1990-1991, he has been advisor on primary health care of the federal Minister of Health. Since 1997, he has been a member of the Flemish Health Council. Actually, he is the chairman of the Flemish Strategic Advisory Council for Welfare, Family and Health.

Prof. J. De Maeseneer was a member of the Knowledge Network "Health System" of the WHO Commission on Social Determinants of Health. He actually is a member of the Scientific Committee for the Renewal of Primary Health Care of WHO. Since October 2010 he is leading the International Centre for Primary Health Care and Family Medicine, a WHO Collaborating Centre on Primary Health Care.

He is promoter of the Primafamed-network (www.primafamed.ugent.be), a network involved in training of family physicians in Africa. Since September 2007, Jan De Maeseneer is the Secretary General of the Network "Towards Unity for Health" (www.the-networktufh.org).



SALMAN RAWAF

PROFESSOR OF PUBLIC HEALTH
IMPERIAL COLLEGE LONDON
UNITED KINGDOM

Salman Rawaf qualified in medicine with subsequent training in paediatrics and public health. Professor Rawaf until January 2009 was the Director of Public Health in NHS Wandsworth, London: a post which he held since 1988 in South West London. He is currently Professor of Public Health and Director of WHO Centre at Imperial College London, Hon. Professor of Public Health at the Middlesex University, Hon Professor of Primary care at Ghent University Belgium, and Senior Lecturer at St George's University of London. He serves on many national and international committees and groups. He has published more than 120 scientific papers, 2 books (Assessing Health Needs RCP Publishing Group, and Health Improvement Programmes RSM Publishers) and many international reports. He is the Founder and Editor-in-Chief of the journal Public Health Medicine and a member of other editorial boards. He is well known for his international work and his contribution to global health. He is an adviser to the WHO on primary care, public health, health system and medical education. He has been invited to undertake many international assignments in many countries around the world.

Professor Rawaf is a Fellow of the Royal Colleges of Physicians London and the UK Faculty of Public Health and Member of the Faculty of Public Health Medicine Ireland. He is the Chair of the International Committee, Faculty of Public Health UK, Executive Member of the International Committee of the Academy of the Royal Medical Colleges, Council Member of Chelsea and Westminster Hospital Foundation Trust, Member of WHO Advisory Committee for Health research, and Programme Leader of the Postgraduate Diploma/MSc in Family Medicine Middlesex University. His contributions to public health and primary care in research and service delivery are well documented. Among the many innovative approaches are young people and addictive behaviour and Staying Healthy: a programme to assess risk factors for chronic diseases in community settings and enable individuals to engage in their own health. Since started his work in 1988 in South West London as a Director of Public Health, he and his team received many awards and recognitions for the works to improve health. At International level is well recognised in his work supporting countries in strengthening their health system including primary and public health. He runs well renowned training programme of health system development both in and outside the UK.
May 2009

SAMUEL WONG

PROFESSOR IN FAMILY MEDICINE AND PRIMARY HEALTHCARE
CHINESE UNIVERSITY OF HONG KONG
HONG KONG

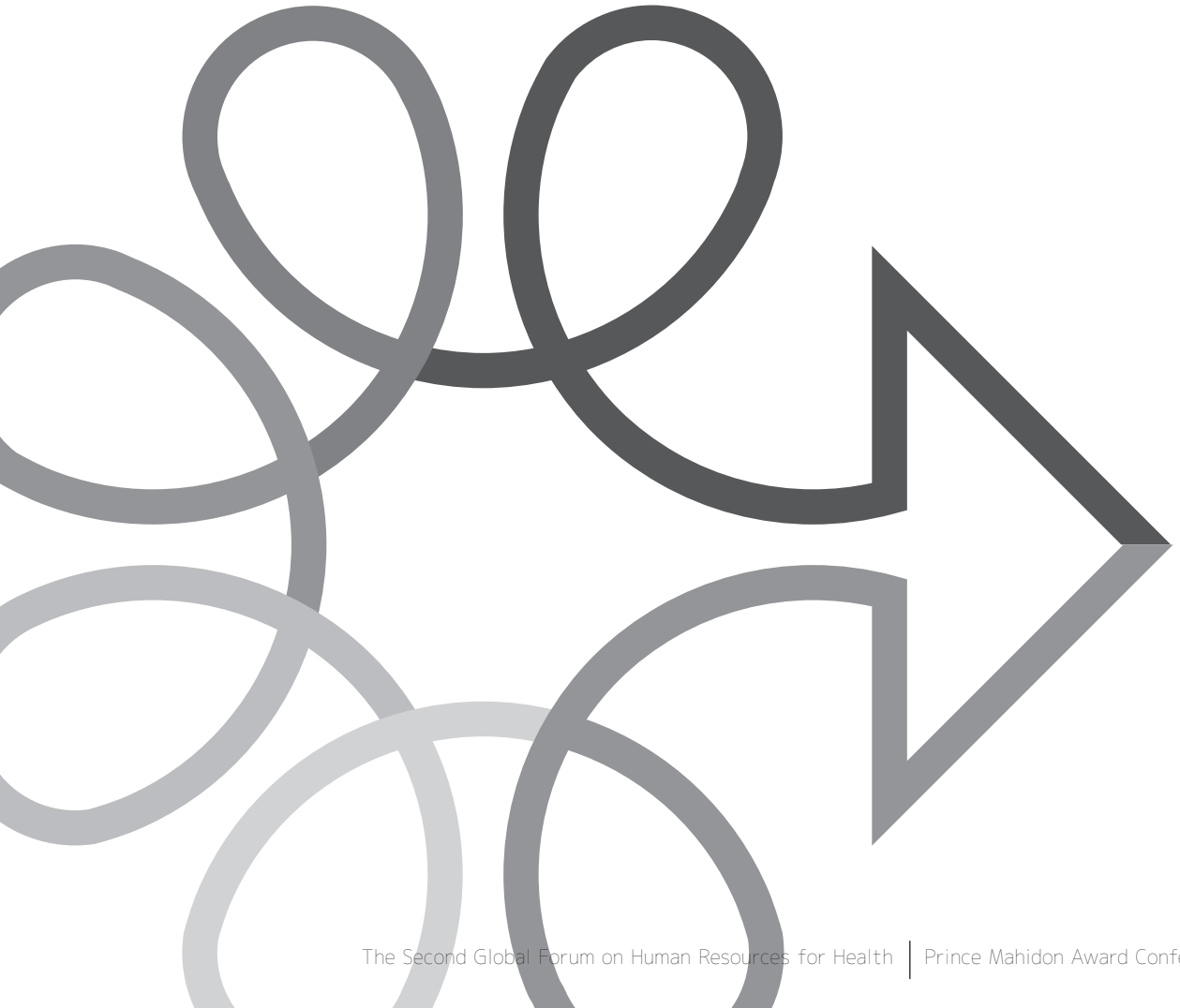
Professor Samuel Wong is Professor in Family Medicine and Primary Healthcare and is the Head of the Division of Family Medicine and Primary Healthcare of the School of Public Health and Primary Care. He is also the Associate Director (Undergraduate Education) of the School of Public Health and Primary Care at the Chinese University of Hong Kong.

Professor Samuel Wong received his Doctor of Medicine degree from the University of Toronto and completed his residency training in Family Medicine at Dalhousie University, Canada. He is a certificant member of the College of Family Physicians of Canada and a Fellow of the Royal Australian College of General Practitioners. He completed his Master of Public Health degree at the Johns Hopkins University, USA and his Doctor of Medicine (MD) research degree at The Chinese University of Hong Kong. He is a council member of the Hong Kong College of Family Physicians and chairs the Research Committee of the Hong Kong College of Family Physicians. He is the editor of the Hong Kong Practitioner, the official journal of the Hong Kong College of Family Physicians and is an editorial board member of the International Journal of Family Medicine and the Journal of Medical Case Reports.

He is currently a member of the Grant Review Board of the Health and Health Service Research Fund of the Food and Health Bureau, Hong Kong SAR Government and is the Director of the Diploma in Family Medicine and the Master in Family Medicine of the School of Public Health and Primary Care. In the past several years, he has also been involved in training general practitioners/family doctors in both mainland China and Macau. His research interests include the evaluations of mental health interventions that include the use of mindfulness based interventions for psychological problems in primary care, evaluation of primary care quality using the Primary Care Assessment Tools (PCAT) and multi-morbidity with a focus on the co-morbidity of chronic conditions and depression. He has published more than 60 research papers in international peer-reviewed journals since 2003.

PARALLEL SESSION 12 :

Financing health worker education and training



NIGEL CRISP
MEMBER
HOUSE OF LORDS
UNITED KINGDOM

Lord Crisp KCB, of Eaglescliffe in the County of Durham
Nigel Crisp is an independent crossbench member of the House of Lords and works mainly on international development and global health. From 2000 to 2006, he was both Chief Executive of the NHS, the largest health organisation in the world, and Permanent Secretary of the UK Department of Health and led major reforms in the English health system.

His new book Turning the world upside down - the search for global health in the 21st Century takes further the ideas about mutual learning between rich and poor countries that he developed in his 2007 report for the Prime Minister - Global Health Partnerships: the UK contribution to health in developing countries - and shows how this will shape healthcare in the future.

He has a particular interest in human resources and global partnerships. In 2007 he co-chaired an international Task Force on increasing the education and training of health workers globally with Commissioner Bience Gawanas of the African Union. Its report, Scaling up, Saving Lives, sets out practical ways to increase the training of health workers in developing countries.

He subsequently co-founded the Zambia UK Health Workforce Alliance in 2009 in order to implement some of the Task Force proposals and assist the Zambian Government to increase the numbers of health workers trained in the country. He is a Commissioner on the Independent Commission on Professional Education, a member of the Health Worker Migratory Advisory Council and a Champion Advocate for the Global Health Workforce Alliance.

Nigel Crisp chairs Sightsavers International, is a Senior Fellow at the Institute for Healthcare Improvement, a Distinguished Visiting Fellow at the Harvard School of Public Health and an Honorary Professor at the London School of Hygiene and Tropical Medicine. He is also an Adviser to HLM Architects, on the Advisory Boards of Doctors.Net.UK and the African Centre for Global Health and Social Transformation, a Trustee of RAND Europe and an Honorary Fellow of St John's College, Cambridge, the Royal College of Physicians and the Royal College of Pathologists.

A Cambridge philosophy graduate, he worked in community development and industry before joining the NHS in 1986. He has worked in mental health as well as acute services and was from 1993 to 1997 the Chief Executive of the Oxford Radcliffe Hospital NHS Trust, one of the UK's leading academic medical centres.
For further information see nigelcrisp.com

MAURICE MIDDLEBERG

VICE PRESIDENT FOR GLOBAL POLICY
CAPACITY PLUS
UNITED STATES

Maurice Middleberg has over 27 years of experience in the field of global health as an advocate, analyst, senior executive, teacher, and writer. Currently, Middleberg is the Director of CapacityPlus and serves as IntraHealth's Vice President for Global Policy, as well as provides leadership to the organization's advocacy for evidence-based global health policy, with a special focus on the global health workforce crisis. He brings to these roles an acute understanding of the needs, constraints, and opportunities facing health workers as they serve their communities. Prior to joining IntraHealth, Middleberg served as vice president for public policy at the Global Health Council, executive vice president at EngenderHealth, health director for CARE, visiting assistant professor at the Emory University Rollins School of Public Health, director of the Population Policy Program at the Futures Group, and population program coordinator for USAID/Niger. He is a political scientist by training and the author of numerous publications.

TARUN SEEM

HEAD OF HEALTH SYSTEMS SUPPORT UNIT
PUBLIC HEALTH FOUNDATION
INDIA

SUMMARY: Physician, career bureaucrat, national health policy-planner and erstwhile director of the flagship National Rural Health Mission, presently on deputation with the Public Health Foundation of India, heading the Health Systems Support Unit. His core areas of work have included policy development, programme planning and implementation, monitoring and evaluation. Special interests: health financing, urban health, stakeholder engagement, e-health, community monitoring, health information systems

APPOINTMENTS

2005-2010: Director / Deputy Secretary, Ministry of Health and Family Welfare, Government of India
1992-2005: Joint Commissioner / Deputy Commissioner / Assistant commissioner of Income-tax, Department of Revenue, Ministry of Finance, Government of India
1990-1992: Medical Officer, Central Himalayan Rural Action Group, District Nainital, UP.

ADVISORY

2008: Temporary Advisor, World Health Organization. "Unlocking the Market for Global eHealth" Rockefeller Foundation, Bellagio Center, Italy.
2007: Temporary Advisor, World Health Organization. Regional meeting on "Revisiting Community Based Health Workers and Community Health Volunteers", Chiang Mai, Thailand
2007: Temporary Advisor, World Health Organization. Asia-Pacific Action Alliance on Human Resources for Health, Beijing
2007: Government of India Representative. "Health Promotion Foundations", Manila
2007: Government of India Representative. Regional Consultation on "Health Systems Strengthening based on PHC Approach", Pyong yang, North Korea
2006: Government of India Representative. Regional Workshop on e-applications of ICT in population and its related fields: e-Learning and e-Health in July 2006, Lanzhou, Gansu, China. Economic and Social Commission for Asia and the Pacific.

COMMITTEES AND TASK FORCES (selected)

(2006-10) As Director, National Rural Health Mission (NRHM):

- Advisory Group on Community Action for NRHM
- ASHA Mentoring Group for NRHM
- Management information systems of Ministry of Health and Family Welfare
- eHealth initiatives of Ministry of Health and Family Welfare
- Website development for NRHM

(2009-2010) National Urban Health Mission task force

POLICIES AUTHORED (selected)

National Rural Health Mission document (co-authored)
National Rural Health Mission Implementation Framework
Common Review Mission of National Rural Health Mission
Guidelines for Indian Public Health Standards
Guidelines for Accredited Social Health Activists (ASHA)
Guidelines for Integration of National Programmes under NRHM,
Protocols for Empowered Programme Committee and Mission Steering Group under NRHM
National Urban Health Mission (ongoing)

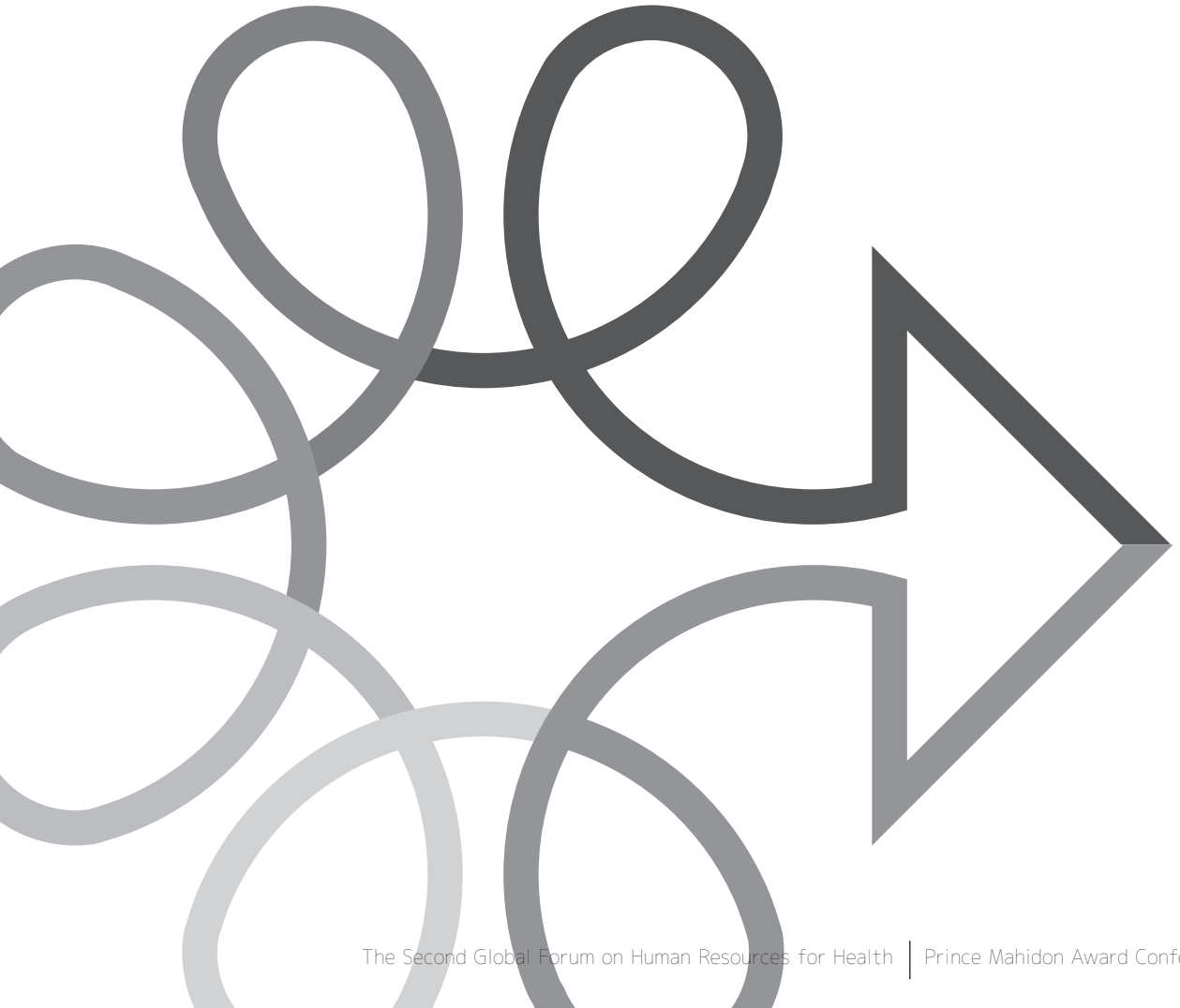
MARIE-ODILE WATY

LEAD HEALTH SPECIALIST
WORLD BANK GROUP/IFC
UNITED STATES

Ms. Marie-Odile Waty is seconded from the Agence française de Développement (AFD) to the IFC/World Bank "Health in Africa Initiative (HiA)" since November 2009. As a Lead Health Specialist based in Paris, she works with the HiA team to promote private sector development in the health sector in Africa. She has made all her career in the health sector: before joining IFC, she was the head of the Health and Social Protection Division at AFD for six years, from October 2003 to 2009. Before AFD, she was a senior Health Advisor at the Council of Europe Development Bank in Paris for three years, and a Senior Health Economist at the World Bank in Washington, DC for seven years. Before joining the World Bank, she was managing a Paris-based consulting firm specialized in the health sector in developing countries. Marie-Odile holds an MBA from HEC, Paris, a pre-doctorate degree in Development Sociology from EHESS, Paris, and a MA in Health Economics (INSEE).

PARALLEL SESSION 13 :

Dedicated Spirit: The Charm and Charisma of HRH



DAW NAN THAN THAN OO

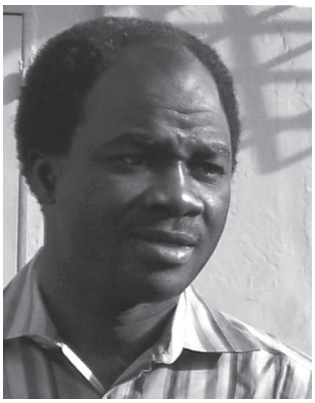
MIDWIFE
LWE'SATONE SUB-CENTER, MAI YAN RURAL HEALTH CENTER
MYANMAR

Daw Nan Than Than Oo, 50 years old Midwife is a Shan ethnic, born in Taunggyi, Shan State (South) in 1960. After passing basic high school in 1978, she attended midwifery training at Central Women's Hospital, Yangon in 1981 and became a midwife in 1982. She was appointed as a midwife, since 18.10.82 at Htin Shu Taung sub Rural Health Center (Sub RHC) under Pan Lin RHC in Mogok Township, Mandalay Division and worked there for five years up till 1987. Her second post was at Shwe Nyaung Pin Sub RHC under Kinn RHC. In July 1989, she was transferred to Kyun Gyi Sub RHC under Minchaung RHC at Nyaung Shwe Township in Shan State (South) which is her native place. There was no maternal and child death during her service. She got prizes for best performance of immunization and nutrition services at that Township. In May 1994, she was moved to Wan Tone Sub RHC under Mine Lin RHC at Tachileik Township, Shan State (East). She performed her best to get the 100% Antenatal care, EPI and Vitamin A supplementation. She was transferred again to Lwe-Satone Sub RHC under Mai Yan RHC in July 2000 and this is still her present post. It is situated near the border of Thailand covering population of 4,942 with additional estimated 3,000 mobile people. She tried to visit at least two times to all nine villages per month. In Tachileik District, all villages are mandated as "Village with no maternal death" by means of full community participation and she used to give reproductive health education to adolescent once in every month at Sunday school opened at the Church and also to husbands of pregnant women and family members according to the motto "Reproductive Health Education for all". For these activities she achieved a prize as outstanding health worker for performing RH/ HMIS in 2002, given by the Minister of Health. In 2009, there was severe diarrhea outbreak in Yan Aung Myay village, she had tried for timely referral of patients to hospital by car with the help of well wishers. Her performance regarding maternal and child health care was outstanding as she used to refer the complicated delivery cases to reach to the hospital in time, and even donated her blood for those in need. Midwife Nan Than Than Oo also tried to obtain "Village with no maternal death" in her area of work by encouraging community participation. Apart from maternal and child health care she is also keen to involve in disease control activities such as management of DHF, Tuberculosis and surveillance of A H1N1cases during outbreak. She has also become a multipurpose health worker as she is taking part in all elements of primary health care and she used to provide services with all her interest and might and initiative in caring of patients around her.

CARMEN DOLEA

MEMBER OF THE WHO GUIDELINES REVIEW COMMITTEE
WORLD HEALTH ORGANIZATION
SWITZERLAND

Dr. Carmen Dolea is a physician by training, with extensive international experience in public health and health systems policies, particularly in health workforce development. She graduated medical school in 1994 in Romania and specialized in family medicine. After four years of clinical practice in Romania she moved into a public health career, and earned her Masters degree in public health and management of health services in Romania in 2000. Following a research fellowship with London School of Hygiene and Tropical Medicine in 2001, she started to work with the World Health Organization in Geneva, initially with the burden of disease group, producing global estimates for the burden of disease of maternal conditions. Since 2002 she has been heavily involved in WHO's work on health workforce development, providing policy analysis, research and technical support to countries on many topics in this field. In 2006 she was part of the team that produced the "World health report: working together for health", and in 2008 she was a member of the WHO Secretariat in the Global Health Workforce Alliance Task Force on scaling up education and training of health workers. In the latter capacity, she contributed substantially to the production of the task force report "Scaling up, Saving lives". Most recently, she managed the production of the WHO global recommendations on increasing access to health workers in remote and rural areas through improved retention. This involved a year-long consultative efforts and management of a large group of international experts, as well as coordination of the research and writing activities for the production of these recommendations. As part of this work, Dr Dolea also managed a special theme issue on health workforce retention hosted by the Bulletin of the World Health Organization. Dr Dolea also serves as editorial adviser for the Bulletin of the World Health Organization, and was recently nominated to be a member of the WHO Guidelines Review Committee, a body that advises on the production of evidence-based guidelines in WHO.



SAIDOU EKOYE

DOCTOR
TAHOUA REGIONAL HEALTH OFFICE
NIGER

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

HO THI THANH HOA

MEDICAL DOCTOR
DOT COMMUNE HEALTH CENTRE
VIETNAM

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

BRIDGET LLOYD
GLOBAL COORDINATOR
PEOPLE'S HEALTH MOVEMENT
SOUTH AFRICA

Bridget Lloyd has worked in South African civil society for more than 20 years. She first became involved in the NGO sector working for Health Care Trust. Initially employed as a PHC nurse and trainer, Bridget ran clinics in disadvantaged communities; and developed health promotion and health training programmes. In 1992 after 3 years community consultation, a Community Health Worker (CHW) programme focussing on comprehensive PHC and the social determinants of health was launched – at this time there were no other health services to these communities. Bridget worked full time on CHW projects for the next 12 years, moving to senior management positions after 5 years.

In 2002, Bridget started doing part time work for the People's Health Movement (PHM) in South Africa, and through this became increasingly involved in global health and issues of equity and social justice. Parallel to this she was working for a number of South African NGO's and community based organisations and was involved with the African civil society consultation for the Commission on Social Determinants of Health.

In 2005, Bridget took up full time work coordinating Global Health Watch 2, an alternative world health report - the book was published late 2008, with more than 20 launches held around the globe.

In 2009, Bridget conducted and co-authored research for a trade union, on the human resource requirements for implementation of a national health insurance in South Africa. The research highlighted the need for an alternate model of HRH, with CHW and mid level workers centrally utilised within the public health system.

In June 2009, the PHM global secretariat moved to South Africa, and Bridget took up the position as global coordinator. She completed her Master's in Public Health in 2010, looking at the HRH requirements for a national health insurance.

Bridget continues to have a strong interest in human resources for health, particularly CHW's and HRH requirements for poorly resourced areas; the impact of social determinants on health; and issues of social justice.

BARBARA MCPAKE

DIRECTOR
INSTITUTE FOR INTERNATIONAL HEALTH DEVELOPMENT
UNITED KINGDOM

Barbara McPake (BA Economics, University of York, 1983; PhD Health Economics, University of Wales, 1993) is a health economist specialising in health policy and health systems research. She has 24 years experience in these areas based in three UK university departments: Centre for Development Studies, University of Wales (1986-90); London School of Hygiene and Tropical Medicine (1991-2005) where she was Head of the Health Policy Unit (2001-3) and the Institute for International Health and Development, Queen Margaret University (2005 to present). She is currently the Director of the Institute for International Development where she has been establishing post-graduate training in health systems and human resources for health. She helped to establish a Masters programme in Health Management in the College of Medicine, Malawi (from 2006) and is currently working to establish post graduate training programmes in Human Resources for Health Management in collaboration with the Health Services Academy, Islamabad, Pakistan (to get underway January 2011) and with Gadjah Mada University in Indonesia (also planned for 2011). She has substantial teaching experience in health economics, health systems and human resources for health in these three university departments and as a visiting speaker and teacher internationally.

She has undertaken a substantial portfolio of research work in the areas of health policy, health systems and human resources for health. This has included work on financing policy (user fees and the Bamako Initiative); using contracts and 'pay for performance' to improve the provision of health services (in Zimbabwe, Cameroon and Uganda); understanding the implications of reforms increasing the management autonomy of hospitals (in Zambia, Uganda and Colombia) and looking at the informal economies in which health workers are engaged (in Uganda). She has supervised or is currently supervising 26 PhD candidates in related areas. While at LSHTM, she was a senior member of the UK Department for International Development (DFID) funded Health Economics and Financing Programme (1991-2005) and was the Programme Director of the Health Systems Development Knowledge Programme (2001-6), focused on extending the reach of health systems to the poorest and undertaking significant research in human resources for health and maternal health systems. From 2011 she will be one of two Research Directors of 'REBUILD' a new DFID funded Research Programme Consortium on health systems development. REBUILD will focus on the lessons to be learned from the re-establishment of health systems in post-conflict settings and will work with

partners in Zimbabwe, Uganda, Sierra Leone and Cambodia and affiliates in a larger number of countries. Its main areas of focus concern Health Financing and Human Resources for Health.

She has published widely in the major journals of health systems, human resources and international health and development, and is the author of one of the leading text books of health economics for international post-graduate students of which a third edition has been commissioned. She is Chair of the Tropical Disease Research Programme's thematic reference group on Social Science and Gender and a member of the Countdown working group on Health Policy and Systems and has served on several expert committees of WHO the World Bank and UNICEF.

EBELE OMEKE MICHEAL

DOCTOR
DISTRICT HEALTH OFFICER OF MOROTO DISTRICT
UGANDA

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

LEOCHRIST SHALI MWANYUMBA
DISTRICT PUBLIC HEALTH NURSE
TAVELA DISTRICT HOSPITAL
KENYA

Leochrist Shali Mwanyumba is a registered community health nurse. She holds a diploma in community health nursing from Kenya medical training college, a diploma in leadership development programme sustainability , a certificate in modern clinical nursing from second medical military university in shanghai China and is currently pursuing a bachelors degree in nursing at the Kenya Methodist university on distance learning mode.

She has also done a number of short courses in counseling, HIV management, nutrition and reproductive health.

She started her carrier in 2003 working for the ministry of health. Between 2004 and 2008 she was the officer in charge of the maternal and child health department of Taveta hospital in one of the remote hardship areas of Kenyan coast. This is a key department in implementation of strategies aimed at achieving the MDGS. Her work basically included care of under fives in immunization, growth monitoring, curative and promotive care. Offering ante natal, post natal and family planning services to women of child bearing age and partners. And even comprehensive HIV. Care to the infected and affected.

It was during this time that she managed to revive focused antenatal care and comprehensive prevention of mother to child transmission strategies to the pregnant mothers which included early infant diagnosis to the HIV exposed babies. She also worked with partners and started the malaria prevention programmes for under fives and pregnant women. She streamlined implementation of PHC activities, strengthened community involvement and ownership through health education, training of community health workers, home visiting and community outreach programmes on child survival and reproductive health programmes. And it was during this time that she won the award for the outstanding nurse of the year in Kenya.

From 2009 to date she is working as the district public health nurse. Basically working with communities at the lower levels of community units, dispensaries and health centre levels focusing more on preventive and promotive health care for all cohorts as stipulated in the Kenya national health sector strategic plan.

KARAMOKO NIMAGA
DOCTOR
MARKAKOUNGO 80 KM FROM BAMAKO
MALI

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

To this day, he regularly participates in vaccination campaigns organized in villages in his area, sometimes as far as 25km away and has been elected 3 times as President of the Association of Rural Doctors, an association he's coordinated for the past 8 years. More importantly, Dr. Nimaga has become a model for young doctors as he provides them with another vision of rural healthcare by confirming it's not a sacrifice but a lifestyle.

PERA DORAPAGE LALITHA PADMINI

PUBLIC HEALTH MIDWIFE
DIMBULAGALA MEDICAL OFFICER OF HEALTH DIVISION
SRI LANKA

Pera Dorapage Lalitha Padmini is a Public Health Midwife(PHM), serving in a remote village named Medagama in the Dimbulagala Medical Officer of Health Division in the Polonnaruwa District of the North Central Province of Sri Lanka. She assumed duties as a PHM on the 01st July 1998, and continues to serve the people in this rural area for the last 13 years.

At that time Dimbulagala where she served was plagued with many a problem. On top of the poverty, malnutrition, communicable diseases, high suicide rates, teenage pregnancies etc. this border village of the civil war affected area, was frequently a target of terrorist attacks.

Despite all these setbacks Lalitha was determined to improve the lives of those unfortunate people. She won the hearts of these poor people and they all rallied around her to improve their village. With the help of the villagers she improved the clinic facilities, visited their homes regularly giving advise not only on health but how to cope with their other social problems.

Her outstanding performance is reflected in the results she got:

Immunization:

Tetenus Toxoid coverage for pregnant mothers	100%
Rubella coverage for pregnant mother	96%
DPT 1 – Penta 1 coverage	100%
Rubella coverage of females between 16-44	100%

Nutrition:

% of LBW	9.0%
Infant weight +2SD to – 2SD	98.1%
Pre School, 1to 2 years +2SD to – 2SD	96.9%
Pre School, 2to 5 years +2SD to – 2SD	96.1%

Family Planning, Maternal & Reproductive Health:

Current users of modern method	78.8%
Teen age pregnancies 2008-10	0%

No Maternal Deaths in her area for the last 13 years.

Innovative activities:

a To improve Nutrition (A Colour code system at weighing post and pre Schools which enlightens mothers about the nutritional status of their children.

b Reduction of teenage pregnancies through counseling and health promotion with the help of volunteers.
c Best immunization clinic centre in North Central Province (NCP) in 2008 with the help of community participation and achievement of best immunization coverage.
d ECCD Activities. Development of a Play ground, play areas with toys with the help of community.
e Introduction of Healthy Adult Clinics and other NCD and CD Prevention programs.

Certificates and Awards:

a Certificate of Registration as a Public Health Midwife, Sri Lanka Medical Council
b Certificate on Public Health Information System - 2004.
c Best PHM for the MOH area 2003/2004.
d Best Model Clinic in the Province in 2008.
e Best PHM for Clinic services 2008.
f Special Recognition Award – Asia-Pacific Action Alliance on Human Resources for Health(AAAH), Oct. 2010.

Other Achievements:

She has served as a Resource Person for PHM Curriculum Revision.
Served as a Supervising Public Health Midwife during the last 2 years.

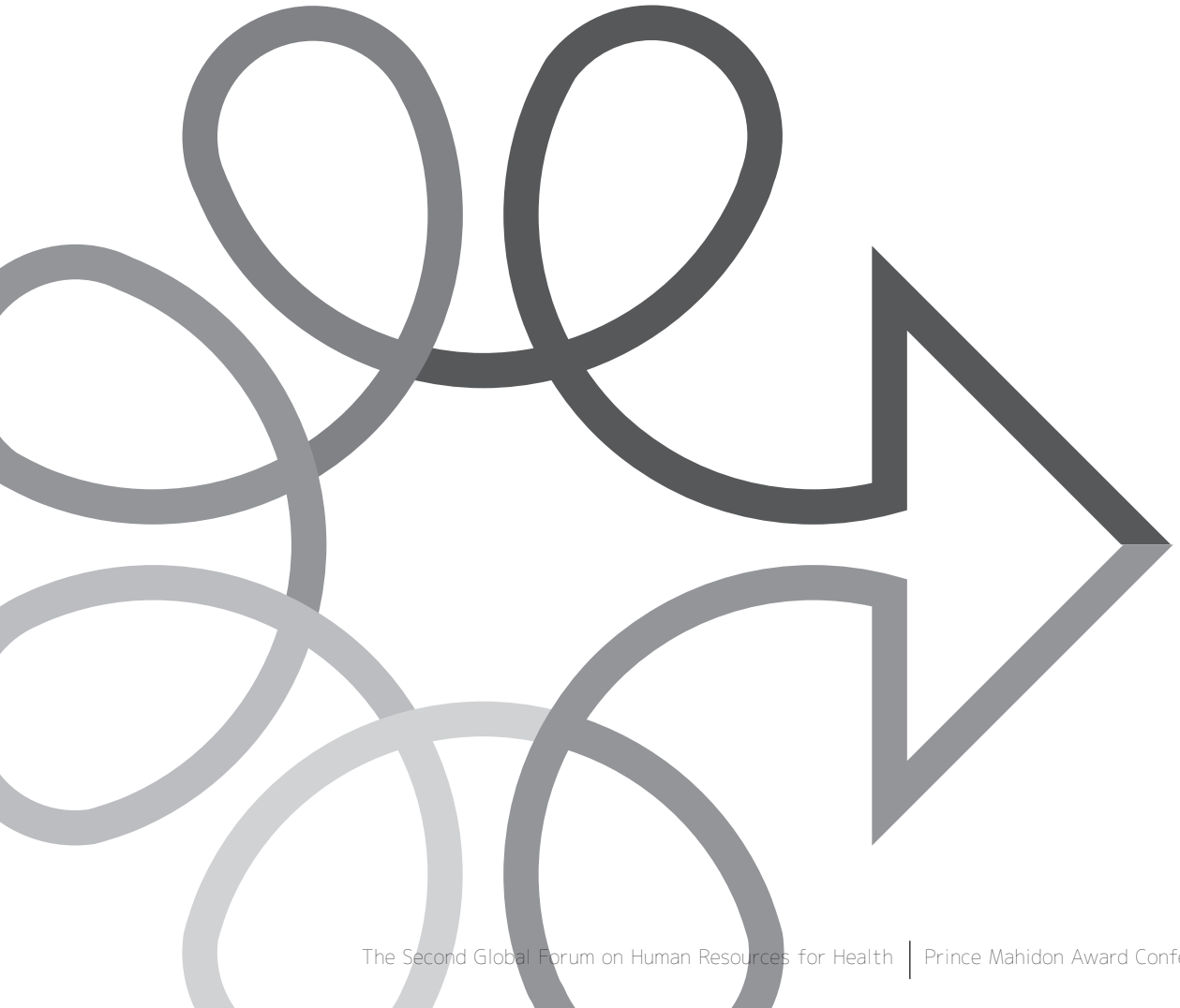
Lalitha is a creative and an energetic community health worker serving the humanity with commitment. She is a role model for the community health workers not only in Sri Lanka but for the other parts of the world.

PAKDEE SUEBNUKARN
DOCTOR
DANSAI HOSPITAL
THAILAND

Contrary to the majority of rural hospitals in Thailand, the Dansai district hospital is able to retain qualified health workers resulting in a turnover rate of only 3%. Dr. Pakdee Suebnukarn committed the past 21 years of his life to ensure not only better healthcare for the 52'184 people living in the district, but also to improve the infrastructure and quality of care at the Dansai hospital. The progress made since his arrival in 1987 is noteworthy. From being the sole physician in a 30-bed hospital to its current capacity of 60 beds, including 5 doctors and 100 staff, the stride is significant. Dr. Suebnukarn's strategy was multifaceted: hiring of indigenous staff, developing a standard payment system and encouraging staff to pursue personal projects directly benefitting the community. Furthermore, for more specialized care, Dr. Suebnukaran has ensured that a pool of voluntary specialists from tertiary hospitals (both public and private) regularly visit Dansai, avoiding referral to remote areas for the local population.

PARALLEL SESSION 14 :

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



REBECCA AFFOLDER

ADVISER
GLOBAL HEALTH POLICY AND COORDINATION
UNITED NATIONS

Rebecca Affolder is Adviser on Global Health Policy and Coordination in the UN Secretary-General's Strategic Planning Unit, where she leads work on the Secretary-General's "Every Woman, Every Child" effort. "Every Woman Every Child" is a global effort which has brought together leaders from governments, philanthropic institutions, multilateral organizations, civil society, the business community, health-care workers and professionals, and academic/research institutions to develop and make a wide range of commitments in support of the Global Strategy for Women's and Children's Health, which was launched during the United Nations Millennium Development Goals Summit.

Prior to joining the Secretary-General's office, Rebecca was Head of the Executive Office for the GAVI Alliance Secretariat in Geneva. In 2005, Rebecca was part of Secretariat to the Commission for Africa, chaired by the UK Prime Minister. She was responsible for the health section of the Commission's Report, as well as for consultation and presentation of the overall human development recommendations following its publication. Prior to this, Rebecca held posts with the UK Department for the Environment, Food and Rural Affairs and the Canadian International Development Agency. She holds a BA (Hons) in history from the University of Alberta and an MPhil from the University of Cambridge, where she studied the political and social history of famine in Africa.

HELGA FOGSTAD

SENIOR HEALTH ADVISER, GLOBAL HEALTH AND AIDS DEPARTMENT
NORWEGIAN AGENCY FOR DEVELOPMENT COOPERATION
NORWAY

Helga Fogstad is Coordinator of maternal, newborn and child health at the Norwegian Agency for Development Cooperation, which is under the Norwegian Ministry of Foreign Affairs. She is actively involved in the Prime Minister's MDG4&5 Initiative, as well as several global initiatives focusing on MNCH. Prior to joining Norad, she was six years at the World Health Organization in Geneve, where she worked on health systems issues for maternal and newborn health. She contributed to the World Health Report 2005 Make every mother and child count, as well as several Lancet articles on this topic. Helga has also many years of experience working in Africa on health planning and development at facility, district and national levels. She is a health economist.

GONZALEZ CANALI

HEALTH SPECIAL ADVISOR,
MINISTRY OF FOREIGN AND EUROPEAN AFFAIRS
FRANCE

Dr Gonzalez Canali has obtained his medical degree in Uruguay and specialised in Internal Medicine in France. Prior to his appointment as Special Health Adviser for the Development Policies Division, and at present at the General Directorate for Globalisation at the French Minister of Foreign and European Affairs, Dr Gonzalez-Canali served as adviser to the former French Minister Delegate for Cooperation, Development and Francophony, in charge of Health, Humanitarian Aid, relationships with NGOs, as well as bilateral relationships with East and Central African countries. He also worked as a physician and clinical investigator on AIDS vaccine trials in Paris, with the French Agency for AIDS and Hepatitis Research (ANRS). Other key positions have included Medical Director for the Luc Montaigner's Centre in Paris on HIV research and follow-up of HIV infected patients, and in charge of the Outpatient clinic at the Institut Pasteur. He is currently a Board member of the GAVI Alliance and has also worked during many years with the NGO "Médecins du Monde".

A. F. M. RUHAL HAQUE

MINISTER
MINISTRY OF HEALTH & FAMILY WELFARE
BANGLADESH

Father's Name : Late Nazir Ahmed
Mother's Name : Late Asia Khatun
Education :

A) Secondary Education (SSC) : Nalta High School, Satkhira, 1959.
B) Higher Secondary Education (HSC) : Notredame College, Dhaka, 1961.
C) MBBS : Dhaka Medical College, Dhaka, 1968.
D) FRCS : Royal College of Surgeons, Edinburge, London, UK.
E) FICS : International College of Surgeons, USA.
F) Honorary Colonel, Bangladesh Army

Co-Founder, Chairman & Chief Patron : Nalta Hospital and Community Health Foundation, Head Office, 22/8/A, Mirpur Road, Dhaka.

President : International College of Surgeons, Bangladesh.

Political activities:

1. Ex. VP, Dhaka Medical College.
2. President, Swadhinata Chikitsak Parisad (an organization of doctors)
3. Senior Vice President, Satkhira Zilla Awami League
4. Joint Convener, Sammilita Peshajibi Samannay Parishad
5. Patron, Bangabandhu Parishad, Satkhira Zilla
6. Participate in National Election 2001, nominated by Bangladesh Awami League for Satkhira-4

Personal Profile:

1. Date of Birth : 11 February 1944.
2. Resident Address : Road # 7, House # 2, Sector # 9, Uttara, Dhaka-1230.
3. Permanent Address : Village-Nalta, Upazila-Kaliganj, District-Satkhira.
4. Professional experience:
   A) Resident Surgeon: Holly Family Hospital, Dhaka, 1970 to 1971.
   B) Registrar: Orthopaedics Canterbury, Brighton, Oxford, London, UK, 1971 to 1981.
   C) Associate Professor (Orthopaedic Surgery): Sher-E-Bangla Medical College, Barisal, 1981 to 1982.
   D) Associate Professor (Orthopaedic Surgery): National Institute of Traumatology and Orthopaedics Rehabilitation, Dhaka 1982 to 1993.(Ex. RIHD)
   E) Associate Professor (Orthopaedic Surgery): Dhaka Medical College Hospital, Dhaka, 1993 to 1996.
   F) Director & Professor: National Institute of Traumatology and Orthopaedics Rehabilitation, 1996 to 1999.
   G) Professor and Chairman: Orthopaedic Surgery Department, Bangabandhu Sheikh Mujib Medical University (Ex. P.G Hospital), Dhaka 1999 to 2001.
   H) Examiner: FCPS, Diploma & MS (Orthopaedics) courses.

05. Attachment with Social and Health Service Organizations:

A) President: International College of Surgeons, Bangladesh.((ICS)
B) Ex. President & General Secretary: Bangladesh Orthopaedics Society.
C) Member of Executive Council: World Orthopaedics Concern.
D) Life Member: European Arthroscopic Society.
E) Vice President: Central Ahasania Mission, Nalta, Satkhira.
F) Life Member: Dhaka Ahasania Mission, Dhaka.
G) Member: Rotary Club of Ramna, Dhaka, Bangladesh.
H) Ex. President: Nalta High School Ex-Students Association, Dhaka.
I) Ex. President: Greater Khulna Somity, Dhaka.
J) Adviser: Satkhira District Association, Dhaka.

06. Publication:

More than 50 (Fifty) research publications published in different national & international journals and newspapers.

07. Overseas Tours & Travels:
As a Government representative and professional expert, he attended many Seminars, Symposium and Conference in England, America, Switzerland, Germany, Japan, Thailand, Singapore, Nepal, Pakistan, Srilanka, India, etc. to present scientific papers in Professional Surgical Association.
08. Award:
A) Awarded Fellow from British Orthopaedic Association.
B) Dr. Bidhan Chandra Roy International Award-2006
C) Bangabandhu Sriti Sarnapadak-2008

CAROL JENKINS

CHAIR ELECT
AFRICAN MEDICAL &
RESEARCH FOUNDATION (AMREF)
UNITED STATES

Carol Jenkins is Chair of the Board of Directors of AMREF USA. The African Medical & Research Foundation, a 53 year old organization based in Nairobi and founded as The Flying Doctors, is the largest African health NGO on the continent. AMREF operates in more than 30 countries in the delivery of services, training of a local health workforce, and providing safe water and sanitation. AMREF is winner of both The Bill and Melinda Gates Award for Global Health and The Hilton Humanitarian Prize.

Ms.Jenkins is a vocal advocate for women's issues. An award-winning writer, producer and media analyst, she is a sought-after speaker and writer on issues relating to the media, specifically the participation of women and people of color; women's participation in the political and economic structures in the US; and the health of women in developing countries, particularly the African continent.

An Emmy-winning former television journalist, she was founding president and board member of The Women's Media Center, the groundbreaking non-profit aimed at increasing coverage and participation of women in the media. In that WMC role she conceived the acclaimed Progressive Women's Voices media leadership program, and acquired and expanded the largest portfolio of women experts in the country, SheSource.

In addition to continuing to serve on The Women's Media Center board, she is Chair of the Black Maternal Health Advisory Board of Women's eNews, the online international women's newspaper; member of the President's Council of Advisors at The National Council for Research on Women; and an Advisory board member of the Caring Economics Campaign, a project of Riane Eisler's Center for Partnership Studies. Ms Jenkins formerly served on the boards of The Ms Foundation for Women and The Feminist Press.

Carol Jenkins is the co-author, with her daughter Elizabeth Gardner Hines, of Black Titan: A.G. Gaston and the Making of a Black American Millionaire. A biography of her uncle, it was winner of Best Non-Fiction award from the Black Caucus of The American Library Association. She was an Executive Producer of Eve Ensler's Sundance award-winning documentary, What I Want My Words to Do to You and is a contributor to the recently published book, Secrets of Powerful Women, Leading Change for a New Generation.

A recipient of both the Lifetime Achievement and International Reporting awards from the National Association of Black Journalists/NY, she holds honorary degrees from the women's colleges Marymount Manhattan College and The College of New Rochelle. Recent honors include The 2009 North Star News Prize, and the 2008 Women's Equality Award from The National Council of Women's Organizations.

MASATO MUGITANI

CHAIR-ELECT, GLOBAL HEALTH WORKFORCE ALLIANCE AND ASSISTANT MINISTER FOR GLOBAL HEALTH, MINISTRY OF HEALTH LABOUR AND WELFARE
JAPAN

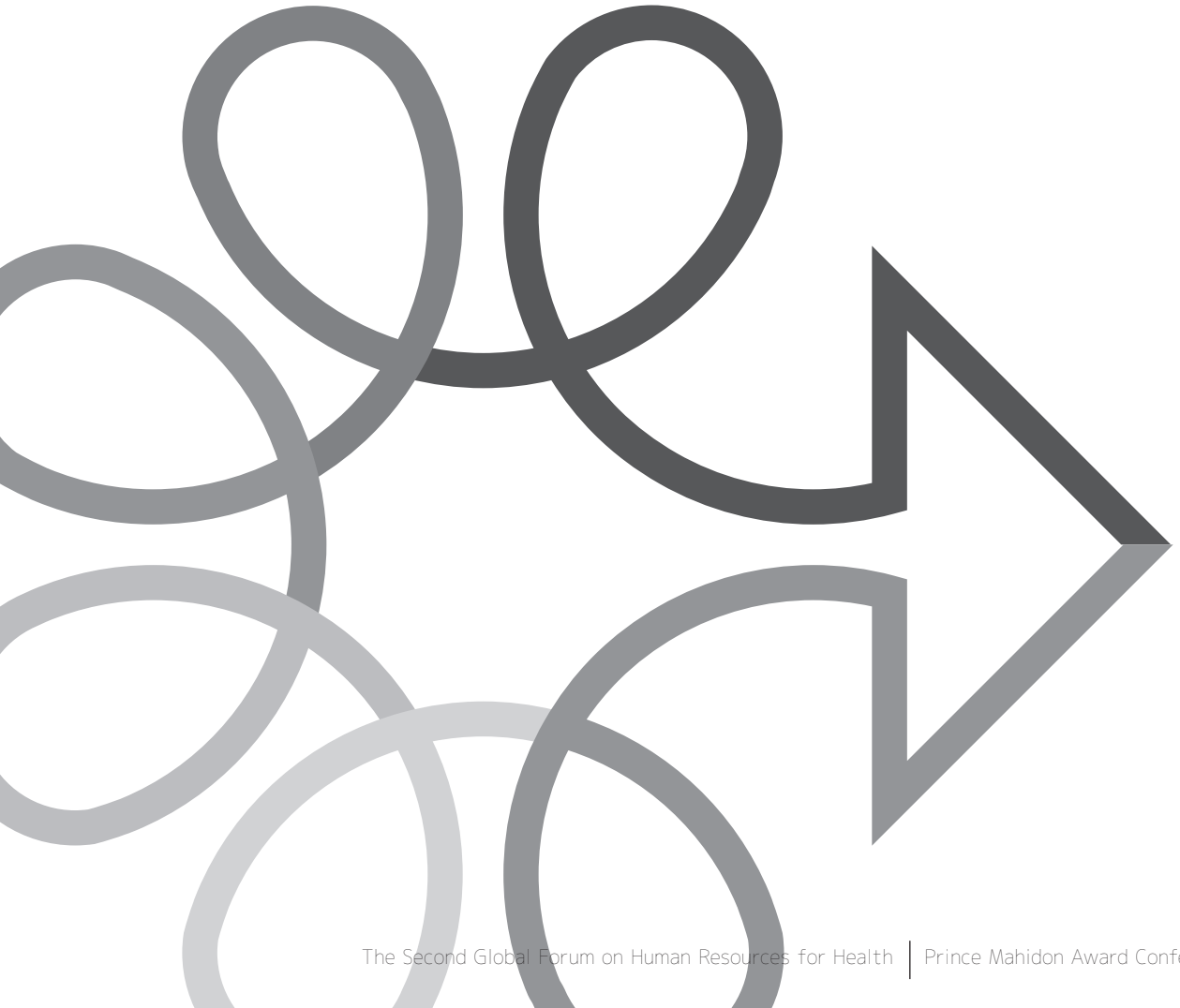
Dr Masato MUGITANI, Assistant Minister for Global Health, Ministry of Health, Labour and Welfare, Japan, is currently a Board Member for the Global Health Workforce Alliance. Dr Mugitani is a medical doctor with professional and profound engagement in the global health, pandemic Influenza response, cancer policies, medical system and public health policies at global, regional and national level.

Dr Mugitani has demonstrated strong and committed leadership in global health, including Chair of the Committee A at the 63rd World Health Assembly in 2010, Chair of the 2010 APEC Health Working Group (1st and 2nd meeting), and Vice-chair of the Open-Ended working group of Member States on Pandemic Influenza Preparedness from 2010. He has also been serving as a board member of the International Agency for Research on Cancer (IARC) and a senior official member of Global Health Security Action Group (GHSAG).

He has been keenly interested in Health System Strengthening with special emphasis on Health Workforces, demonstrating his capacity to liaise with global health partners and achieve consensus on difficult public health issues through his strong public speaking and health diplomacy skills. He has an excellent management ability and strategic visions to ensure effective functioning and performance-focused decision making to find solutions to health workforce crises.

PLENARY SESSION 4 :

Making HRH Innovation Work for Strengthening Health Systems



Innovations in Nursing Education in South Africa

Professor Leana R Uys
School of Nursing
University of KwaZulu-Natal, Durban, South Africa
uys@ukzn.ac.za

Introduction

Nursing education world-wide faces many challenges, but these are particularly daunting in middle and low income countries. In many of these countries the infrastructure and resources for nursing and midwifery education is limited, they are losing highly trained nurses (including nurse educators) to the out-migration to higher income countries, the burden of disease is high and there is a shortage of health professionals, leading to a wide scope of practice for nurses and midwives, and a high demand for their services.

When nurse educators in these countries study the literature, which is mainly produced by high income countries, they cannot afford many of the positive strategies and innovations They demand resources and infrastructure just not available, although the problems they address are common.

South Africa is a middle income country and has a strong nursing education sector. The School of Nursing at the University of KwaZulu-Nata was recognized in the 1990's as a World Health Organization Collaborating Centre on the strength of its innovative nursing and midwifery programs. I would like to share some of our strategies with you. These innovations were implemented from the period of 1994 to 2010 and covers preregistration and post-registration nursing programs, as well as post graduate education.

Innovation 1: A community-based BSN program

Most nursing schools in South Africa are based in hospital-connected nursing colleges. The education is, to a large extent, still focused on the nurse in the hospital. However, the country has a Primary Health Care system which is nurse-based – that is, only nurses offer the PHC service in 90% of clinics. There is therefore a mismatch between the training and the performance expected from the registered nurses.

The UKZN program was therefore changed to be community-based. The programme looks as follows:

Year	Hospital-based	Community or PHC based
1		Care of healthy children, adults and elderly
2		Health promotion in a community
3	General nursing in a general hospital	
4	Midwifery in hospital	Mental Health Nursing and Primary Health Care in Clinics and communities

The program is aimed at ensuring that students understand the context of health care, and internalize an approach to health care that is strongly focused on health promotion, illness prevention and self-care. The work in the second year is NOT done from a clinical setting, but students work directly in other community settings, so that they become comfortable in moving around in marginalized and low-income communities.

We have evaluated the program and found that students are much more confident in their own extended roles than before, and that the clinics that they eventually work with, also becomes more community-involved. The program has also given the Nursing School a high profile in the three communities in which students are placed and with the media.

Innovation 2: A problem-based BSN program

Teaching in nursing schools has traditionally been textbook and notes-based, with a strong emphasis on lectures and demonstrations. While BSN programs attract strong academic candidates, this was not exploited by allowing for more self-direction. Instead, it was only used to add more content. In 1994 we commenced with a unique problem-based program in which the nursing and midwifery content is taught through a real-time problem-based approach.

The students of each small PBL group are placed in slimier unites in different hospitals. They use a patient survey to identify the most common conditions in the unit, and then study patients with those conditions. Each student brings one case study to class, and students explore the conditions, treatment, nursing care, ethics, cultural aspects, etc. The compare cases from different settings and has the opportunity to actually implement the care suggested by the literature.

This approach has the benefit that there are no gap between theory and practice, and the curriculum cannot become outdated. Academic facilitators follow up their own group in the practical settings, and are therefore kept in close contact with the clinical realities.

We have evaluated the graduates of all the PBL programs in South Africa by comparing them with graduates from traditional program 6 months after graduation and found that our graduates do have a much better problem solving ability. They use a wider variety or problem solving strategies and are more interpersonally skilled to implement the strategies.

Strategy 3: A self-study clinical laboratory

In line with our philosophy of self-directed learning, students in the BSN program do not receive group demonstrations. We have a Self-study Clinical Laboratory that is staffed by a tutor the whole day. Each psycho-motor and interpersonal skill is offered in the laboratory by means of a package including a video, CD or computer program. Student are required to identify which skills they would need in the clinical setting in which they are placed, make an appointment to study and practice the skill, and then get assessed before they implement the skill in the clinical setting. Students sometimes use peer assessment before they ask to be assessed by the tutor. They often also study in pairs rather than as individuals. Their use of the laboratory is monitored, and a minimum use is prescribed.

We have also evaluated the competence of our students compared with those from traditional programs, and found them to be as competent as their peers.

Strategy 4: Case –based programs

Since PBL groups have to be taught in small groups of no more than 12 students, we could not afford to introduce this approach in more than the single BSN program. However, we have introduced a closely related approach, the case-based approach in many more programs. This approach can be used in large classes, and is therefore much more economical.

A curriculum of cases is developed to cover the required content, much as is done in the paper-based PBL curriculum. Students are given comprehensive case descriptions, each with specific tasks the student has to complete before the class session. Class sessions are then used to monitor learning; to practice skills; to achieve more process-based objectives such as critical thinking and interpersonal engagement; and to address difficult or problematic aspects of the work in more depth.

This is an approach that combines a content and process approach to curriculum development, and many academics are more comfortable with this combination than with a purely process-based curriculum.

Case	CC Content ent	Skills	Class activities
First week of RN in new clinic	Situation analysis	Reading and interpreting statistics	Small groups to study statistics
Preparing a budget and doing the inventory	Budget process Inventory process	Costing a project Writing a proposal	One student presents budget, three responds to it in plenary
Preparing an induction program for new staff and a continuing education program for existing staff	Induction of new staff Continuing professional development Legal requirements	Doing a learning needs assessment Planning an educational program	Role play the induction interview with a new RN Quizz on CPD

Strategy 5: Decentralized mixed-mode education

About 40% of nurses live and work in rural areas. Many of them cannot access further education because they cannot afford to take off work to study, cannot get study leave or cannot leave their families for a year or more to study. They often also do not have the educational qualifications for the jobs they do. For instance, most nurses working in clinics are only qualified as general nurses and midwives, and do not have the competency to rehabilitate and maintain patients with psychiatric problems in the community or manage a clinic. UKZN therefore created an extensive system of decentralized education which involves 50% of face-to-face teaching in about seven different rural settings around the province, and 50% paper-based and work-based teaching through work-books and projects.

We employ a coordinator in each rural setting to manage the logistics in the setting, and we employ a large number of part-time tutors to do the clinical teaching. We offer pre-teaching induction programs for these part-times, and also annual continuing education. These tutors therefore not only benefit by making additional money, but also by becoming more informed and competent in their own field.

Student usually pay their own fees, and the fees are enough to cover the cost of offering the program, since initially the University was reluctant to become involved in an expensive outreach that they could not finance. However, employers sometimes are so keen to have their nurses competent in a specific field, that they are willing to fund the studies. These programs have made a significant difference in the level of post-basic education in the province of KwaZulu-Natal.

Strategy 6: Tele-education

The province of KwaZulu-Natal has a tele-conferencing infrastructure that links 16 district hospitals with the Medical School at UKZN. Over the last two years the School of Nursing seconded a nurse educator to the Telemedicine Department to learn the skills and transfer them to the School of Nursing. Now the School has obtained external funding to achieve two objectives:

- Create Communities of Practice in different areas of nursing that meets monthly by video-conferencing to support each other; develop their practice and get continuing education. This first group to start will be the nurses working in the Casualty Departments of the District Hospitals under the leadership of one of the professors of Nursing at the School of Nursing.
- Developing the capacity to link distance education students to the Self-study Laboratory for specific procedures to be transmitted to them on request. This service will be available to all district hospitals, including their assistant nurse and enrolled nurse pupils.
- Develop the capacity to link two PHC clinics to the School of Nursing in order to do clinical supervision and practice development. The idea is that fixed cameras will be able to link the academic supervisor at eh School of Nursing with the colleague in the PHC clinic to supervise practice and advice on clinical care.

Strategy 7: Research supervision

The Faculty of Health Sciences have very few PhD qualified faculty. Since there is a drive nationally to increase the PhD production as part of the development of Research and Development, the numbers of PhD students have increased exponentially. This creates a difficulty with unskilled and inexperienced supervisors. The solution which was first developed by the Faculty of Education, was to link each individually supervised student to a group of candidates at the same stage in their PhD research for group supervision.

The group supervision takes place over two days every three months. About four expert supervisors from different disciplines form the organizing team, and they attend all sessions. Usually the group consists of between 15 and 30 candidates, although at any one session is usually not attended by all candidates. They arrange for some lectures from

experts dealing with issues the group of candidates is currently dealing with, but the main activity is to provide an opportunity to each student to present their work since the previous session. Their own supervisors are also invited to attend, and the group and experts provide feedback and suggestions. Between sessions the group keeps contact via a MOODLE site to that useful information can be passed on, candidates can ask for assistance, and the next meeting can be arranged.

Candidates and inexperienced supervisors evaluate the program as very useful, supportive and of great benefit. The problems candidates experience within the administration of the PhD program are identified and dealt with, and students are kept to targets in a much more effective manner. The limitations of their own supervisors are addressed indirectly, without the student being negatively affected.

Another supervision issue we have had to deal with, was in a project to initiate Masters programs in other African countries. We are currently working in three countries where the student group does not work in English, but in either French or Portuguese. To provide the research supervision for these students is a challenge. We initially tried to recruit supervisors from Canada or Brazil to do the supervision by email, or from the country of residence for face-to-face. This did not work, since the supervisors mostly abandoned the task within months, and students could not access email reliably and at an affordable rate.

We then initiated a system of intermitted supervision. One English-speaking supervisor supervises about 12 students, and visits them every three months for two weeks. During this time she sees each student at least three times, and the students work on the research report on a full-time basis. She works through an interpreter, who interprets not only the conversation with the student, but also the written work. During the meetings the work done in the previous three months are discussed, and the work for the next three months is planned. Using this approach the student in the first setting, Lubumbashi in the Democratic Republic of the Congo, has made steady progress and are expected to all complete their research on time.

Conclusion

Approaching problems as opportunities for innovation and change, instead of seeing them as barriers that prevents progress, is the key to educational development in challenging situations. This is a mind-set that not only should be implemented by nurse-educators, but should be transferred to their students.

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Uys L R, Gwele N S, McInerney P A, Tanga T & van Rhyn L (2004) The competence of nursing graduates from problem-based programmes in South Africa. Journal of Nursing Education 43(8) : 352-361

FRANCISCO CAMPOS

PROFESSOR
FEDERAL UNIVERSITY OF MINAS GERAIS
BRAZIL

Francisco Campos was the National Secretary of Labor and Education Management in Health of the Ministry of Health - Brazil from 2005 to 2010. Graduated in Medicine, Dr. Campos holds a Doctoral Degree in Public Health and has been a Full Professor at the Medical School of the Federal University of Minas Gerais for the last 30 years. His main areas of professional involvement are human resources for health (HRH), with focus on Medical Education and more specifically on the professional education and the scaling up of HRH education in developing countries. From 1989 to 1996, while working for the Human Resources Development Department of the Pan American Health Organization (PAHO/WHO), in Washington D.C., he was responsible for the Education Sector. Lately, in addition to being responsible for developing and coordinating Brazil's policies and strategies on HRH, he is also a Board Member of the Global Health Workforce Alliance, a partnership dedicated to identifying, implementing and advocating solutions for the critical shortage of HRH in the world.

OLUWAFUNMILOLA DARE

EXECUTIVE SECRETARY
AFRICAN COUNCIL FOR SUSTAINABLE HEALTH DEVELOPMENT
NIGERIA

Lola Dare is a community physician and epidemiologist. She graduated MB;BS from the College of Medicine University of Ibadan in June 1985; obtained Masters of Science degree in Epidemiology (London School of Hygiene and Tropical Medicine) in 1991; awarded certificates in Population and Development and International Health as David E. Bell and Takemi Fellow of the Harvard School of Public Health, USA in 1994 and 2000 respectively. Dr. Dare is a member of the West African Postgraduate Medical College in the Faculty of Public Health (1990) and a fellow of the Nigerian National Postgraduate Medical College in the Faculty of Community Medicine (1992). Dr. Dare also holds a certificate in Advance Management from the European Business School in France (2006) and is a member of the UK Faculty of Public Health by distinction.

Dr. Dare is Executive Secretary of the African Council for Sustainable Health Development (ACOSHED); Chair of the Technical Evaluation Reference Group of The Global Fund to Fight AIDS, Malaria and Tuberculosis; the Southern Civil Society Representative for the International Health Partnership and related initiatives (IHP+) and is a member of working groups and steering committees of regional and global advocacy, performance monitoring, evaluation and research programmes.

Dr Dare facilitates health leadership development and management programs and serves consultant for many regional and global organizations in public health and social development (health, education and poverty reduction), working at local, national and regional levels to advocate for, and support the increased application of management and business tools to improve the performance of African health and social development systems.

MARK STIRLING
UNAIDS COUNTRY COORDINATOR
UNAIDS
CHINA

Mr. Mark Stirling is currently the United Nations Country Coordinator on AIDS in Beijing, China and brings to this position over twenty-five years of experience in the UN system and an extensive knowledge of development issues, HIV and international cooperation.

Prior to this appointment Mr. Stirling was the UNAIDS Regional Director for Eastern and Southern Africa (2003-2009). Before joining UNAIDS, Mr. Stirling served as Chief of UNICEF's HIV/AIDS Unit in New York; as UNICEF Representative in Mozambique, Somalia, Swaziland and Zambia; and as Senior Programme Officer in Angola and Emergency Health Project Officer in Uganda.

Mr Stirling is an Australian national, holds a Bachelor degree in Economics from Monash University in Australia and a Master's degree in Economics and African Studies from the School of Oriental and African Studies in the UK. Mr Stirling is married with three children.

LEANA R UYS

CHIEF EXECUTIVE OFFICER
FUNDISA
SOUTH AFRICA

Professor Leana Uys (D Soc Sc, ASSAf) is the Chief Executive Officer of FUNDISA, the Forum of University Nursing Deans of South Africa as well as Professor of Nursing at the University of KwaZulu-Natal in Durban, South Africa. For the last six years she has been the Deputy Vice-Chancellor and Head of the College of Health Sciences, University of KwaZulu-Natal.

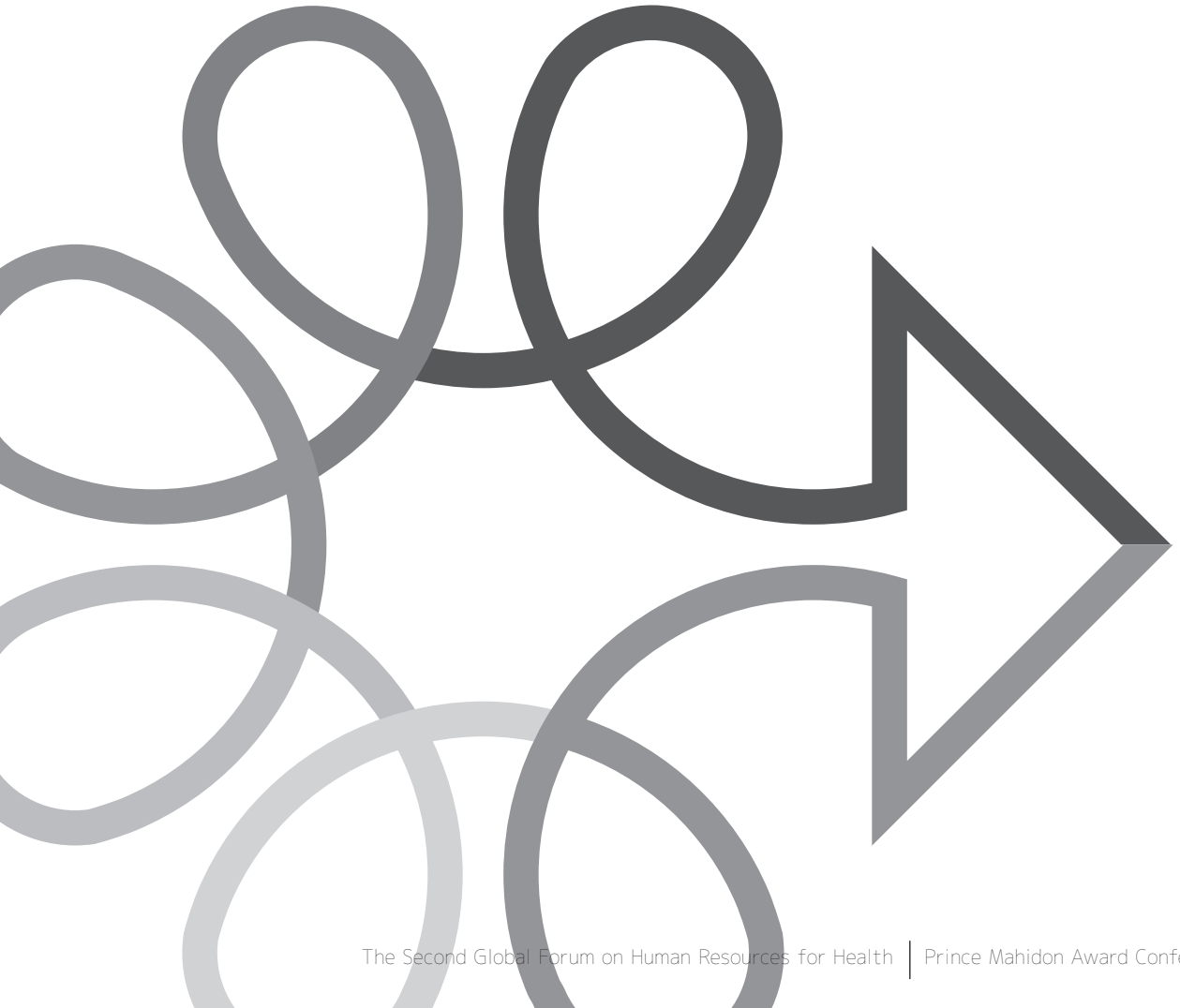
She has published 27 books or chapters in books and serves on a number of editorial boards. As an educator, she led her school into innovative nursing education programs, such as a Community and Problem-based Bachelor's degree and a Case-based Bridging qualification.

She has also been active as a nurse researcher, and is currently the only nurse in South Africa with a B-rating as a researcher from the National Research Foundation. She has led many national and international research teams, leading to over 100 peer reviewed journal articles.

Professor Uys has received many honours, such as the " Women Super Achievers Award" at the Asia's Best Business School Award ceremony in Singapore for academic management and leadership in July 2010, and the Mary Tolle Wright Founders Award for Excellence in Leadership: Sigma Theta Tau International, in 2007, Baltimore, Maryland, USA.

PARALLEL SESSION 15 :

Building capacity to generate evidence in HRH action oriented research



Social determinants and equity in the training of the health workforce

Fran Baum, Director Southgate Institute for Health, Society and Equity, Flinders University, Adelaide Australia & Co-Chair Global Steering Council, People's Health Movement fran.baum@flinders.edu.au

Introduction

The Commission on the Social Determinants of Health (CSDH) was launched by the World Health Organisation (WHO) in 2005 and its final report released in August 2008 (Commission on Social Determinants of Health 2008). Its central task was to consider how action on the social determinants of health could result in greater health equity globally and within countries. Its mandate was to cover the situation of poor, middle-income and rich countries. The Commission identifies how broad social, economic and political factors act as determinants of differential health outcomes in populations, by shaping proximal living conditions and the distribution of socioeconomic advantage or disadvantage either within nations or between them (Blas, Gilson et al. 2008; Commission on Social Determinants of Health 2008; World Health Organization 2008).The Commission's report makes three over-arching recommendations, to:

(1) Improve daily living conditions in which people are born, grow, live, work and age.
(2) Tackle the inequitable distribution of power, money and resources - the structural drivers of daily living conditions - globally, nationally and locally.
(3) Measure and understand the problem of health inequities and assess the impact of action.

In regard to workforce issues the CSDH made the following point the third of its principles of action:

Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health

Two recommendations were particularly relevant to education and training:

16.5. Educational institutions and relevant ministries make the social determinants of health a standard and compulsory part of training of medical and health professionals

16.6. Educational institutions and relevant ministries act to increase understanding of the social determinants of health among non-medical professionals and the general public

The CSDH expanded on these recommendations by noting that a new form of health literacy needs to develop which includes the ability to access, understand, evaluate and communicate information on the social determinants of health (Commission on Social Determinants of Health 2008, p 189)82688. This call moves health literacy beyond a preoccupation with individual understanding of improving health behaviours to a concern with community and society wide determinants of health.

This paper will consider what it will take to put these recommendations of the CSDH into practice. The paper considers the barriers to implementing these recommendations, some ideas about what would enable them to be implemented in initial training and in staff development and finally the need for leadership in health systems to implement the CSDH's recommendations.

Barriers to training on SDH & equity
These barriers are common to initial education and in-service training and professional development.

Individualism and behaviouralism
There is a strong ethic of individualism underpinning much medical and other health professional training (Tesh, 1988). The results of this are a belief that individuals are largely responsible for their own health and behaviours. This means that the message on social determinants is not easily heard. Often preventive and promotive programs place emphasis on directly changing people's behaviours rather than changing the environments that give rise to the behaviours. This individualism both supports and reflects the growing neo-liberalism that has been evident in the political systems of many countries and the policies of the World Bank and International Monetary Fund.

Medical imagination
A strong medical imagination has dominated health since the early days of formal medicine. There has always been an alternative view within medicine (for example Virchow in the 19th Century (Mackenbach 2009), and Halfdan Mahler's leadership of WHO in the 1970s/1980s) but this view struggles to be heard in a world dominated by the appeal of the cure and the view of medicine as the task of working miracles. The medical imagination dominates the training of most health professionals which means a thorough understanding of the power of social determinants and the persistent of health inequities is not provided. It also means that medical cure receives most status in health systems and that the disciplines which stress the power of prevention - health promotion and public health - are often second class citizens.

The pressure for curative services is strong in low, middle and high income countries. This pressure is fuelled by the supply of medical and pharmaceutical services that are supplied by the for-profit sector. The profit from this sector comes from selling drugs and medical services and not from promoting health.

The dominance of the medical imagination also means that communities and citizens will demand more curative health services (not infrequently funded by industry) but, without some input about the importance and values of disease prevention and health promotion will not be advocates for these activities.

Focus on the tip of the iceberg

Most health system responses to diseases and health problems focus on the tip of the iceberg and do not delve below the surface to consider the underlying factors (Baum 2009). This means that actors in the system do not perceive the need to train the workforce in delving beneath the surface. A workforce that is focused almost entirely on treating illness and disease will not see the need to be trained for prevention and health promotion. A focus on the tip of the iceberg will also mean masking the underlying social, economic and political factors underpinning health inequities.

Initial Education and Training for SDH & Equity

There is not space in this paper to spell out a complete curriculum for initial training but some broad guidelines can be provided. These guidelines draw on the values and philosophy of the People's Health Movement (www.phmovement.org) as expressed in the People's Charter for health, work reported in the US (Gould, Mogford et al. 2010; see also: Just Health Action 2010), and a public health text book which has the social determinants of health at its core (Baum 2008). Clearly the exact content will differ according to the learners' age, skill level and length of time available for the training. Most crucially the training should focus on what promotes health at a population level rather than in individuals and explain that the two are not the same as described above.

Values and appreciation of the political nature of health: training about the SDH and equity require a grounding in the political economy of health and an understanding that medicine and health are reflections of the broader political system of which they are part (see Part 2 in Baum 2008 pp. 69-134). It must include a discussion of values and examine the operation of power and politics in shaping responses to health and medicine. The value explanation should also allow students to examine their values and motivation for working in health. The movement for social accountability in medical schools is important in encouraging this examination of values (Boelen 2008). The CSDH was very clear on the importance of values to achieving health equity and

in its opening statement noted "Social justice is a matter of life and death···These inequities in health, avoidable health inequalities, arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces" (Commission on the Social Determinants of Health 2008, foreword).

Knowledge: understanding the SDH and that health is a human right. This includes determining what health is and seeing it in a broad social context and explaining the prevention paradox (Rose 1985). Understanding the pattern of health inequalities and health inequities is crucial and will be most effective if local examples can be used. Gould et al suggest students are encouraged to conduct a "causes of the causes" analysis to identify the upstream determinants of health (2010). Werner and Sanders (1997, pp. 11-12) offer a good example of this type of analysis with their story of the death of Rakku's baby. They note that the baby's death from diarrhea and dehydration were "only the final links in a long chain of causes: physical, biological, cultural, economic and political." Understanding the power of social determinants will also require analysis of the factors that have extended life historically and should refer to the work of McKeown (1979) and Szreter (1988).

Planning action: this type of activity is concerned with taking action and can include understanding advocacy for health, working collectively for health change, and determining what students can do in terms of their work roles and as citizens.

Skills: these will include working in local communities to identify key issues associated with the social determinants of health rather than just those associated with the need for sick care and working in a hospital. Training should also include the opportunity to develop a range of advocacy skills.

Action: ideally students should be linked to local action on the SDH that is on-going - this may in concert with local NGOs or community health centres.

In-service training and staff development

The basis aim and shape of in-service training and staff development is much the same as for initial training in terms of knowledge and skills. The actions, however, need to be linked to the everyday work that people do. This training will be most effective when there is policy support for action on the SDH and the organisation is supportive of work on equity and SDH. Such training would be most effective when work groups can do the training together and then, using an action learning methodology, apply the new learnings in their work place.
The People's Health Movement has developed an International People's

Health University (http://www.iphu.org/) which is developing a range of curricula which allows for a critical examination of social determinants and the political and economic processes which act to create and reproduce health inequities. Many young health professionals who also take on an activist role have been inspired by the course which has been delivered in more than 10 countries. The work of non-government organisations in encouraging education on the SDH is particularly important in setting where there is little government and university support. In the US Just Health Action provides another example of ways of working in an environment that is not very supportive of action on SDH and health equity (Just Health Action 2010).

Leadership for SDH & Equity

It is very unlikely that the CSDH's recommendation on education and training for the social determinants of health and health equity will be implemented in a health system unless there is strong leadership for this to happen. There is evidence that public spending on health can have positive effects on life expectancy (Mackintosh and Koivusalo 2005) and health equity (Houweling, Kunst et al. 2005). Given the degree to which heavily privatized systems rely on clinical throughput to maximize shareholder profits, the establishment (or reestablishment) of strong public health care sectors based on the principles of equitable, universal coverage will require considerable political and sectoral leadership (Baum, Begin et al. 2009). The link between mixed private and public funding of health services and rapid cost escalation is well-established. The private medical sectors in low- and middle-income countries are even more strongly oriented toward a richer clientele than government health services, reinforcing the need, from a health equity viewpoint, for a revitalized public sector (Evans 2007). Strengthening the public health care sector in low- and middle-income countries will assist public health systems to work towards equitable access to health care and the power of the social determinants of health. These leaders will need to understand and address the root causes of the weaknesses of these systems, including limited taxation capacity and limited ability on the part of the government to translate spending into delivery, including tackling the "brain drain" (Chen, Evans et al. 2004; Mullan 2005), and ameliorating the effects on health systems of global economic and political power differences. It will be hard for any country to take effective action on SDH without a political system committed to a strong public health system, a health in all policies approach (Kickbusch 2010) and an explicit commitment to equity.

Perhaps there needs to be a mechanism to provide social health literacy training for new Ministers of Health and senior bureaucrats. What I would like every Minister of Health to understand when they take office is:

- Health and medicine are central political issues and achieving a

health system committed to equity and action on the SDH will require strong political leadership which is willing to stand up to the many vested interests.

- Prevention paradox - Treating high-risk or diseased individuals does not have much impact on population health levels overall, but changing a risk factor across a whole population by just a small (and often clinically insignificant) amount can have a great impact on the incidence of a disease or problem in the community (Rose 1985).
- Healthy places make healthy people - healthy behaviour flows from healthy environments
- Behaviour change strategies on their own do not result in behaviours change across a population
- Health systems should be based on comprehensive PHC and universal public coverage to maximise health and equity
- The health sectors should offer leadership to other sectors to encourage them to take health outcomes in to account in their decision making

It is rare to find examples of strong commitment to the social determinants approach. One of the strongest I've seen was in South Australia. In the late 1980s the Labor Health Minister encouraged the development of a Social Health Strategy and in the forward to the strategy wrote:

A social view of health implies that we must intervene to change those aspects of the environment which are promoting ill health, rather than continue to simply deal with illness after it appears, or continue to exhort individuals to change their attitudes and lifestyles when, in fact, the environment in which they live and work gives them little choice or support for making such changes (Cornwall 1988, Introduction)

A clear statement of commitment to a social determinants approach from a health minister will make it much easier to support relevant training about and action on the social determinants.

Conclusion

The CSDH set out clear recommendations for action in terms of the need for training on the SDH and health equity. Implementation of these recommendations (Cornwall 1988) will not happen without a political commitment to health equity across government, within health ministries and universities. The education and training recommended also requires a commitment to a set of values and practices that are compatible with health equity and an understanding of health rooted in the social determinants. It is imperative that the CSDH's recommendations are implemented by health systems and universities and that education and training provide a strong grounding

in an understanding of health that both takes seriously the social and economic roots of health and health inequities and examines the ethical mandate for health equity.

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POLICY BRIEF
TASK SHIFTING TO OPTIMISE THE ROLES OF HEALTH WORKERS TO IMPROVE THE DELIVERY OF MATERNAL AND CHILD HEALTHCARE

Harriet Nabudere,1 MD, MPH
Delius Asiimwe,2 BA, MA
Rhona Mijumbi,3 MD, MPH, MSc

1. Project Coordinator, Supporting Use of Research Evidence for Policy Project, College of Health Sciences, Makerere University. International Research Chairs Initiative (International Development Research Centre, Canada)
2. Research Scientist, Supporting Use of Research Evidence for Policy Project, College of Health Sciences, Makerere University. International Research Chairs Initiative (International Development Research Centre, Canada)
3. Project Officer, Supporting Use of Research Evidence for Policy Project, College of Health Sciences, Makerere University. International Research Chairs Initiative (International Development Research Centre, Canada)

Address for correspondence:
Dr Harriet Nabudere
Project Coordinator,
Supporting Use Research Evidence for Policy Project
College of Health Sciences, Makerere University
Kampala, Uganda
Email: hnabudere@gmail.com

Introduction

This is a summary of an evidence brief for policy that addresses the need for improving maternal and child health in Uganda through optimising the roles of health workers to. The methods used to prepare this policy brief are described in detail at these references.[1],[2],[3],[4],[5],[6] This policy brief assesses a health systems problem, potential policy options to address the problem and strategies for implementing those options. This report brings together global research evidence (from systematic reviews) and local evidence to inform deliberations about optimising the use of different cadre of health workers to deliver cost-effective MCH programs and services. The purpose of this report was to inform deliberations among policymakers and stakeholders, and specifically as a background document to be discussed at meetings (policy dialogues) of those engaged in developing policies for task shifting or likely to be affected by these policies.

The problem

There is a shortage of human resources for health, particularly specialized health workers, in sub-Saharan Africa, including Uganda.[7]Expanding the roles of less specialised health workers or 'task shifting' - a process of delegation whereby tasks are moved, where appropriate, to less specialised health workers – is one way of addressing this problem.[8]

We have chosen to use the term 'optimising health worker roles' to clarify that the focus is primarily on optimising the roles of less specialised health workers to deliver MCH interventions that are currently not accessible for the majority of the population and are not being provided by more specialised health workers.

Size of the problem

Uganda is making slow progress towards meeting the Millennium Development Goals for maternal and child health.[9] The maternal mortality ratio is still high at 440 per 100,000 live births. The under-five and infant mortality rates are 140 and 82 per 1000 live births, respectively.[10] Lack of access to effective healthcare is a major cause of unnecessarily high maternal and child mortality.[11]

In 2002, Uganda had a total of 2,919 medical doctors with 71% working in the central urban region which is inhabited by only 27% of the total population. Similarly, 64% of the nations' total of 20,186 nurses and midwives are working in the central urban region. Forty-seven percent of the approved positions in the public sector are vacant.[12]

Uganda is recognized as one of the countries implementing task shifting at an informal level as a pragmatic response to the health workforce shortage. This has occurred, for example, for the provision of antiretroviral therapy for HIV/AIDS, integrated management for childhood illnesses, obstetrical care (with traditional birth attendants) and in establishing village health teams.[13],[14],[15] However, much of the task shifting that has occurred has been without a clear policy, planning, or monitoring and evaluation. As a consequence, some of this task shifting is in conflict with current health professional regulations and licensure. Furthermore, the lack of an explicit policy limits the extent to which task shifting can be implemented and coordinated effectively, efficiently and equitably.

Factors underlying the problem

Effective task shifting requires appropriate MCH care seeking by mothers and children, effective training and incentives for health workers to provide those services, adequate supplies and equipment, increased supervision of less specialised health workers by health professionals, changes in referral processes, and the resources to pay for these supports.

The way human resources are planned, trained, placed and managed affect the quality, character and costs of healthcare provision. However, current information systems for monitoring human resources for health are paper-based and inadequate. Computerisation of the health management information systems (HMIS) in Uganda has been slow due to financial and technical limitations.[16]

Health workers lack incentives to expand their roles. Community health workers are not paid and reimbursement systems of other health workers do not provide incentives for appropriate delivery of cost-effective interventions. Non-financial incentives are also inadequate. Ugandan health workers are dissatisfied with their jobs, especially their compensation.[17] This draws health workers away from government facilities that are already understaffed.[18]

There is a support supervision system and a quality assurance unit in the Ministry of Health that is responsible for supervision. However, the system is not functioning adequately. Because resources are limited, only more accessible health facilities tend to receive supervision visits, and only a few times per year.

The task shifting that has occurred has been without a clear policy, planning, or monitoring and evaluation. Moreover, some of this task shifting may be in conflict with current health professional regulations and licensure with some health workers feeling that problems that arise can backfire on the concerned health worker who does not have legal protection for additional tasks.[19] Professional protectionism is also an issue. Many professionals are reluctant to cede tasks to others for fear of being replaced. For example, some doctors are reluctant to have clinical officers perform any type of surgery.30

There are varied views on task shifting. Those in favour of task shifting see it as a potential solution to Uganda's dual problem of lack of skilled personnel and high demand for services. Those opposed to task shifting see it as a quick fix and an approach that could dilute the quality of care and compromise the health system in the long term. Donor and international agencies widely support task shifting,[20],[21] although the World Health Organization is now opposed to training traditional birth attendants.[22]

Policy options

Options for optimising the use of health workers to improve the delivery of cost-effective MCH services include optimising the use of 1) lay health workers, 2) nursing assistants, 3) nurses, midwives and clinical officers, and 4) drug dispensers. These four options are complementary, with the primary aim of ensuring the optimal use of non-medically trained primary healthcare workers to ensure universal delivery of cost-effective MCH services.

These four options are described below, including the advantages, disadvantages and acceptability of each option. The costs and cost-effectiveness of all four options is uncertain.

Policy option 1:
Optimise the role of lay health workers

Lay (non-professional) health workers include community health workers (CHW's) and traditional birth attendants (TBA's). Examples of cost-effective MCH services that they could deliver include: ([23],[24],[25],[26],[27])

- Promotion of appropriate care seeking and breastfeeding
- Provision of contraceptives, cord care and clean delivery kits, iron folate supplementation during pregnancy, balanced protein-energy supplements during pregnancy, antiretroviral, vitamin A supplementation in children, preventive zinc supplementation for children, insecticide-treated bednets, intermittent preventive treatment for malaria
- Improved diarrhoea management (zinc and oral rehydration therapy)
- Community detection and management of pneumonia with short course amoxicillin
- Improved case management of malaria including artemisinin-based combination therapies (ACTs)
- Recognition, triage and treatment of severe acute malnutrition in affected children in community settings

Advantages:

- CHW's and TBA's can potentially deliver most MCH interventions for which there is evidence of cost effectiveness in primary care.
- Expanding the use of CHW's may reduce morbidity and mortality in children under five and neonates.
- Training for TBA's may improve perinatal outcomes and appropriate referrals.

Disadvantages:

- Ensuring the quality of care delivered by CHW's and TBA's would require increased training, supplies and equipment, increased supervision by health professionals, changes in referral processes, and incentives.

Acceptability:
- Some policymakers and advisors in the Ministry of Health and WHO are sceptical about providing training to TBAs.
- Some health professionals are sceptical about expanding the use of CHW's and TBA's.

Policy option 2:
Optimise the role of nursing assistants
Various terms may be used to describe nursing assistants, including nursing auxiliaries, nurse extenders and health care assistants. Nursing assistants may have various degrees of training, but they have less training than registered or qualified nurses. MCH services that they could deliver include: ([28],[29],[30])
- Promotion of breastfeeding
- Provision of contraceptives, iron folate supplementation during pregnancy, balanced protein-energy supplements during pregnancy, antiretrovirals, vitamin A supplementation in children, preventive zinc supplementation for children, insecticide-treated bednets, in termittent preventive treatment for malaria
- Improved diarrhoea management (zinc and oral rehydration therapy)

Advantages:
- Expanding the use of nursing assistants in facilities might increase the time available from nurses, midwives and doctors to provide care that requires more training.

Disadvantages:
- The impacts of expanding the use of nursing assistants on the quality of care are uncertain.
- Ensuring the quality of care delivered by nursing assistants would require increased training, increased supervision by health professionals and incentives.

Acceptability:
- The Ministry of Health has recently decided to phase out nursing assistants.
- Nurses, midwives and clinical officers may be reluctant to take responsibility for supervising nursing assistants and to cede tasks.

Policy option 3:
Optimise the role of nurses, midwives and clinical officers
Nurses, midwives and clinical officers are trained health professionals. MCH services that they could deliver include: ([31],[32],[33])
- Promotion of breastfeeding

- Provision of contraceptives, iron folate supplementation during pregnancy, balanced protein-energy supplements during pregnancy, antiretrovirals, vitamin A supplementation in children, preventive zinc supplementation for children, insecticide-treated bednets, intermittent preventive treatment for malaria
- Interventions for prevention of post-partum haemorrhage and use of oxytocic agents
- Basic newborn resuscitation with self inflatable bag and mask
- Community detection and management of pneumonia with short course amoxicillin
- Improved case management of malaria including artemisinin-based combination therapies (ACTs)
- Recognition, triage and treatment of severe acute malnutrition in affected children in community settings

Advantages:
- Expanding the use of nurses, midwives and clinical officers to deliver cost effective MCH interventions in areas where there is a shortage of doctors would probably improve MCH outcomes and reduce inequities.

Disadvantages:
- Expanding their use would require strategies to ensure that they can be recruited and retained in underserved communities.
- Ensuring the quality of care delivered by nurses, midwives and clinical officers would require increased training, supplies and equipment, supervision doctors, changes in referral processes, and incentives.

Acceptability:
Some nurses, midwives and clinical officers are concerned about taking on additional responsibilities.
Doctors may be reluctant to take responsibility for supervising nurses, midwives and clinical officers and to cede tasks.

Policy option 4:
Optimise the role of drug dispensers
The term 'drug dispensers' is used here purely descriptively to collectively refer to trained pharmacists, formally trained dispensers, clinicians dispensing drugs and untrained retailers in drug shops and other outlets. MCH interventions that they could deliver include: ([34],[35])
- Promotion of appropriate care seeking
- Provision of contraceptives, cord care and clean delivery kits, iron folate supplementation during pregnancy, balanced protein-energy supplements during pregnancy, antiretrovirals, vitamin A supplementation in children, preventive zinc supplementation for children, insecticide-treated bednets, intermittent preventive treatment for malaria

- Improved diarrhoea management (zinc and oral rehydration therapy)

Advantages:
- Expanding the use of drug dispensers to promote and deliver cost-effective MCH interventions and improving the quality of the services they provide could potentially improve health outcomes and reduce inequities, but the impacts of doing this are uncertain.

Disadvantages:
- Ensuring the quality of services delivered by drug dispensers would require increased training, supplies, and incentives.

Acceptability:
A review by Goodman and colleagues found popular use of medicine sellers in Sub-Saharan Africa. Informal drug outlets are the first point of call for a majority of caregivers in childhood illness.[36]

Implementation considerations
Optimizing the roles of health workers is just one solution to improving the delivery of maternal and child health care and addressing other health system challenges. Implementing changes in the roles of health workers requires other changes. It is also an opportunity to address other health system problems. Implementation strategies can capitalise on enablers of optimising health workers' roles as well as addressing barriers to doing so.

A process is already underway to develop a policy and guidelines for task shifting in Uganda.37 Other enablers of optimising health workers' roles to deliver effective maternal and child health care include:
- There is widespread support for improving MCH care.
- Demand for care is unmet and there is a shortage and uneven distribution of health professionals.
- Health facilities are widely available and the hierarchical organisation of the health system provides a structure for delegating tasks to less specialised health workers, referring patients who need more specialised care, and providing supportive supervision.
- Mothers feel more comfortable with health workers with less training and people in rural areas prefer free public health services that are close to home.
- There is international support for task shifting.
- Successful task shifting is already occurring in Uganda and internationally.

Key barriers to implementing the policy options and implementation strategies to address these are summarised in Table 1.

Table 1. Implementation considerations

Barriers to implementation	Strategies for implementation
Mothers' knowledge and care seeking behaviour Mothers have limited knowledge of effective MCH interventions and may not recognise symptoms and signs and seek care from appropriate health workers when needed Mothers have mixed attitudes - they want health professionals with more training, but feel more comfortable with health workers with less training.[38,39,40,41,42,43,44,45]	**Outreach by CHWs and drug dispensers** CHWs and drug dispensers could be used to teach mothers and promote appropriate use of health services. **Community mobilisation** Community mobilisation could include active community participation, contextualization of information in the local customs and culture, involvement of a broad range of key stakeholders, home visitation and peer counselling.[46] **Mass media campaigns** Mass media information on health-related issues could induce changes in health services utilisation, both through planned campaigns and unplanned coverage.[47] **Patient education materials** A wide range of patient education materials could be used to inform mothers in combination with other strategies.[48] **Reduction or elimination of out-of-pocket costs** • User fees could be reduced or removed completely for some or all women and children and for some or all types of MCH care • Other ways of reducing or eliminating out of pocket costs include voucher schemes, community-based health insurance schemes, community loans for emergency transport and care, and conditional cash transfers (payments conditional on utilisation of services such as immunisations or prenatal care)[49, 50, 51, 52]

Barriers to implementation	Strategies for implementation
Health workers' knowledge and competency Health workers lack necessary knowledge and competency to expand their roles[53]	**Educational meetings, outreach visits, audit and feedback** Educational meetings (training workshops), educational outreach (a personal visit by a trained person to health workers in their own settings) and audit and feedback (a summary of performance over a specified period of time given in a written or verbal format) could be used alone or in combination with each other and other interventions to improve health worker practice[54,55,56,57,58,59]
Incentives for health workers Health workers lack incentives to expand their roles. CHWs are not paid and reimbursement systems of other health workers do not provide incentives for appropriate delivery of cost-effective interventions. Non-financial incentives are also inadequate[60]	**Adequate payment** • Health workers could be paid in any of the following ways or combinations of these: salary (a lump sum for a set number of working hours or sessions per week), capitation (a payment per patient), fee-for-service (payment for each item of service or unit of care)Payment in kind (material incentives) includes, for example, housing, transport, childcare facilities, free food and employee support[61,62] **Pay for performance** Pay-for-performance refers to the transfer of money or material goods conditional on taking a measurable action or achieving a predetermined performance target[63] **Non-material incentives** Non-material incentives include, for example, community recognition, peers support, and acquisition of valuable skills (and the prospect of future employment) [48,50,64]

Barriers to implementation	Strategies for implementation
Referral processes and transportation There is a support supervision system and a quality assurance unit in the Ministry of Health that is responsible for supervision. However, the system is not functioning adequately Patients are often referred without any direct communication between the different levels of care and patients are often responsible for organising their own transportation [41,65,66,67,68,69]	**Strategies to implement referral guidelines** Strategies to implement referral guidelines include passive dissemination, educational activities, structured referral sheets and the use of financial incentives[70] **Educational meetings, outreach visits, audit and feedback** Educational meetings, educational outreach and audit and feedback (as described above) could be used alone or in combination with each other and other interventions to improve referrals[41,71,72,73,74,75] **Pay for performance** Pay-for-performance (as described above) could be used to motivate appropriate referrals[41,76,77,78,79,80] **Reduction or elimination of out-of-pocket costs** User fees could be reduced or removed completely for some or all women and children and for some or all types of referrals. Other ways of reducing or eliminating out of pocket costs for referrals include voucher schemes, community health insurance schemes, community loans for emergency transport and care, and conditional cash transfers (e.g. for delivery at a facility with skilled birth attendance)[33] **Community referral and transport schemes** Schemes that are used vary widely and may include paying for travel costs, establishing a transportation plan, and providing various means of transportation, including canoes, loan of a truck, and ambulance transport using bicycles, motorcycles or 4-wheel drive vehicles. Establishing effective communication between primary and referral level facilities is a key component of transport systems[33]

The National Policy Dialogues:
This policy brief was discussed as a background document at two policy dialogue meetings in Kampala. Participation at these meetings included: members of parliament, policy makers, health managers, researchers, civil society, professional organisations, the media and development partners. The purpose of these dialogues was to conduct a structured discussion of the policy brief on task shifting. These deliberations among health policymakers and other stakeholders can potentially contribute to evidence-informed health policies by adding value to the policy brief through clarification of the problem and solutions and developing a shared understanding of the problem and possible solutions.

Many participants came to the deliberations with strong prior opinions; both supporting and opposing the options described in the policy brief. The policy brief and dialogues had little if any observable impacts on these opinions. Moderation of the proceedings was also a challenge. One lesson learned here was that a strong, neutral moderator with a clear understanding of the process is crucial to achieving the objectives of a policy dialogue.

Despite these challenges, participants in the meetings evaluated the policy brief and dialogues positively. Next steps coming out of the dialogues include presenting the policy brief to the senior management at the Ministry of Health at one of their regular meetings, further dissemination of the policy brief, and engagement of interested participants in future activities in Uganda aimed at improving the use of research evidence in health systems decisions.

Acknowledgements
This policy brief was prepared under the Supporting the Use of Research Evidence (SURE) for Policy in African Health Systems, a collaborative project that builds on and supports the Evidence-Informed Policy Network (EVIPNet) in Africa and the Regional East African Community Health (REACH) Policy Initiative. SURE is funded by the European Commission's 7th Framework Programme. The authors of the brief are also supported by the International Research Chairs Initiative funded by the International Development Research Centre (IDRC) to build capacity in knowledge translation in the African region. Technical support for the preparation of this policy brief was provided by the Norwegian Knowledge Centre for the Health Services, World Health Organisation, Department of Research Policy Cooperation and McMaster University (Canada). Preparation of this policy brief was coordinated and facilitated by Dr Andy Oxman. The authors would like to thank Nelson Sewankambo, John Lule, Charles Karamagi, Charles Isabirye, Miriam Sentongo, John Lavis, Kaelan Moat, Dela Dovlo, Yoswa Dambisya, Metin Gulmezoglu, Susan Munabi Babigumira and Simon Lewin for reviewing earlier versions of the report.

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FRAN BAUM

PROFESSOR OF PUBLIC HEALTH
FLINDERS UNIVERSITY
AUSTRALIA

Fran Baum is Professor of Public Health at Flinders University, Adelaide, Australia. She is also Foundation Director of the Southgate Institute for Health, Society and Equity & the South Australian Community Health Research Unit. She holds an Australian Research Council Federation Fellowship focusing on the social determinants of health inequity and social inclusion. She is the Co-Chair of the Global Steering Council of the People's Health Movement. She also served as a Commissioner on the World Health Organisation's Commission on the Social Determinants of Health from 2005-08. She is a Fellow of the Australian Academy of Social Science and of the Australian Health Promotion Association. She is also a past National President and Life Member of the Public Health Association of Australia.

Fran Baum is one of Australia's leading researchers on the social and economic determinants of health and community based health promotion and has been researching Healthy Cities since its inception in Australia in 1988. She has an extensive teaching career in public health, including writing a number of distance education courses and designing a doctor of public health course for senior public health professions. Her text book The New Public Health (3rd edition 2008 Oxford University Press) is widely used as a core public health text.

MICKEY CHOPRA

CHIEF OF HEALTH/ASSOCIATE DIRECTOR PROGRAMMES
UNICEF
UNITED STATES

Dr. Mickey Chopra took up his post as Chief of Health and Associate Director of Programmes at UNICEF's New York Headquarters in August 2009, leading the agency's work on maternal, newborn and child health, immunization, paediatric HIV/AIDS, and health systems strengthening, policy and research.

Prior to his appointment to UNICEF, Dr. Chopra was the director of the Health Systems Research Group of the South Africa Medical Research Council.

A British national, Dr. Chopra is qualified as a medical doctor with an additional degree in medical sociology from the University of Southampton in England. After completing his internship, he went to work as a district medical officer in the rural health district of Hlabisa, South Africa. He had a particular focus on child health and nutrition programmes and received his Diploma in Child Health during this time.

After receiving his Masters in Public Health (Primary Health in Developing Countries) at the London School of Hygiene and Tropical Medicine in 1997, he joined the nascent School of Public Health at the University of the Western Cape in South Africa. In 2008, he earned his PhD from Faculty of Medicine, University of Uppsala in Sweden.

Dr. Chopra has published over 70 international peer-reviewed papers and contributed to numerous book chapters concerned with international child health and nutrition. He currently lives in New York with his wife and two children.

About UNICEF & Child Survival
In recent years, UNICEF's programme for child survival, growth and development has grown to a 1.5 billion USD programme that works in more than 150 countries.

A. METIN GÜLMEZOGLU

MEDICAL OFFICER
REPRODUCTIVE HEALTH AND RESEARCH
WORLD HEALTH ORGANIZATION
SWITZERLAND

A. Metin Gülmezoglu qualified as an obstetrician and gynaecologist in Turkey in 1990. He worked as a clinician and researcher in South Africa between 1990-1995 and completed his PhD at Witwatersrand University. Between 1995 and 1998 he worked first at the National Perinatal Epidemiology and then at the UK Cochrane Centre focusing on systematic reviews and the development of the WHO Reproductive Health Library (RHL) project. In 1998 he joined the Department of Reproductive Health and Research, WHO in Geneva as a medical officer. He is the coordinating editor of the RHL, a specialist database in sexual and reproductive health and coordinates research synthesis activities and conducts multicentre research projects on maternal and perinatal health.

He is the focal person for knowledge synthesis and exchange including implementation research activities within the Department of Reproductive Health and Research following a comprehensive knowledge to action framework to improve sexual and reproductive health.

PISAKE LUMBIGANON
DEAN FACULTY OF MEDICINE
KHON KAEN UNIVERSITY
THAILAND

is a dean, Professor of Obstetrics and Gynecology and Convenor of the Thai Cochrane Network based at Khon Kaen University, Thailand. He got his MD and Obstetrics and Gynaecology training from Ramathibodi Hospital, Mahidol University in Thailand and Master of Sciences in clinical epidemiology from the University of Pennsylvania in the US. He has been involved with various WHO Reproductive Health Research projects including many multicentre randomized controlled trials. He is also the co-principle investigator for the SEA-ORCHID project which is a collaborative project (2004-2008) between Australia, Thailand, Malaysia, the Philippines and Indonesia. He has been convening the Thai Cochrane Network since its incetion in 2002. He has published more than 100 papers in various indexed journals. His main areas of interest includes maternal and perinatal health, evidence based practices, systematic review and meta-analysis.

HARRIET NABUDERE
SURE PROJECT COORDINATOR
MAKERERE UNIVERSITY
UGANDA

Harriet Nabudere is working as the Project Coordinator for the Supporting Use of Research Evidence (SURE) for Policy in African Health Systems Project at the College of Health Sciences, Makerere University since June 2009. SURE is a collaborative project that builds on and supports the Evidence-Informed Policy Network (EVIPNet) in Africa and the Regional East African Community Health (REACH) Policy Initiative. The project involves teams of researchers and policymakers in 11 African countries and is supported by research teams in four European countries and Canada . SURE is funded by the European Commission's 7th Framework Programme. She is also the focal officer for the REACH Uganda Country Office hosted by the Uganda National Health Research Organisation in Entebbe, Uganda.

Academic Background:
She is a public health physician with Bachelor of Medicine and Bachelor of Surgery degrees from Makerere University Medical School (October 1992 to June 1998).

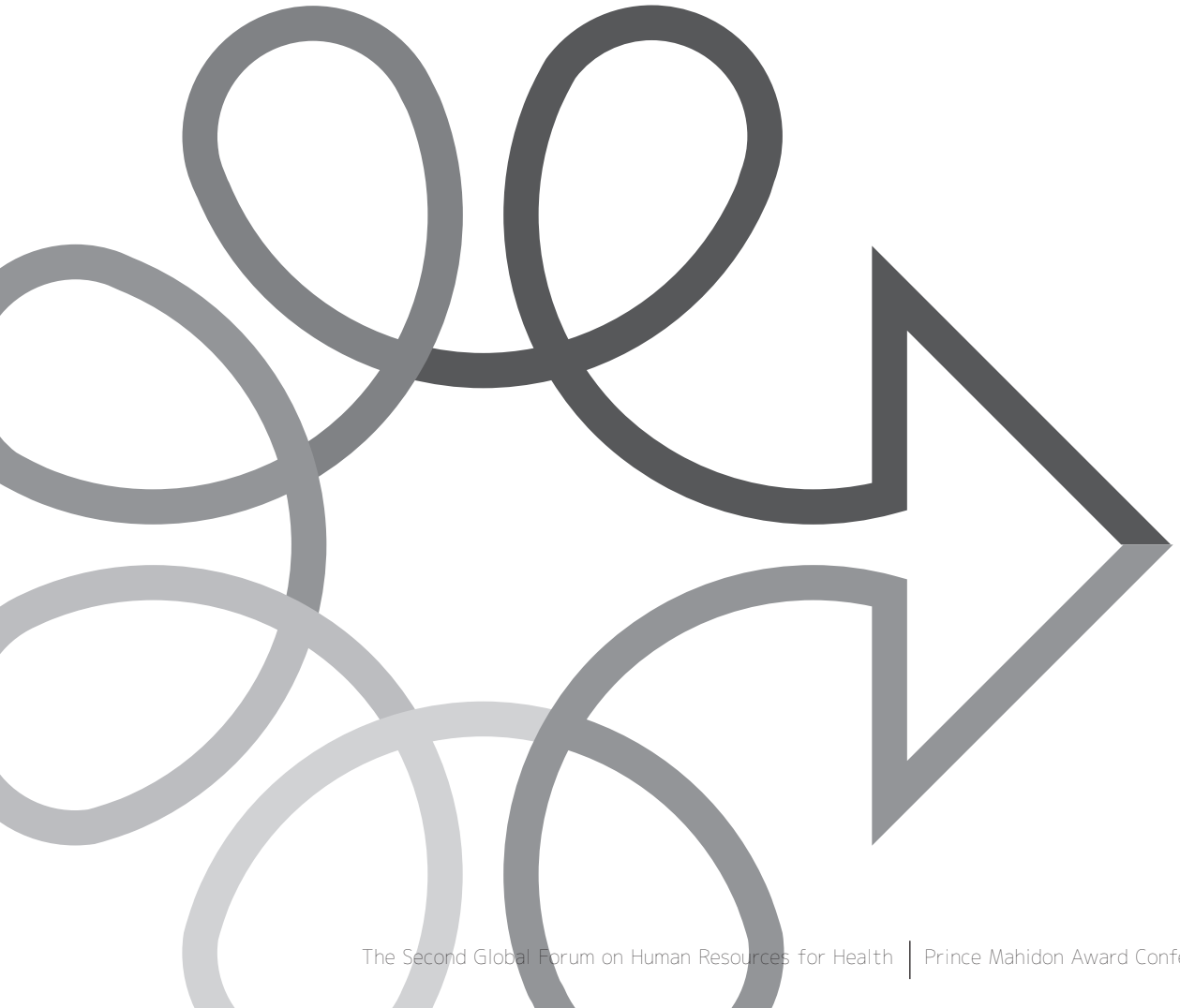
A Master of Public Health degree from the James P. Grant School of Public Health, BRAC University, Dhaka, Bangladesh (February 2005 to February 2006).

Previous Work Experience:
She worked with the East African Community, an inter-governmental organization comprised of the five partner states; Uganda, Kenya, Tanzania, Rwanda and Burundi under the Regional East African Community Health Policy Initiative; a Knowledge Transfer Platform linking Health Researchers and Health Policymakers for evidence-based policy (June 2007 to June 2008).

She was appointed as Medical Officer and later, Senior Medical Officer with the International Medical Group from August 1999 till December 2004. International Medical Group is a private healthcare management organization comprised of International Hospital Kampala, International Air Ambulance clinic and International Medical Centre.

PARALLEL SESSION 16 :

Innovative education and training for HRH



Interprofessional education (IPE) as a technical approach to scale-up of education for health workers in rural areas

HIDEOMI WATANABE

1. Background in KD/AGA: need for IP collaboration and IPE

From view points of reviewing MDGs and KD/AGA

AGA 3.2 states that immediate priority is given to expansion of education and training to increase community and mid-level health workers, alongside highly-skilled staff [1]. Access to quality HIV services benefits from a task shifting approach employing community health workers (CHWs). However, barriers to the implementation of a task-shifting approach have been found to be resistant from higher level cadres [2]. Effective utilization of available health workers is developed through interprofessional collaboration. To communicate effectively between CHWs and higher cadres, the attitudes toward interprofessional collaboration are required to be fostered in pre-service education, especially for highly-skilled staff.

From view points of health-professionals' education

Recently the Commission on Education of Health Professionals for the 21st Century, which was launched in early 2010, has published an article calling for a global social movement in order to promote a new century of transformative professional education [3]. In the problem statements, gaps and inequities in health within and between countries have become evident, and new infections, environmental, behavioral risks threaten health security. The problems pointed out are mismatch of competencies to patient and population needs, poor teamwork, persistent gender stratification, narrow technical focus without broader contextual understanding, episodic encounters, predominant hospital orientation, imbalance in the professional labor market, and weak leadership. To overcome the problems a series of instructional and institutional reforms, which should be guided by two outcomes of transformative learning and interdependence in education respectively, are proposed. One of five recommendations to improve performance of instructional reforms is to promote inter-professional and trans-professional education that breaks down professional silos while enhancing collaborative and non-hierarchical relationships in effective teams [3].

2. IPE initiatives in the world, Japan

Deterioration in the quality of health professionals is a big concern and HRH crisis predicting shortages, resulting in community health care being scarcely maintainable, is looming in rural areas. To overcome this serious problem, the Japan Interprofessional Working and Education Network (JIPWEN) has been established by ten (now 11) universities in 2008. Among JIPWEN universities the programs vary in content, as do their individual backgrounds, goals, methods, modules, student

compositions, facilitation systems, and timing of their respective university curricula. JIPWEN aims at presenting plural models so that institutions who are interested in the IPE programs can adapt the models to their academic and social settings [4]. All universities perform assessments of their IPE activities using their original evaluation systems. For example, four factors play an essential role in the development of IPE training programmes; "Role and responsibility", "Teamwork and collaboration", "Structure and function of training facilities", and "Professional identity" [5].

Worldwide initiatives

WHO has recently published a report describing framework for action on IPE and interprofessional collaborative practice [6]. The report recognized that present and future health workforces are tasked with providing health-services in the face of increasingly complex health issues, and stated that opportunities to gain interprofessional experience help them learn the skills needed to become part of the collaborative practice-ready health workforce. In the framework, 5 factors of educator mechanisms (staff training, champions, institutional support, managerial commitment, learning outcomes) and 8 factors of curricular mechanisms (logistics &scheduling, programme content, compulsory attendance, shared objectives, adult learning principles, learning methods, contextual learning, assessment), which develop and deliver IPE, are identified [6]. Further information will be provided in a side meeting entitled 'Human Resource development in community health' organized by JICA and JIPWEN.

There are several national or international networks for IPE in the world [6]. An international interprofessional conference, All Together Better Health VI, will be convened at Kobe, Japan in 2012 [HP in preparation].

3. IPE making students be interested in community health

Recently Western Canadian Interprofessional Health Collaborative (WCIHC) has published an article addressing evidence for an outcome of IPE [7]. The authors concluded that implementing IPE enhances the attraction of graduates to rural areas or less popular healthcare specialties [7]. The rural experience in the community-based IPE project improved interest in rural health care in undergraduate students. In JIPWEN universities similar effects were found. The case study performed by the students in Gunma University will be presented. Another case in the Sapporo Medical University will be presented in a side meeting entitled 'Human Resource development in community health' organized by JICA and JIPWEN on 25 January 2011.

4. Importance of IPE in higher-cadres education

For the successful delivery of IPE programmes, emphasis is placed on avoiding stereotypes, enhancing communication and learning about the scope of practice of the different professions [8]. Since higher-functioning teams are expected to have lower Physician Centrality scores [9], it has been implied that doctor authority may be detrimental to collaborative practice [10]. In some reports, furthermore, the goals of the IPE initiatives seem to go beyond communication and role understanding, and suggest changing the culture of health professional interaction, referred to as "flattening hierarchies" [11]. However, it has been suggested that if collaboration depends on reducing doctor authority, it is unrealistic to expect that all doctors will readily be engaged in this process [10]. It is thus conceivable that the purpose of IPE may be changing the culture of health professionals in which a professional respect authority guaranteed by accreditation and recognize the real roles of other professionals in the clinical settings, but not referred to as "flattening hierarchies" [6].

It might be unrealistic that IPE programs are delivered to students including pre-qualified CHWs' learners at present. However, even among higher cadres only conceptual models of teamwork and collaboration can articulate the desired nature of interaction between professionals with different degrees of responsibility and authority. These collaborative-ready health workers educated with pre-qualified IPE will actively attend post-qualified IPE programs with CHWs and may build the robust communication network with all health workers in each community.

5. A proposal of how to incorporate IPE into mandatory curricula

It is difficult for IPE to be incorporated into mandatory curricula when the academic staff hesitate and do not initiate the planning for IPE programs which the individual institutes can adapt to their academic and social settings, even if government and/or academic leaders do recognize the importance of the IPE program. WHO and the World Federation for Medical Education (WFME) issued guidelines for accreditation of basic medical education institutions and programmes in reply on the need for quality improvement in medical education [12]. In the guideline, the criteria must be the WFME global standards for quality improvement in basic medical education [13]. Since the quality improvement of education of other health professionals is essential for addressing workforce shortages from task-shifting point of view, a self-assessment instrument adapted from a generic self-assessment instrument based on the WFME Global Standards is introduced into education of health professions other than medical doctor [13], [14]. The clear description of "IPE" in the Global Standards is one of the way for IPE to be incorporated as mandatory

curricula, because capacity of implement interprofessional collaborative practice is fundamental competency required for effective health-care delivery.

6. Advocacy

IPE is fundamental in fostering interprofessional collaborative practice, the best communication skill in the improvement of community health system. Although the outcome is expected in the future, the action must be done with mandatory and effective tools immediately.

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MANUEL M. DAYRIT

DIRECTOR
HUMAN RESOURCES FOR HEALTH
WORLD HEALTH ORGANIZATION
SWITZERLAND

Manuel M. Dayrit was Secretary of Health (Minister) of the Philippines from 2001 to 2005. Under his guidance, national coverage of social insurance doubled from 30 to 60%, lower priced generic medicines became more widely available through the government supply chain, the national TB control program achieved its global targets, and SARS was contained to 14 cases during the SARS epidemic of 2003. He led 2 national immunization campaigns to stop the spread of the vaccine-derived polio virus, immunizing 12 million children in each round. During his term, the Department of Health was highly regarded by the public and the media for its measures to fight corruption. Dr. Dayrit gained wide recognition for his transparency and leadership as evidenced by high approval ratings in public opinion surveys and citations from private sector and non-governmental stakeholders. This is a legacy which his successors have successfully continued.

Dr. Dayrit began his public health career 33 years ago. Working with his wife Elvira as community physicians in the villages of Davao del Norte, Mindanao during the martial law period, he trained community health workers, organized community-based TB programs and coordinated a Church-affiliated program across the different dioceses of the Catholic Church in Mindanao in Southern Philippines. During this time, he also taught medical students at the Davao Medical School. Established in 1977, the school sought to educate doctors for the Mindanao region. In 1980, Dr. Dayrit became a founding member of the Asian Community Health Action Network (ACHAN) which sought to promote community-based health action in Asia.

Dr. Dayrit joined the Department of Health in 1984 as a research epidemiologist. He was the founding director of the Philippine Field Epidemiology Training Program in 1986 and directed it till 1997. For his work in AIDS, cholera, and red tide, he was named Outstanding Young Scientist by the National Academy of Science and Technology of the Philippines in 1990.

Dr. Dayrit's private sector experience includes working as Vice-President for Health Services of Aetna HMO in Manila, a subsidiary of the multinational insurance firm. He also worked for a Filipino-owned pharmaceutical company United Laboratories Inc. setting up the Office of Regulatory Affairs and a subsidiary company HMO to service its employees.

A Bachelor of Arts honors graduate of the Ateneo de Manila University, Dr. Dayrit earned his Doctor of Medicine degree from the University of

the Philippines in 1976. In 1981-82, he was awarded a British Council Scholarship to the London School of Hygiene and Tropical Medicine (LSHTM) where he completed a Master of Science in Community Health with a mark of distinction. In 2006, in recognition of his service in public health to millions of his countrymen, Dr. Dayrit was made an Honorary Fellow of LSHTM.

Dr. Dayrit joined the World Health Organization in August 2005 and has since been involved in working closely with partners on global health workforce issues. He is Director of the Department of Human Resources for Health in WHO/HQ which has tackled global HRH issues including: a code on international recruitment for health personnel, retention guidelines, and scaling up of education for health workers particularly in countries with critical shortages of health workers.

BARBARA MCPAKE

DIRECTOR
INSTITUTE FOR INTERNATIONAL HEALTH DEVELOPMENT
UNITED KINGDOM

Barbara McPake (BA Economics, University of York, 1983; PhD Health Economics, University of Wales, 1993) is a health economist specialising in health policy and health systems research. She has 24 years experience in these areas based in three UK university departments: Centre for Development Studies, University of Wales (1986-90); London School of Hygiene and Tropical Medicine (1991-2005) where she was Head of the Health Policy Unit (2001-3) and the Institute for International Health and Development, Queen Margaret University (2005 to present). She is currently the Director of the Institute for International Development where she has been establishing post-graduate training in health systems and human resources for health. She helped to establish a Masters programme in Health Management in the College of Medicine, Malawi (from 2006) and is currently working to establish post graduate training programmes in Human Resources for Health Management in collaboration with the Health Services Academy, Islamabad, Pakistan (to get underway January 2011) and with Gadjah Mada University in Indonesia (also planned for 2011). She has substantial teaching experience in health economics, health systems and human resources for health in these three university departments and as a visiting speaker and teacher internationally.

She has undertaken a substantial portfolio of research work in the areas of health policy, health systems and human resources for health. This has included work on financing policy (user fees and the Bamako Initiative); using contracts and 'pay for performance' to improve the provision of health services (in Zimbabwe, Cameroon and Uganda); understanding the implications of reforms increasing the management autonomy of hospitals (in Zambia, Uganda and Colombia) and looking at the informal economies in which health workers are engaged (in Uganda). She has supervised or is currently supervising 26 PhD candidates in related areas. While at LSHTM, she was a senior member of the UK Department for International Development (DFID) funded Health Economics and Financing Programme (1991-2005) and was the Programme Director of the Health Systems Development Knowledge Programme (2001-6), focused on extending the reach of health systems to the poorest and undertaking significant research in human resources for health and maternal health systems. From 2011 she will be one of two Research Directors of 'REBUILD' a new DFID funded Research Programme Consortium on health systems development. REBUILD will focus on the lessons to be learned from the re-establishment of health systems in post-conflict settings and will work with partners

in Zimbabwe, Uganda, Sierra Leone and Cambodia and affiliates in a larger number of countries. Its main areas of focus concern Health Financing and Human Resources for Health.

She has published widely in the major journals of health systems, human resources and international health and development, and is the author of one of the leading text books of health economics for international post-graduate students of which a third edition has been commissioned. She is Chair of the Tropical Disease Research Programme's thematic reference group on Social Science and Gender and a member of the Countdown working group on Health Policy and Systems and has served on several expert committees of WHO the World Bank and UNICEF.

VINICIUS DE ARAUJO OLIVEIRA

COORDINATOR
OPEN UNIVERSITY OF THE NATIONAL HEALTH SYSTEM
BRAZIL

Vinicius de Araujo Oliveira is a Medical Doctor graduated by the Federal University of Minas Gerais, Brazil in 2003, with Master in Publich Health Degree by the same institution in 2007. As a student had experience with webdesign, e-learning, amateur teather, medical education and national health policy - as a member of National Medical Students Association (DENEM). After graduation worked as GP em Belo Horizonte and as family medicine undergraduated preceptor.

From 2005 to 2007 worked as junior consultant in human resources for health for the Ministry of Health (MoH), and since 2008 as national project coordinator responsible for the Open University of the National Health System.

K. SRINATH REDDY

PRESIDENT
PUBLIC HEALTH FOUNDATION OF INDIA
INDIA

Prof. K. Srinath Reddy is presently President, Public Health Foundation of India (PHFI) and formerly headed the Department of Cardiology at All India Institute of Medical Sciences (AIIMS). He has recently been appointed as the First Bernard Lown Visiting Professor of Cardiovascular Health at the Harvard School of Public Health and is also an Adjunct Professor of the Rollins School of Public Health, Emory University. PHFI is engaged in capacity building in Public Health in India through education, training, research, policy development, health communication and advocacy.

Having trained in cardiology and epidemiology, Prof. Reddy has been involved in several major international and national research studies including the INTERSALT global study of blood pressure and electrolytes, INTERHEART global study on risk factors of myocardial infarction, national collaborative studies on epidemiology of coronary heart disease and community control of rheumatic heart disease. Widely regarded as a leader of preventive cardiology at national and international levels, Prof. Reddy has been a researcher, teacher, policy enabler, advocate and activist who has worked to promote cardiovascular health, tobacco control, chronic disease prevention and healthy living across the lifespan. He edited the National Medical Journal of India for 10 years and is on editorial board of several international and national journals. He has more than 250 scientific publications in international and Indian peer reviewed-journals.

He has served on many WHO expert panels and chairs the Foundations Advisory Board of the World Heart Federation. He is a member of World Economic Forum's Global Health Board. He also chairs the Core Advisory Group on Health and Human Rights for the National Human Rights Commission of India. He is a member of the National Science and Engineering Research Board of Government of India. He is presently chairing the High Level Expert Group on Universal Health Coverage, set up by the Planning Commission of India. He also serves as the President, of the National Board of Examinations which deals with post-graduate medical education in India.

His contributions to public health have been recognized through several awards and honours. They include: WHO Director General's Award for Outstanding Global Leadership in Tobacco Control (World Health Assembly, 2003), Padma Bhushan (Presidential Honour, India, 2005), Queen Elizabeth Medal (Royal Society for Health Promotion, UK, 2005), Luther Terry Medal for Leadership in Tobacco Control (American Cancer Society, 2009), Membership of the US National Academies (Institute of Medicine, 2005), Fellowship of the London School of Hygiene and Tropical Medicine (2009), Fellowship of the Faculty of Public Health, UK (2009), Cutter Lecture (Harvard, 2006), Koplan Lecture (CDC, 2008), Gopalan Oration (2009), Ramalingaswami Oration (2010) and Paul Dudley White Lecture (AHA, 2010)

BERHANU FEYISA
DIRECTOR
FEDERAL MINISTRY OF HEALTH
ETHIOPIA

I'm from the rural farmer family and after my high school completion I have attended a two years diploma level Biology study (1988/89-1989/90) in Bahir Dar Pedagogical College. After a five years teaching career I joined Addis Ababa University, AAU (1995/96-1998/99) for a BA in Educational Administration. After three years of principal ship assignment at high school I moved to a bureaucratic position, team leader in Planning and Program in one of the Conflict Resolution Office. During the period 2004/05-2005/06 I again joined AAU for MA study in Educational Planning and Management, EdPM. Before joining the health sector at the position of head, Pharmaceutical Supply and Logistic Department, PSLD I was a senior expert in District Level Decentralization Program of the Capacity Building Bureau. I worked for two years at a position of PSLD in the responsibility of managing procurement, storage, distribution, fleet management of pharmaceuti-calproducts, medical equipments and other products for the national consumption. I'm currently assigned and working at a position of Director of Human Resource Development for the last two years. I participated in several national and international workshops, best practice sharing conferences and different training and courses. The Harvard School of Public Health training on Strengthening Human Resource for Health, August 2010 and The University of Western Cape Summer School course on Health Workforce Development, 2010 were among the few training and courses attended, respectively.

I have over 15 years of experience working in the public sector with close contacts and collaboration with international and local development counterparts. In the public sector I had served in various positions as highlighted above. Currently, I'm the director of Human Resource Development in FMOH responsible to make strategic interventions on the challenges of the overall country wide HRH related issues. In this enormous endeavor I shoulder the responsibilities to lead and deliver work on the far reaching health reform the way HRH is to be managed at the federal level as well as to give technical assistance for the proper implementation of the new HRH strategy at the regional and operational levels. The new HRH strategy requires detailed operational planning in different angles and I am learning many international and regional best practices in the perspective of strengthening HRH. I have made my evaluation on how I might, and through me the FMOH, benefit from 2nd Global Forum on Human Resources for Health in Bangkok, Thailand in January 2011.

From my educational background as well as experience I have the advantage to be the member of the Health Education Council, a high level management and decision making body responsible for identifying as well as prioritizing the HRH need (middle and high level) of the country. This helped me to play my role to bridge the usual competitive attitude elsewhere between the two Ministries, Health and Education. My current position, Directorship of HRD gave me the privilege of participating in different national and international meetings, trainings, workshops etc as well working with different multilateral and bilateral organizations especially in HRH Planning, Management and Development.

I have also a track record of working as a course module writer for one of the University College, St. Mary. On another subject I'm the member of the Addis Ababa City Council and responsible for the issuance of Legislation. This is an additional responsibility I do care as a citizen and an opportunity for me to materialize the Five Years Growth and Transformation Plan of the Country where health sector plan is core among this.

I believe that my brief educational background and work experience in Human Resource for Health would be informative to the purpose intended.

HIDEOMI WATANABE
DEAN
GUNMA UNIVERSITY
JAPAN

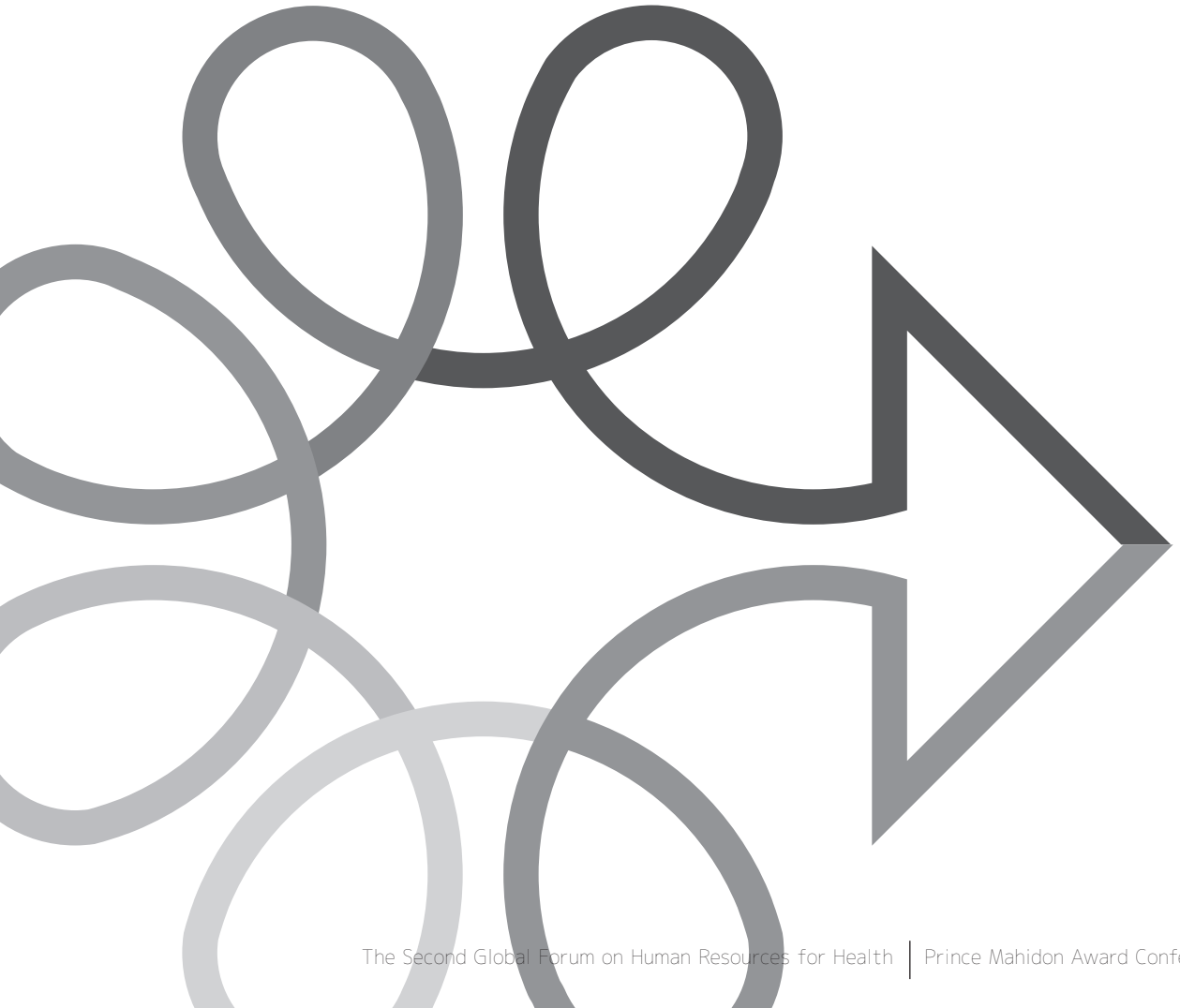
Dr. Hideomi Watanabe is Professor of the Department of Physical Therapy, Gunma University School of Health Sciences. He obtained his M.D. degree (1979) and his PhD (1988) from Gunma University in cellular oncology. He was a Postdoctoral Fellow at Michigan Cancer Foundation, presently Karmanos Cancer Institute, in Detroit and engaged in the basic research in cancer metastasis. In 1990 he joined the Department of Orthopaedic Surgery, Gunma University Faculty of Medicine. He has purified a metastasis-related motility factor, determined its molecular structure, and contributed significantly to apply the molecular information for patients with cancer in clinical settings. While he performed his basic research, he was also engaged in the medical practice for patients with musculoskeletal tumors as an orthopedic surgeon. He introduced positron emission tomography (PET) with radioactive fluorine-deoxyglucose as a diagnostic tool, and elucidated the significance and limitations of the modality. New surgical procedure was also devised. The performance of these researches and challenges has been published in English journals (69 basic and 64 clinical articles) as well as Japanese journals (19 basic and 85 clinical journals). He was a risk-manager in a ward, and promoted team-based medicine in order to prevent the medical accidents or incidents.

In 2005 Hideomi Watanabe joined the School of Health Sciences. He has been served as Dean of the school since 2009, and engaged mainly in educational development. Gunma University has systemically implemented unique interprofessional education (IPE) program since 1999. Several Japanese universities have recently developed and implemented extensive unique IPE programs. The initiatives of these universities have been approved as Good Practices by the Japanese Government. The Japan Interprofessional Working and Education Network (JIPWEN) was established in 2008 comprising these ten universities, presently 11 universities. Hideomi Watanabe is the coordinator of JIPWEN. JIPWEN aims to discuss critical IPE issues together and to present broadly applicable plural models so that institutions interested in the IPE programs can adapt those models to their own academic and social settings. JIPWEN is a member of the Global Health Workforce Alliance (GHWA) [http://www.who.int/workforcealliance/members_partners/member_list/jipwen/en/index.html]. JIPWEN issued an English book entitled "Advanced initiatives in interprofessional education in Japan: Japan interprofessional Working and Education Network", edited by the JIPWEN coordinator. JIPWEN intended to describe, in detail, the diverse IPE programs and provide plural models for the increasing number of institutions aiming to develop their own IPE programs.

JIPWEN does not aim at creating a permanent association for IPE. Instead, the Japan Association for Interprofessional Education (JAIPE) provides an annual meeting to discuss openly about IPE with the association members in the fields of various health and welfare professions. JIPWEN member universities provide board members of JAIPE. JAIPE has close communication with international academic network of IPE, InterEd. Hideomi Watanabe is the chairman of the International Committee of JAIPE, and promotes the global communication.

PARALLEL SESSION 17 :

HRH situation and trend in developed countries and their potential implications to developing countries



ELIZABETH ADAMS

INTERNATIONAL COUNCIL OF NURSES
SWITZERLAND

Elizabeth Adams is currently a Consultant, Nursing and Health Policy with the International Council of Nurses. In addition, she is an Adjunct Associate Professor with Curtin University of Technology, Western Australia.

Prior to this she served as Deputy Nursing Services Director for the Health Service Executive in Ireland. In this national role, she actively drove the strategic direction and policy development of nursing and midwifery. Her areas of expertise included positive practice environments, workforce planning, strategy and policy development. This role included leading and implementing nurse and midwife prescribing nationally.

Over the 26 years of her nursing career (17 years in clinical practice/ management and 9 years in policy positions driving the strategic direction of nursing and midwifery in regard to professional practice, education and workforce issues) she has worked for both the Department of Health in Ireland and Western Australia. In her time at the Department in Ireland she researched the first national study of nursing and midwifery resource. While in the Department in Western Australia she helped to manage significant health reform and was instrumental in establishing the nurse practitioner role in Western Australia. In addition she has held various national positions and has had the opportunity to work with a number of national, European and international organisations.

LINDA H. AIKEN

PROFESSOR OF NURSING AND SOCIOLOGY
UNIVERSITY OF PENNSYLVANIA
UNITED STATES

Linda H. Aiken, PhD, RN conducts research on health care workforce and outcomes of health care in the United States and around the world. She directs the Center for Health Outcomes and Policy Research, and is The Claire M. Fagin Leadership Professor of Nursing and Sociology at University of Pennsylvania. She co-chairs the U.S. Council on Physician and Nurse Supply that monitors trends in physician and nurse workforce and international health workforce migration to the U.S. She has won numerous awards including the AcademyHealth Distinguished Investigator and Article of the Year awards, the Baxter International Graham Prize in Health Services Research, and the Individual Codman Award from the Joint Commission for her leadership utilizing performance measures to demonstrate relationships between nursing care and patient outcomes. She was recently inducted into the Inaugural Sigma Theta Tau International Nurse Researcher Hall of Fame and received the Inaugural HRH Princess Muna Al-Hussein Award for significant contributions to healthcare across borders. Dr. Aiken is a former president of the American Academy of Nursing and an elected member of the Institute of Medicine of the National Academy of Sciences, the American Academy of Arts and Sciences, and the American Academy of Political and Social Sciences. She directs the Multi-State Nursing Care and Patient Safety Study in the U.S. and RN4CAST in 12 countries in Europe, China, South Africa, Botswana, and United Arab Emirates. Dr. Aiken has consistently been included in Modern Health Care's 100 Most Powerful People in Health Care in the U.S.

JAMES BUCHAN
PROFESSOR
QUEEN MARGARET UNIVERSITY
UNITED KINGDOM

Professor Buchan has more than twenty years experience of policy advice, consultancy and research on human resource for health (HRH) issues, specializing in supporting the development of national HRH policies and strategies; skill mix; pay and reward strategies and incentives; workforce planning; and health worker migration .

His other current appointments include Adjunct Professor at the WHO Collaborating Centre at the University of Technology; Policy Associate at the WHO Observatory on Health Systems and Policies, Europe; and Professional Adviser to the Centre for Workforce Intelligence, NHS England.

Prof Buchan has directed health workforce policy and consultancy projects for a broad range of clients internationally including the World Health Organisation, the World Bank, International Council of Nurses, the Commonwealth Secretariat and OECD. Recent projects have focused on health worker incentives, skill mix, national HRH strategies, and migration of health workers. In addition to work in the UK, he has recently worked in Australia, Brazil, Cambodia, Lao PDR, Portugal, the Solomon Islands, and Vanuatu.

His background includes periods working as a senior HR manager at national level in the National Health Service (NHS) in the UK, and as a HRH specialist at the World Health Organisation (WHO).

BJØRN-INGE LARSEN

DIRECTOR-GENERAL OF HEALTH
CHIEF MEDICAL OFFICER OF NORWAY
NORWAY

Dr. Bjørn-Inge Larsen is a graduate of the University of Oslo Medical School and University of California, Berkeley. He did his residency training in internal medicine, surgery and primary care in Harstad, before serving as a Lieutenant and physician in the Airborne Special Forces of the Norwegian Army. He then worked as a physician in the Department for Preventive Medicine in the Norwegian Board of Health. This was followed by a period as Deputy County Medical Officer in Buskerud. In 1994, he became Chief County Medical Officer of Finnmark, the northernmost county of Norway. After a period of three years, he moved south and became Chief County Medical Officer of Vestfold. Here, he served another four years, which was followed by a short period as Deputy Director-General of the Norwegian Board of Health. In 2001 he was appointed Director-General of the Norwegian Directorate of Health and Chief Medical Officer of Norway. Dr. Larsen is currently Chair of the National Advisory Board on Quality and Priorities in the Health Sector, Chair of the Norwegian Council on Health Preparedness, Chair of the Norwegian Pandemic Flu Committee, Chair of the National Campaign for Patient Safety, and member of the Norwegian Health Library Board and the Norwegian Preparedness Board.

Dr. Larsen has been engaged in and committed to global and regional health issues over the last decade. He has been a Norwegian Delegate to the World Health Assembly and the Regional Committee for Europe since 2002. He became a member of the Standing Committee for the Regional Committee in 2006, becoming Vice-Chair in 2007 and Chair from 2008 to 2009. In 2010 he became a member of the Executive Board of the World Health Organization. As a consequence, Dr. Larsen has extensive experience of global and regional health governance institutions.

Dr. Larsen is interested in a broad range of global health issues. He has paid particular attention to the health workforce crisis. Here, he has initiated projects in Norway, paying attention to developed countries' responsibilities towards developing countries, and in WHO and WHO EURO, where he played a significant role in the adoption of the WHO global code on international recruitment of health personnel at the 63rd World Health Assembly in 2010. Dr. Larsen has also been active in promoting the importance of tackling non-communicable diseases, particularly in regards to reducing the marketing of unhealthy foods and beverages to children. He is also concerned with health system strengthening, and the potential negative effects of the current financial

crisis on health systems and health outcomes. One constant in Dr. Larsen's engagement in global health, and one which he intends to carry into his future work in the Executive Board, is his concerns for equity - between and within countries. He is particularly mindful of the needs of developing countries, and the urgency that is required in order to improve health outcomes in these countries.

MARK PEARSON

HEAD OF THE HEALTH DIVISION
ORGANISATION FOR ECONOMIC
CO-OPERATION AND DEVELOPMENT (OECD)
FRANCE

Mark Pearson is Head of the Health Division at the Organisation for Economic Co-operation and Development (OECD) where he helps countries to improve their health systems by providing internationally comparable data, state-of-the-art analysis and appropriate policy recommendations on a wide range of health policies. Major current work of the Division is on the economics of preventing obesity; comparisons of the prices of health care goods and services; assessing long-term care policies; trends in health spending; expanding health coverage; co-ordination of care; pay-for-performance; use of evidence in health care; the migration of the health-care workforce; health care quality indicators; measuring health care outcomes, outputs and inputs; and health and ICTs. Key publications resulting from the work he has managed include OECD Health at a Glance and Achieving Better Value for Money in Health Care. Latest publications include The Economics of Prevention: Fit not Fat; and Value for Money in Health Spending. Mark gave evidence to the US Senate on health reform during their recent deliberations. Prior to this, he headed up work on social policy at the OECD for many years, giving policy advice to governments on how best to integrate income transfers with social and employment services. Mark has written a number of books for the OECD, including Growing Unequal?; Making Work Pay; the Caring World; a series of studies of social assistance policies (The Battle against Exclusion), and of family policies (Babies and Bosses). He initiated the renewal of the OECD social indicators programme (Society at a Glance) and designed frameworks for international monitoring of benefit policies (Benefits and Wages) and pensions (Pensions at a Glance). He initiated a cross-cutting initiative on gender statistics and gender policies across the OECD. He has written a number of other books on tax policies, environmental policies and education and work, and journal articles on all the above topics as well as disability policies, the relationship between inequality and growth, projections of health and social expenditures and the interactions between tax and benefit systems. Before moving to Paris, he was employed by the Institute for Fiscal Studies in London, and he has been a consultant for the World Bank, the IMF and the European Commission.

CHRIS RAKUOM
CHIEF NURSING OFFICER
MINISTRY OF MEDICAL SERVICE
KENYA

Chris Rakuom is the Chief Nursing Officer of the Ministry of Medical Service Kenya. He joined nursing in 1980 and has worked in many parts of Kenya as nurse manager until he joined Ministry of Health Headquaters in 1996 as staffing officer. As staffing officer he got challenged by lack of data on human resource in the health sector. In 1997 he sought establishment of an electronic data base. This started in 2002 and has now been rolled to other countries in the SSA region.

He has also been involved in establishing Social Health Insirence in Kenya from 2003 to 2005 during which he was trained on SHI at the ILO training centre in Turin Italy. He has published Case study on Nursing Workforce in Kenya with ICN and his other publication on Nursing Database is worked on by Commonwealth Health Secretariat in London. Mr Rakuom is a registered nurse, registered midwife and intensive care nurse.

BETH SLATYER

HEALTH ADVISER
AUSTRALIAN AGENCY FOR INTERNATIONAL DEVELOPMENT (AusAID)
AUSTRALIA

Beth Slatyer is a Health Adviser in the Australian Agency for International Development (AusAID).

Beth has had a long career in health policy and administration in Australia and internationally, focussing on improving health care systems and addressing the fundamentals which ensure affordable, accessible and safe health care. She has been closely engaged in reforms to primary care, health financing and the health workforce within the Australian health care system and a range of countries in the Asia Pacific region. Since joining AusAID in 2006 she has been involved in scaling up Australia's program of health development assistance and supporting dialogue on health system strengthening and aid effectiveness in Asia and the Pacific, working closely with other international health agencies.

AusAID's health program focuses on strengthening health systems in order to improve service delivery for the poor in the Pacific and Asia and support countries to reach the Millennium Development Goals. The Australian aid program is currently undergoing a significant expansion in funding and geographic coverage, with an increasing focus on sector reform and a closer relationship with multilateral partners.

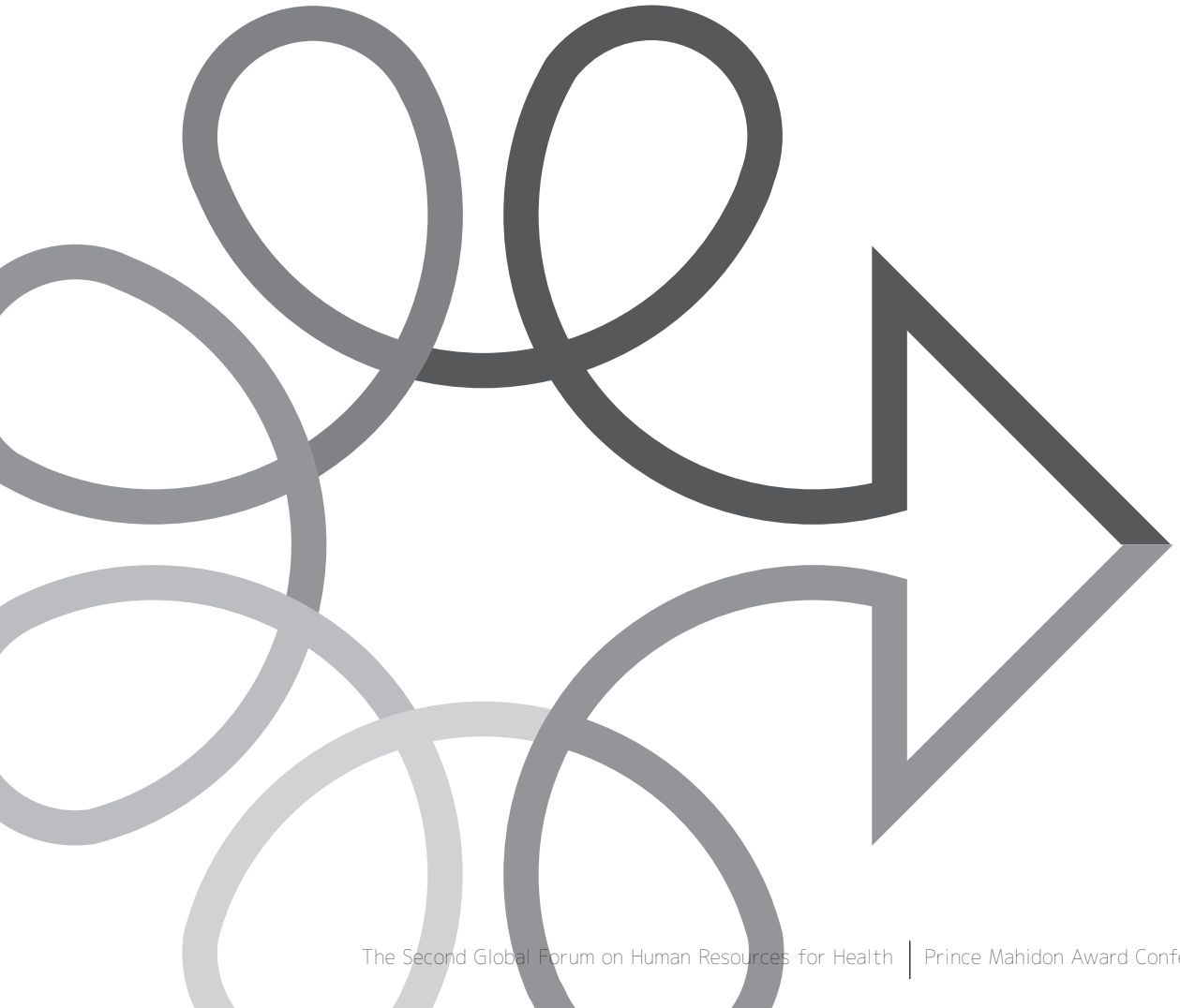
Beth's role includes advising on the use tools and strategies to better identify and develop solutions to the workforce challenges of small island states and countries with complex geographic and health system challenges such as PNG. She works closely with Pacific Island countries, WHO and the World Bank on a range of workforce studies and initiatives, was involved in the establishment of the Pacific Human Resources for Health Alliance and is also a member of an expert group advising the AusAID funded Human Resources for Health Knowledge Hub based at the University of New South Wales.

Prior to joining AusAID, a major focus of Beth's work was to improve the distribution of the workforce and to address attraction, retention and recruitment issues for the rural health workforce. She was involved in developing and implementing a number of long term reforms including the establishment of rural clinical schools and scholarships programs, rural workforce recruitment and locum arrangements, a national registration and accreditation scheme for health professions and new funding arrangements for primary care services. This work included representing the Australian Government on a range of key health workforce planning and training bodies such as the Australian Health

Workforce Officials Committee (now the national Health Workforce Principal Committee of the Australian Health Ministers' Advisory Council), the Australian Medical Council and the Medical Training and Review Panel, as well as a range of rural workforce advisory groups.

PARALLEL SESSION 18 :

Trade in health services and impact on HRH



CRISTIAN C. BAEZA
DIRECTOR
HEALTH NUTRITION AND POPULATION
WORLD BANK
UNITED STATES

Dr. Cristian C. Baeza is the Director for Health, Nutrition and Population at the World Bank. Dr. Baeza's work has focused on Health Systems Financing and Insurance, on Health Systems Reform and their contribution to health care access, household income protection, poverty alleviation, and country competitiveness and macroeconomic performance.

Immediately prior to this appointment, Dr. Baeza was a Partner in McKinsey and Company leading the Global Health Systems Financing group (Health Systems Policy, Financing, and Health Insurance) with particular focus on the design and implementation of national health financing systems, insurance financing arrangements, and the management of their fiscal, labor and macroeconomic implications.

Prior to McKinsey, Dr. Baeza was the Lead Health Policy Specialist in the Latin America region of the World Bank and led the formulation of the new World Bank 2007 Strategy for Health, Nutrition and Population Results.

Before joining the Bank, Dr. Baeza was CEO of the Chilean National Health Fund (FONASA), Senior Health Systems and Health Insurance Specialist for Social Security Policy and Development at the International Labor Organization (ILO) in Geneva, Switzerland, and co-editor of the World Health Report 2000 on Health Systems Performance at WHO headquarters in Geneva.

Dr. Baeza has written and lectured extensively on health care financing and health systems globally and has been a senior contributing member to a number of multilateral initiatives on health systems and health financing including co-leading the technical team for World Health Report 2000, participating in the World Commission on Macroeconomics and Health (WG 2), the Global Forum for Health Sector Reform, and the World Economic Forum Agenda Council.

Dr. Baeza is a Medical Doctor from the University of Chile and holds a Master of Health Policy and Financing from Johns Hopkins University, completed a Master in Neurosciences Program from the University of Chile, and a Master level program in Development and Social Policy from ILADES.

NIGEL CRISP

MEMBER
HOUSE OF LORDS
UNITED KINGDOM

Lord Crisp KCB, of Eaglescliffe in the County of Durham Nigel Crisp is an independent crossbench member of the House of Lords and works mainly on international development and global health. From 2000 to 2006, he was both Chief Executive of the NHS, the largest health organisation in the world, and Permanent Secretary of the UK Department of Health and led major reforms in the English health system.

His new book Turning the world upside down - the search for global health in the 21st Century takes further the ideas about mutual learning between rich and poor countries that he developed in his 2007 report for the Prime Minister - Global Health Partnerships: the UK contribution to health in developing countries - and shows how this will shape healthcare in the future.

He has a particular interest in human resources and global partner ships. In 2007 he co-chaired an international Task Force on increasing the education and training of health workers globally with Commissioner Bience Gawanas of the African Union. Its report, Scaling up, Saving Lives, sets out practical ways to increase the training of health workers in developing countries.

He subsequently co-founded the Zambia UK Health Workforce Alliance in 2009 in order to implement some of the Task Force proposals and assist the Zambian Government to increase the numbers of health workers trained in the country. He is a Commissioner on the Independent Commission on Professional Education, a member of the Health Worker Migratory Advisory Council and a Champion Advocate for the Global Health Workforce Alliance.

Nigel Crisp chairs Sightsavers International, is a Senior Fellow at the Institute for Healthcare Improvement, a Distinguished Visiting Fellow at the Harvard School of Public Health and an Honorary Professor at the London School of Hygiene and Tropical Medicine. He is also an Adviser to HLM Architects, on the Advisory Boards of Doctors.Net.UK and the African Centre for Global Health and Social Transformation, a Trustee of RAND Europe and an Honorary Fellow of St John's College, Cambridge, the Royal College of Physicians and the Royal College of Pathologists.

A Cambridge philosophy graduate, he worked in community development and industry before joining the NHS in 1986. He has worked in mental health as well as acute services and was from 1993 to 1997 the Chief Executive of the Oxford Radcliffe Hospital NHS Trust, one of the UK's leading academic medical centres.
For further information see nigelcrisp.com

JOHN HANCOCK

COUNSELLOR
WORLD TRADE ORGANIZATION
SWITZERLAND

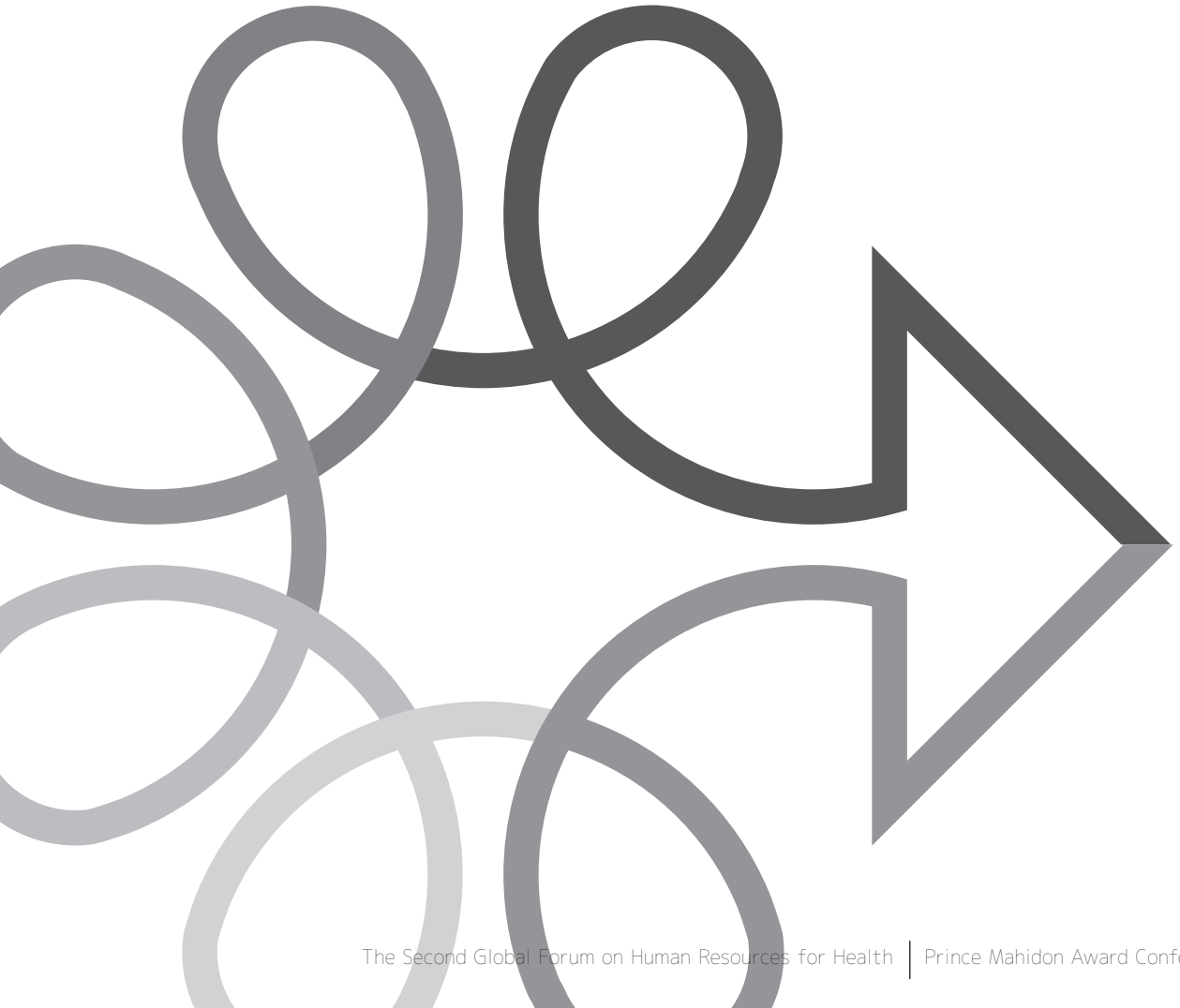
Dr. John Hancock is a counsellor at the World Trade Organization in Geneva, Switzerland, where he has served as policy advisor to the Director-General, representative to the IMF and World Bank, and head of investment issues. He also coordinated the WTO's Aid-for-Trade initiative, and was secretary of the 2006 Task Force on the subject. Prior to the WTO, Dr. Hancock was senior advisor to Canada's trade minister and an advisor to the Prime Minister. He has also been a lecturer at Cambridge University and HEI in Geneva. Dr. Hancock holds a PhD in modern history from Cambridge, and has written and spoken frequently on international issues.

RANGARIRAI MACHEMEDZE
DEPUTY DIRECTOR
SEATINI/EQUINET
ZIMBABWE

Rangarirai Machemedze is the Deputy Director of the Southern and Eastern African Trade, Information and Negotiations Institute (SEATINI) based in Zimbabwe. SEATINI is an African initiative that specializes in helping to build African capacity to better negotiate trade deals at the bilateral, regional as well as multilateral trade negotiating fora. Rangarirai has overall responsibility for SEATINI's full range of programme activities in Zimbabwe including coordinating the Trade and Health Programme in EQUINET (Regional Network on Equity in Health in East and Southern Africa). His research interests are on the World Trade Organisation Agreements on Agriculture (AoA) and Trade Related Aspects of Intellectual Property Rights (TRIPs) and their impact on development. He is also interested in regional trade agreements (RTAs) especially Economic Partnership Agreements (EPAs) with the European Union and their impact on regional integration and sustainable development. He monitors developments on the agreements and prepares papers and lectures on their impact on national economies of developing countries and advocate for sustainable people-centred alternatives. Rangarirai has authored and co-authored papers, policy briefs and articles on the impact of trade on health and health related services. Rangarirai holds an MA in Globalisation and Governance from the University of Hull (UK). He graduated in Mass Communications and also holds a diploma in Public Relations. He has attended numerous training courses including the Equator School post graduate course in Advanced Development Economics and Policy Making, a brainchild of SEATINI and The Other Canon, a Norwegian based institute.

PARALLEL SESSION 19 :

Self reliance to health and well being through local resources and knowledge



Policy Guidelines for self regulation of traditional health practitioners

G. Hariramamurthi, India

Background

Recent estimates of populations seeking healthcare through traditional medicine is as high as 80% (World Health Organization (WHO), 2002). Despite the Alma Ata Declaration (WHO, 1978) recommending integration and utilization of traditional medical practitioners including birth attendants in national health systems, there has not been much progress in action in most countries that have significant presence of traditional health practitioners. The People's Charter for Health, the most widely endorsed consensus document on health since the Alma Ata Declaration "calls on people of the world to support, recognize and promote traditional and holistic healing systems and practitioners and their integration into Primary Health Care."

The World Congress on Traditional Medicine in China (2008) recommended, "Governments should establish systems for the qualification, accreditation or licensing of traditional medicine practitioners. Traditional medicine practitioners should upgrade their knowledge and skills based on national requirements".

The United Nations Environment Program's Conceptual Framework on Poverty and Ecosystem has included the ability to use indigenous medicine as one of the 10 resources of well-being. Similarly, according to the Article 34 of the resolution of the United Nations Committee on Economic, Social and Cultural Rights (2000), states' obligations to respect the right to the highest attainable standard of health include "obligation to refrain from prohibiting or impeding traditional preventive care, healing practices and medicines." Also, the Article 24 of the UN Declaration on the Rights of Indigenous Peoples (2007)[1] stresses on the right to use traditional medicines.

In the light of the above, it is pertinent for the national Government to evolve and implement policy guidelines for self-regulation of traditional health practitioners while maintaining their autonomy which would enable them to enjoy continued social legitimacy and community support.

This paper discusses a few issues including the urgent need for evolving and implementing Policy Guidelines for Self Regulation of Traditional Health Practitioners in the light of increasing potential and scope offered by them especially in effective delivery of public health services in India.

Need for self regulation of traditional health practitioners

In the Indian context, traditional medicine consists of two streams: the codified and non codified. The codified stream is practiced by the institutionally trained practitioners of Ayurveda, Siddha, Unani and Gso-wa Rig-pa whereas the non-codified oral stream is practiced by non-institutionally trained practitioners both at the household and village levels. The rich traditional health practices of non-codified stream are ethnic community and eco-system specific. They use more than 6200 flowering medicinal plant species for management of a range of simple to complex health conditions. The non-codified health traditions have co-existed as a part of the pluralistic and rich health culture of India, along with the institutionalized and codified Indian systems of medicine mentioned above as well as Allopathic and Homeopathic systems of medicine.

WHO considers that traditional medicine is the only available source of healthcare for 65% of the population in India (WHO 2002: 13). Another conservative estimate (Peters and Muraleedharan, 2008) indicates the presence of 1.25 million local health practitioners in 1995. This means that there are nearly two non-institutionally trained traditional health practitioners for every single institutionally trained practitioner practicing any of the above mentioned codified Indian Systems of Medicine.

Local health traditions make use of ecosystem specific plants, animals, metals and minerals which are easily available and accessible. The non-institutionally trained practitioners provide health services mostly on a part time basis and are not livelihood dependent on their practice. They do not require a registration to practice, as long as they provide their services to those who come to seek them in their premises (mostly home) without any canvassing for clientele or giving publicity. Hence, they do not need to be registered similar to the institutionally qualified physicians of Ayurveda, Unani and Siddha who acquire their knowledge and skills from an institution that trains them both in theory and practice of the respective system of Indian medicine, irrespective of the fact whether s/he has any prior knowledge or expertise on the subject.

The rich cultural diversity of the local health traditions range from simple household health practices including home remedies for primary health care, ethnic recipes of seasonal foods, customary rituals to specialized health practices of traditional orthopedic practitioners, traditional birth attendants, healers who treat poisonous bites and mental disorders, spiritual practitioners, traditional ophthalmologists, healers who manage paediatric conditions, skin diseases, gastrointestinal or respiratory conditions, jaundice, veterinary conditions, etc.

Even for prevention and management of communicable diseases namely malaria and HIV/ AIDS, local health traditions have a contemporary relevance. For example, malaria decoction camps which were organized in selected malaria endemic villages of the states of Karnataka, Andhra Pradesh and Orissa for prevention of malaria with local health practices documented and assessed from local health practitioners have resulted in significant reduction of yearly incidence of malaria amongst the beneficiary populations in the study villages (Unnikrishnan and Prakash 2008)[2].

According to a draft for discussion on the findings of a national survey (Ritu Priya and Shweta A.S., 2010 - to be published) on the status and role of AYUSH and local health traditions under the National Rural Health Mission launched by Government of India, by the National Health Systems Resource Centre, Ministry of Health and Family Welfare, Government of India, confirms widespread household use of local health traditions. The household use varied from 50-75% (in states with higher average state per capita incomes and with better developed general health services in the public and private sectors) to 80-100% (in states with low average state per capita incomes).

Despite the continued services being provided by local health practitioners based on community support, they were being equated with quacks by the mainstream practitioners of both Indian and Allopathic codified systems of medicine. Especially, the traditional health practitioners have had no institutional mechanisms or facilities until very recently to document and validate them in order to support and promote their use on a wider scale. The distinction of local and codified practitioners is marked by the institutionalization process of Indian Systems of Medicine. After the Act of Central Council of Indian Medicine (1970) was implemented by the Government of India, the institutionally trained and qualified practitioners began questioning the legitimacy of non-institutionally trained practitioners

In India, high out of pocket health expenditure is one of the important causes for rural indebtedness. Self reliance in primary health care through community based approaches merits greater consideration in comparison to the present institutionalized approach to public health delivery. Especially in the absence of health insurance coverage for the vast majority of its population, amongst whom significant percentage live below poverty line, Indian health policy makers need to make the best use of such strengths as that of a million strong community supported health service providers. India is fortunate to have had the comparative advantage in terms of presence of both codified and non-codified streams of heath culture, which have co-existed with allopathy and homeopathy. It is pragmatic to nurture, strengthen

and maintain this pluralistic health culture rather than regret having contributed to its loss. On the one hand, Indian health policy makers and implementers have to ensure equitable access to primary health care, and on the other, they also have to address the concerns of quality, safety and efficiency of traditional health practices.

Recent Policy Statements recognize Local Health Practices and Practitioners

The National Policy on Indian Systems of Medicine of the Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (2002), the National Rural Health Mission Statement (2005), 11th Five Year Plan documents on health (2007) and the draft National Health Bill of Government of India (2009)[3] recognize local health practices and practitioners.

As per the recommendations made at the International Healers Conference in Bangalore, India in November 2009, a National Task Force was set up by the Department of AYUSH, Government of India to develop policy guidelines to officially and legally recognize the role and definition of traditional health practitioners. Further to this, a pilot scheme for certification of prior learning of Grama Vaidyas (village based traditional health practitioners) is being implemented by the Indira Gandhi National Open University in collaboration with Quality Council of India and Institute of Ayurveda and Integrative Medicine. This process would enable Gram Vaidyas to get recognized for their role and responsibility based on a self-regulatory process of certification or accreditation of prior learning of Grama Vaidyas.

Certification of Prior Learning or Knowledge of Grama Vaidyas as a means of self-regulation

This voluntary process of self regulation may bestow upon the traditional health practitioners a social and policy recognition which they lacked for so long. It will also distinguish them from the quacks with whom they have been often equated with by the mainstream codified practitioners of Indian and Allopathic systems of medicine. The operational framework of the voluntary certification process involves following steps:

a) Consultation with multi-stakeholders
b) Identification of a district in the pilot states
c) Rapid survey for identification of traditional health practitioners as well as their areas of expertise
d) A set of minimum standards of competency to be evolved in consultation with the competent and experienced healers
e) Grama Vaidya who seeks accreditation to be invited for an oral interview cum practical demonstration in front of a district accreditation committee'

The presence of expert traditional health practitioners from both non codified and codified streams in the district accreditation committee makes it easier to address the issues of safety and efficacy of traditional health practices used by the local healers, since they have an advantage to apply the principles of Ayurveda, Siddha or Unani to understand both the disease and the treatment with the locally available natural resources. In addition, the presence of experts of both institutional traditions of Indian Systems of Medicine and Allopathy in the district accreditation committee, thus strengthening intersystem relationship which is crucial in a health system approach. It needs to be understood that revitalization of traditional health practices is feasible only with the involvement of all the stakeholders of health sector to develop and implement policy guidelines on important matters such as status, role and involvement of traditional health practitioners in public health delivery. Hence, the scheme of self regulation through certification of prior learning of traditional health practitioners involves all the key stakeholders including both the community and practitioners of both institutionalized and non institutionalized streams of medicine including allopathy.

Successful certification of prior learning of Grama Vaidyas as a self-regulation process is expected to result in many benefits which are listed as follows:

1. Better quality service to the patients serviced by the Gram Vaidyas
2. Improved public health policies outreaching primary health care to every citizen in their village itself.
3. Enhanced public awareness of the services of Gram Vaidyas in their own village
4. Professional self-respect
5. Voluntary accreditation allows every Gram Vaidya to rise to a minimum standard of competence and be an authentic health care service provider to their community in their respective village / area of practice.

Expected Outcomes/ Benefits of Certification of Prior Learning and Knowledge of Gram Vaidya:

- Helps India to know the strengths, weaknesses and opportunities of traditional health practices and practitioners through a community based and a voluntary process of self-regulation
- Provides society with reliable information on quality of traditional health practices and practitioners available in their respective villages.

1 See http://www.un.org/esa/socdev/unpfii/en/drip.html - Article 24 - Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.

2 Global incidence of malaria is around 300 million per year leading to mortality as high as 1.124 million and around 40% affected population have no access to effective modern drugs. Many parts of India continue to be high incidence regions of fatal malaria.
3 See http://www.mohfw.nic.in/nrhm/Draft_Health_Bill/General/Draft_National_Bill.pdf

Empowering Health Professionals with Non-institutional and Traditional Knowledge

This speech will present the necessity and feasibility of empowering health professionals with non-institutional and traditional health knowledge across different cultures. Non-institutional healing and medicine still serve for the health needs of majority of the population on earth today. This knowledge transmitted from generation to generation in various forms of apprenticeships carry profound cultural roots and psycho-social meanings. As we face the crises of the modern medicine in the new century, it is imperative that we seek holistic approaches for healing and medicine that can best integrate the non-institutional knowledge into the health care system of the new century.

Ongoing support and training of traditional healers - case studies from africa - Dr. Yahaya Sekagya, Uganda (OBJ 2.3)

By Dr. Y. Sekagya[1], Umar Ndiwalana[2], Benard Kato[3]

PROMETRA- Uganda (NGO) was founded in 2000 to respond to the poor health conditions and inadequate modern health services by utilizing traditional medicine because of its comparative advantages of accessibility, affordability and availability. It promotes traditional medical knowledge and practices through mutual cooperation amongst health systems and is affiliated to PROMETRA International, which is based in Senegal, and has 26 National Chapters worldwide.

PROMETRA Uganda activities-

1. MOBILIZING AND ORGANIZING TRADITIONAL HEALERS (THs)

PROMETRA Uganda mobilizes and organizes traditional healers into groups and associations, and enrolling then in training programs.

a) 2334 traditional healers from 16 sub-counties in 3 districts of Mpigi, Gomba, and Butambala in central Uganda have been mobilized, sensitized and organized.
b) In 2003 PROMETRA Uganda initiated the formation an umbrella association of all traditional healers' associations in Uganda, "The Uganda National Integrated Forum for Traditional Health Practitioners". It is recognized by the Ministries of Health and culture

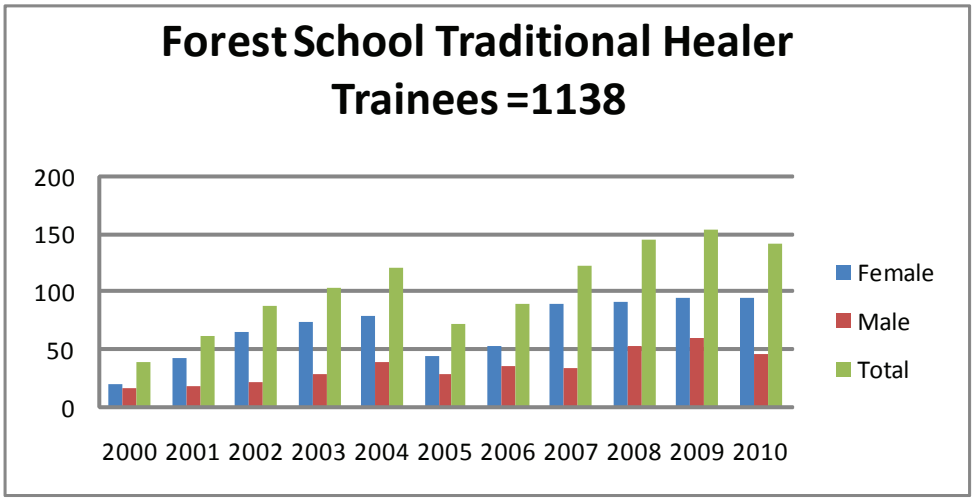
2. TRAINING AND CAPACITY BUILDING

The Forest School is endowed with a diversity of medicinal plants and facilitates learning, sharing and prevention of the loss of traditional healing knowledge, development of models for accreditation, self-regulation, environmental and biodiversity conservation. The training targets traditional healers, university students, researchers, homecare volunteers, policy makers and biomedical workers.

a) 1100 traditional healers enrolled for training at the Forest School for Traditional healers.
b) Trained traditional healers form groups that link to district and national associations. These trained groups train other THs, offer treatment, and cultivate their medicinal plants

Training of Traditional Healers is structured in three class categories (I, II, and III). Method of training is Healers' Self- Proficiency (FAPEG) which allows informal self-motivated exchange of knowledge and learning. It mixes older and experienced traditional healers with younger novices, encouraging knowledge transfer to younger generations.

a) **Class I-** Studies 320 medicinal plants; identification, harvesting, conservation and uses
b) **Class II-** Studies human anatomy, 40 diseases, herbal medicine preparation, palliative care, record keeping, referral, hygiene nutrition, nursery and herbal garden development and conservation of natural resources. AIDS is emphasized.
c) **Class III-** Comprises of specialized categories of Herbalists, Traditional Bonesetters, Traditional Birth Attendants, Traditional Mental Specialists and Spiritualists.



3.

Certified Traditional Healers who completed three-years training at the Forest School by May 2010	
Categories	Number
Herbalists,	327
Traditional Bonesetters	87
Traditional Birth Attendants,	124
Traditional Mental Specialists	90
Spiritualists	183
Total	811

4. **Training of Non-Traditional Healers**
a) These includes students of pharmacology, botany, forestry, community development, environmental science, cultural and medical anthropology and public health, mainly from Makerere, Uganda Martyrs and Mbarara Universities
b) NGOs like Concern Worldwide, Hospice Africa-Uganda, Mildmay International, THETA-Uganda, Cross Cultural Foundation and African Palliative Care

c) Health workers from Mulago National Referral Hospital, district hospitals like Gombe and Nkozi and other health centers within the district
d) PROMETRA Uganda offers an internship through IE3 Global Internships in the USA.

5. Treatment and Care at Community Clinic Using Traditional Medicine

a) Access to healthcare is a human right regardless of the ability to pay. PROMETRA Uganda initiated a community health care clinic at Buyijja Forest School, which offers free material and non-material health services to the surrounding rural communities.
b) Trained traditional healers work hand in hand with a Western trained doctor and have developed a mutually respectful collaborative disease management system.
c) Traditional healers train in documentation/record keeping, and identification of complications necessitating immediate referral.
d) The community clinic is a basis for future observational studies and clinical trials on traditional medicine.

6. RESEARCH AND INFORMATION MANAGEMENT

a) Value addition in plant medicines. (Cultivation, processing, product development and marketing). Validation for safety and efficacy has been done by the International Centre for Insect Physiology and Ecology (ICIPE) and the Kenya Medical Research Institute (KEMRI).
   i) 56 samples have been tested for toxicity and none are toxic.
   ii) 31 samples have been verified for safety and efficacy
b) Traditional healers' social demography and their basic health and cultural knowledge. Traditional healer databases of 1172 healers in Kampala and 2,334 healers in Mpigi Districts have been compiled
c) Development of new approaches to AIDS treatment in Sub-Saharan Africa with the Integrative Medicine Foundation (IMF)
d) Documentation on:
   i) Cultural and heritage practices of Mawokota county in Buganda Kingdom
   ii) Positive aspects of culture in HIV/AIDS management with the Cross Cultural Foundation Uganda (CCFU)
   iii) Memory books as records for descendants of HIV/AIDS patients

CONTACT DETAILS Dr. Sekagya Yahaya (DIRECTOR
Postal address: P.O. Box 16465 Kampala, Tel. +256-772-403900,
Email: ysekagya@gmail.com Website : www.prome tra.org

1 PROMETRA Uganda (NGO)
2 Dr. Sekagya Institution of Traditional Medicine
3 Buyijja Traditional Healers' group

Empowering Health Professionals with Non-institutional and Traditional Knowledge

Steve An Xue

This speech will present the necessity and feasibility of empowering health professionals with non-institutional and traditional health knowledge across different cultures. Non-institutional healing and medicine still serve for the health needs of majority of the population on earth today. This knowledge transmitted from generation to generation in various forms of apprenticeships carry profound cultural roots and psycho-social meanings. As we face the crises of the modern medicine in the new century, it is imperative that we seek holistic approaches for healing and medicine that can best integrate the non-institutional knowledge into the health care system of the new century.

VICHAI CHOKEVIVAT

DIRECTOR
INSTITUTE FOR THE DEVELOPMENT OF HUMAN RESEARCH PROTECTION (IHRP)
THAILAND

Dr. Vichai Chokevivat is a general practitioner, a public health specialist, administrator, and policy advocator. He began his career as a director and a practitioner in two rural district hospitals in Thailand from 1973 to 1984. Later he was the Provincial Chief Medical Officer, Director of Epidemiology Division, Deputy Director General of Department of Communicable Disease Control, In spector General of Ministry of Public Health, Secretary General of Food and Drug Administration, Director General of the Department for the Developments of Thai Traditional and Alternative Medicine, and Expert in Health Promotion which is a highest rank of government official (PC 11) respectively. He retired from the Ministry of Public Health in 2007, but still active in health field. He is now the Second Deputy Chairman of Thai Health Promotion Foundation, a Councilor in the National Health Council, a member in the National Health Security Board, and the President of the Government Pharmaceutical Organization. He is also a member of both National Reform Committee and the National Reform Assembly Committee.

His interests are very broad, from health to social moment. He has been extensively involved in the restoration of Thai Traditional Medicine. He has been involving in human research protections both nationally and internationally for more than two decades. He actively involved in the formation of the Forum for Ethical Review Committees in Asia and Western Pacific (FERCAP) which he was elected as chairman for ten years. He also actively involved in the formation of the Strategic Initiative for Developing Capacity in Ethical Review (SIDCER) which he was also elected as chairman until now. He established and become the director of the Institute for the Development of Human Research Protections. He published more than 400 articles mostly in Thai national newspapers magazine and journals. He published more than 10 books and booklets.

GOVINDASWAMY HARIRAMAMURTHI

ASSISTANT DIRECTOR
CENTRE FOR LOCAL HEALTH TRADITION-INSTITUTE OF AYURVEDA AND INTEGRATIVE MEDICINE (IAIM)
INDIA

G. Hariramamurthi heads the Centre for Local Health Traditions, Institute of Ayurveda and Integrative Medicine, FRLHT, Bangalore in his capacity as Assistant Director.

He leads a team of young professionals of Ayurveda, Social Sciences and Outreach who are involved in documenting, assessing and promoting local health traditions across more than 55 locations in 10 states of India with a particular focus on primary health care and public health concerns like malaria, anaemia and diarrhoea.

He and his team are also actively engaged since 1995 and have coordinated the establishment of around 200,000 home herbal gardens for primary health care across 9,200 villages in ten states of India. Home Herbal Garden package consists of 15 to 20 medicinal plant seedlings which are used for preparation of home remedies to manage about 10 top priorities of primary health conditions of both human beings and livestock.

He and his team has also been involved in assisting the traditional health practitioners to organise themselves into grassroots healers associations as well as a number of programs for capacity building of traditional healers through a network of 307 grassroots Block, Taluka and District level associations of traditional health practitioners affiliated to registered state level apex federations that are spread across seven states of India.

He and his team is presently engaged in coordinating the pilot implementation of a scheme for certification of prior learning of traditional health practitioners by Indira Gandhi National Open University in eight states of India, in collaboration with Quality Council of India and Institute of Ayurveda and Integrative Medicine.

He and his team have been associated with establishment of 15 community owned enterprises, including one which manufactures herbal products for veterinary care.

Hariramamurthi is also presently the Chairperson of the Community Knowledge Service Asia, a network of community based organisations which promotes the cause of people to people learning in the areas of natural resource management, traditional agriculture, traditional health and livelihood programs.

He has participated in a number of national, regional and international seminars and conferences and spoken on the themes of revitalisation of local health traditions.

He is also author of a number of papers presented in a number of national, regional and international seminars and conferences and authored articles in a number of national and international publications on the theme of revitalisation of local health traditions.

He is a graduate in French from the Jawaharlal Nehru University, New Delhi and has served for a decade and a half in a public sector corporate enterprise in various capacities such as French Translator, Deputy Manager, Market Planning, Manager, Co-ordination. He has also undergone a short Management Development Programmes both in HMT as well as in the Institute of Rural Management, Anand.

QI ZHANG

COORDINATOR, TRADITIONAL MEDICINE
WORLD HEALTH ORGANIZATION
SWITZERLAND

A native of the People's Republic of China, Dr Qi Zhang graduated from the Southeast University School of Medicine in Nanjing, China and practiced medicine for three years before obtaining his Master's degree in Integrated Traditional Chinese Medicine with Western Medicine from the China Academy of Chinese Medical Sciences.

In his capacity as Project Officer at the State Administration of Traditional Chinese Medicine (SATCM) of China, Dr Zhang organized the development of national guidelines surrounding traditional Chinese medicine, including "The Classification and Code of Diseases and Syndromes", and administered regulations and criteria for grading both traditional medicine and integrative medicine hospitals. In 1991, he was selected to join a one year fellowship program with the Western Pacific Regional Office of the World Health Organization. He also received education in public health at the University of California, Los Angeles, USA later.

Dr Zhang acted as the Director of the division integrating Western and traditional medicine in SATCM for three years and then accepted the position as the Director of the Urban Division. He was responsible for the establishment of a national monitoring centre for the quality of medical service in traditional medicine, among other initiatives and reforms to improve the integration of traditional medicine services into the national healthcare system.

In 2001, Dr Zhang became the Deputy Director-General of the Department of Healthcare Service Administration in SATCM, where he became responsible for the measurement and evaluation of traditional medicine services that enabled him to shape national policies, strategies and regulations on traditional medicine.

Appointed as the Director-General of the Department of International Cooperation at SATCM, Dr Zhang implemented national and international collaborations, in addition to building health capacity to strengthen human resources for health.

More recently, Dr Zhang was seconded to the World Health Organization where he served as a Technical Officer in the Traditional Medicine programme. Dr Zhang was appointed as the Coordinator of the Traditional Medicine programme in the Department for Health System Governance and Service Delivery at WHO on 1 October 2010.

YAHAYA SEKAGYA
DIRECTOR
PROMETRA
UGANDA

PROFILE: I, Dr. Sekagya Yahaya, have been an African traditional healer by calling since 1978, an old boy of King's College Budo and a Dental Surgeon from Makerere University 1993. I apprenticed in traditional medicine with reputable healers from many countries in Africa and have a diploma in environmental science and practical skills as well as a certificate in project planning and management. I am currently pursuing apprenticeship in Healing in African Spirituality. I am the Founding Director of Mawokota Heritage Center of Cilivisation, the founder of PROMETRA Uganda NGO and currently serving as a Regional Representative Director of PROMETRA International, an organization with 26 chapters throughout Europe, Africa, and the United States that is dedicated to the preservation and restoration of African traditional medicine and indigenous science. I am General Secretary of the National Integrative Forum for Traditional Health Practitioners in Uganda and the Founding Director of Dr. Sekagya Institution of Traditional Medicine, the PROMETRA Forest School at Buyijja with Traditional Medicine Training, Research, Production and Treatment units. I have long experience in research and practice of traditional medicine. I am married with 6 children.

Nze Dr. Sekagya Yahaya (KAGALI) Muzukulu Wamikago. Ndi mutabani ya Haji Rajabu Zimula e'Lukole-Bombo mu Bulemezi, Muzukulu wa Yunus Lukome, Muzukulu wa Kyalikisolo, Muzululu wa Kagali–e'Lukole eyawereza nga Katikiro Mubwakababaka Bwa Ssekabaka Mulondo, muzukulu wa Sekagya e yali Katikiro mu mulembe gwa Ssekabaka Nakibinge. Baja-jange bali abamu ku basawo babakaba okuviradara ku Sekabaka Chwa Kato Nabakka mutabani wa Kintu.

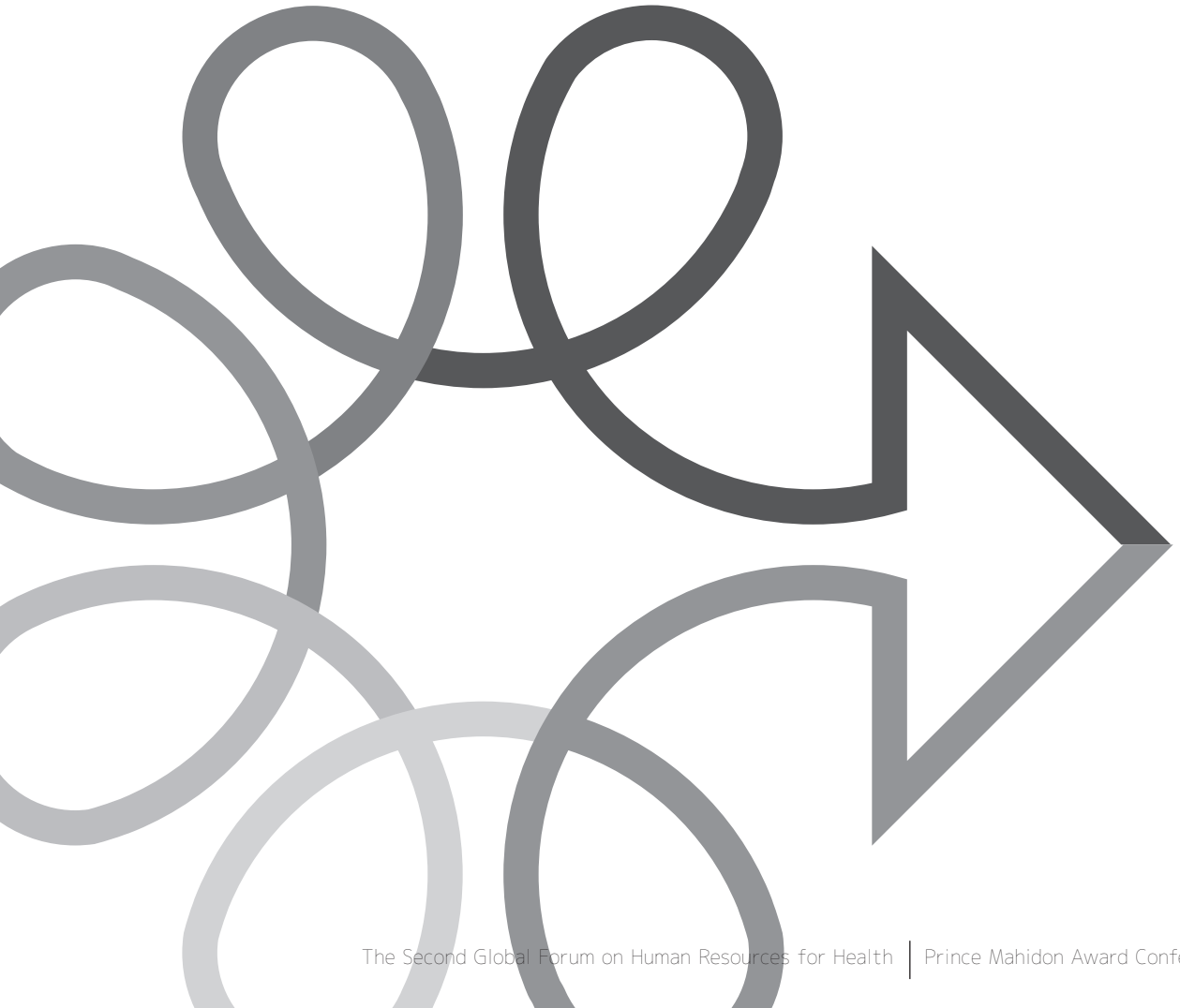
Nsibuka mu lunyiriri lwa Yunus Lukoma, Mumutuba gwa'Kagali e Lukole- Bombo mu Bulemezi. Mu Ssiga lya Kasirivu e'Namgabo, mi Kasorya ka Kyadondo e Kawempe. Neddira Nvuma akabiro Katinvuma.

STEVE AN XUE
PROFESSOR
UNIVERSITY OF HONG KONG
HONG KONG

Dr. Steve Xue has taught and directed doctoral and post-doctoral researchers at Arkansas State University, The University of Houston, Ohio University, Portland State University and the University of Hong Kong. His current lines of research include: (1) Holistic medicine and rehabilitation for new health care systems; (2) Classical Chinese and Western homeopathic treatment of communicative and psycho-social disorders; (3) Quantification and clinical diagnosis of human vocal tract dysfunctions. He is a frequent speaker and strong advocate for non-toxic and sustainable therapies around the world. His major books include: Holistic Medicine and Rehabilitation: sustainable healing systems for health professionals of the 21st century; Homeopathy: a Western natural medical system complementary to Classical Chinese Medicine; and Revised Kent Repertory and Materia Medica. He serves as the editorial reviewer for 12 international academic journals related natural medicine and human behavioral sciences. He is the vice-president for Liga Medicorum Homoeopathica Internationalis (LMHI-China).

PARALLEL SESSION 20 :

Skills mix to achieve universal access to essential health care



Role of Treatment Supporters CHWS in HIV/AIDS and TB Management

Maxensia Nakibuuka Takirambule of Lungujja Community Health Caring Organisation (LUCOHECO) P.O.BOX 7449, Kampala, Uganda.,
E:Mail.lucohecouganda@yahoo.com, Tel. +256- 712 813593

Materials and Methods

- LUCOHECO Catchment area was divided into zones, each zone allocated to Community Health Workers(CHWs)
- Lists of patients from each zone are produced and distributed among the CHWs for follow up. On clinic days TB patients are educated on: follow-up on lab investigations, importance of completing treatment, role of expert supporters (CHWs), and consent to home visiting.
- One very visit to TB patients, treatment supporters fill forms collecting treatment data, and they help the patients fill in the irtreatment cards.
- Nurses make routine community follow up visits to support the patients and treatment supporters based on the TBCHW's reports

Results

- 33 CHWs were identified and trained to follow up HIV/AIDS/TB patients
- Between 2006 - 2007, 238 patients were co-infected with HIV/TB.
- By the end of 2005, default rates averaged at 25%.
- This reduced to 19% in 2006, 11% in 2007, 10% in 2008, and 7% in 2009 among patients visited by CHWs (alsoseefigure3below) By the end on 2009 an overall 639 (57.2%) patients had HIV/AIDS & TB out of an overall 1,117 TB patients ever enrolled on TB treatment at KCCC since the launch of the project in 2004.

Introduction

Non adherence to TB treatment is receiving considerable attention among HIV/AIDS implementers. Where as the Ministry of Health developed different strategies to ensure adherence to TB treatment, including TBDOTS, and increased availability of drugs, there is lack of network systems among patients, their families, and health institutions so as to tackle other challenges that impact on adherence. Most health centers dispense drugs but do not link up with the community for follow upon TB patients. Conclusions The success of TB treatment depended on the link ages between the KCCC clinic, communities, families, and CHWs. TB treatment should look beyond the Directly Observed Therapy (DOTS) Short Course approach, to more sustainable methods, like expert treatment supporters (CHWs).

Acknowledgments
The information presented here was supported through the President's Emergency Plan for AIDS Relief, funded through the Office of the Global AIDS Coordinator and the Human Resources and Services Administration, Department of Health and Human Services, Cooperative Agreement #4U51HA02521-01-03

KCCC is also in debted to the Ministry of Health (Uganda) for the TB drugs and technical support accorded to us. Not forgetting KCCC TB treatment Team for the irtime and efforts towards the project % of defaulters Trend 2004-2009 0% 5% 10% 15% 20% 25% 30% 2004 2005 2006 2007 2008 2009 % of defaulters Trend 2004-2009

Figure 3
Explanation Notes.

Figure 4: In 2005 28% out of 134 patients enrolled managed to produce a sputum for confirmatory tests, 3 died and the rest completed but failed to produce a sputum.

Lessons Learnt
- HIV/TB related stigma & discrimination remains inhibitors to the effective fight of HIV/AIDS &TB.
- Provision of Medical care to patients and family members in not enough to help patients cope with HIV/TB, fear, stress and anxiety. Patients need counseling to cope with their psychological and emotional feelings.
- Inadequate nutritional support remains a barrier to successful TB treatment among patients in low resourced areas.
- Community sensitization on TB is vital in order to prevent further spread, fight stigma and discrimination
- TB Infection does not limit a patient from being in social gatherings such as local brewery places thus leading to further infection.
- Multilevel family involvement, at both the individual case level and the system level, ensures that family involvement is not only a support structure but determinant of sustainability

Recommendations
- There is need to assess TB holistically so as to ensure adherence to treatment
- Health worker should desist from addressing TB at institution all level i.e. hospitals, nursing schools, lecture rooms, and workshops in hotels, because not all the affected people especially the poor can access these places
- Need for the intensification of referral networks from Institutions to families, communities & vice-versa

- Intensified case finding (ICF) should be observed among coughing patients one very clinic visit.

Completed after testing smear -Ve 2004-2009020406080100120140
2004 2005 2006 2007 2008 2009 Year # of patients
Semear–VEDefalters Figure 4
Figure 1: General View of Kamwokya Slum
Figure 2: Home Visit to TB Patients
Figure 5: TB Patient before Treatment
Figure 6: TB Patient after Treatment Figure 7: TB can be transmitted by sharing "Malwa" on the same pot TB of the spinal cord

DAVID C BENTON

CHIEF EXECUTIVE OFFICER
INTERNATIONAL COUNCIL OF NURSES
SWITZERLAND

David Benton took up post as Chief Executive Officer of the International Council of Nurses (ICN) on the 1st of October 2008. Immediately prior to this he worked with ICN for three years where he held the role of consultant nursing and health policy and specialised in regulation, licensing and education.

He qualified as a general and mental health nurse at the then Highland College of Nursing and Midwifery in Inverness, Scotland. His MPhil research degree focused on the application of computer assisted learning to post-basic nurse education and has over the past thirty years had articles published in relation to research, practice, education, leadership, and policy topics.

David has held senior roles for twenty years across a range of organisation. These roles have included working as Executive Director of Nursing at a health Authority in London; as a senior civil servant in Northern and Yorkshire Region; as Chief Executive of a Nurse Regulatory body in Scotland and as Nurse Director of a University Trust Health System.

David has travelled widely looking at various aspects of different health systems and was delighted to receive a Nuffield Policy fellowship in 1999. This enabled him to look at both USA and Spain so as to understand how the professional voice might be best heard within the new constitutional arrangements in Scotland.

David is the recipient of several awards and honours. He is particularly proud of being awarded the inaugural Nursing Standard Leadership award in 1993. He was presented with Fellowship of the Florence Nightingale Foundation in 2001 and awarded Fellowship of the Royal College of Nursing in 2003 for his contribution to health and nursing policy.

ZULFIQAR A. BHUTTA
PROFESSOR
AGA KHAN UNIVERSITY
PAKISTAN

Dr Zulfiqar A. Bhutta is Husein Laljee Dewraj Professor and the Founding Chair of the Division of Women and Child Health, Aga Khan University, Karachi, Pakistan. He also holds adjunct professorships in International Health & Family and Community Medicine at the departments of International Health at the Boston University and Tufts University (Boston) respectively. He was designated a Distinguished National Professor of the Government of Pakistan in 2007. He is also the Dean of the faculty of Paediatrics of the College of Physicians & Surgeons, Pakistan and the Chairman of the National Research Ethics Committee of the Government of Pakistan.

Professor Bhutta was educated at the University of Peshawar (MBBS) and obtained his PhD from the Karolinska Institute, Sweden. He is a Fellow of the Royal College of Physicians (Edinburgh), the Royal College of Paediatrics and Child Health (London) and the Pakistan Academy of Sciences. He has been associated with the Aga Khan University since 1986 and heads a large research team working on issues of maternal, newborn and child survival and nutrition globally and regionally. Dr Bhutta has served as a member of the Global Advisory Committee for Health Research for the World Health Organization, the Board of Child & Health and Nutrition Initiative of Global Forum for Health Research, and the steering committees of the International Zinc and Vitamin A Nutrition Consultative Groups. He is an executive committee member of the International Paediatric Association and on the Board of the Global Partnership for Maternal, Newborn and Child Health (PMNCH). He is a Foundation Council member of the Global Forum for Health Research, a council member for the International Society for Infectious diseases (ISID) and serves on the governing council for the World Alliance for Patient Safety Research. Dr Bhutta is currently the Chair of the Health Sciences Group of the Biotechnology Commission of Pakistan, a member of the WHO Strategic Advisory Committee for Vaccines (SAGE), the Quantitative Vaccine Research (QUIVER) group of WHO, the Advisory Committee for Health Research of WHO EMRO, and its apex Regional Consultative Committee. He is the immediate past-President of the Commonwealth Association of Paediatric Gastroenterology and Nutrition (CAPGAN) and the Federation of Asia-Oceania Perinatal Societies (FAOPS).

Dr. Bhutta is on several international editorial advisory boards including the Lancet, BMJ, PLoS Medicine, PLoS ONE and the Cochrane ARI group. He has published four books, 55 book chapters, and over 320 indexed

publications to date. He has been a leading member of recent major Lancet series on Child Survival (2003), Newborn Survival (2005), Undernutrition (2008), Primary Care (2008) and the forthcoming series on Stillbirths (2010). He has won several awards, including the Tamgha-i-Imtiaz (Medal of Excellence) by the President of Pakistan for contributions towards education and research (2000), the President of Pakistan Gold Medal for contributions to Child Health in Pakistan (2004) and the Outstanding Paediatrician of Asia award by the Asia Pacific Pediatric Association (2006). He is also the first recipient of the Aga Khan University Distinguished Faculty Award for Research (2005). Dr Bhutta was awarded the inaugural Global Child Health award (2009) by the Program for Global Pediatric Research for outstanding contributions to Global Child Health and Research and has recently been elected an honorary Fellow of the American Academy of Pediatrics for contributions to international child health. He was the Windermere Lecturer at the Annual Meeting of the Royal College of Paediatrics and Child Health UK (2010).

Dr Bhutta's research interests include newborn and child survival, maternal and child undernutrition and micronutrient deficiencies. He leads a large research group based in Pakistan with a special interest in research synthesis, scaling up evidence based interventions in community settings and health systems research

FRANCES DAY-STIRK
VICE-PRESIDENT
INTERNATIONAL CONFEDERATION OF MIDWIVES
NETHERLANDS

In June 2008, Frances was elected Vice-President of the International Confederation of Midwives (ICM), a non governmental organisation comprising 100 midwifery associations in over 88 countries globally. A key role in the governance of the influential organisation representing midwives, she along with members of the ICM's executive, holds responsibility for the governance of the ICM, its development and viability.

Frances received her professional education in the UK and has been a midwife for over 30 years, having initially trained as a nurse. Her experience spans midwifery clinical practice, education and maternity service management. Since 1998 she has worked with the Royal College of Midwives and now, as a member of the executive management team, holds the post of RCM Director of Learning Research and Practice Development a multi-faceted role, leading the LRPD, centred on education, research and practice. In addition she leads, represents and co-ordinates the RCM international affairs nationally and internationally including:

- Director of the RCM WHO Collaborating Centre for Midwifery
- Vice-Chair of the European Forum of National Nursing & Midwifery Associations (WHO) steering committee
- Representative to the European Midwives Association

Her professional interests include, organisation of maternity services, homebirth, promoting normality, newborn care and safe motherhood. She has published widely and presented at conferences at home and abroad.

On a personal note, Frances originally from Jamaica, is a mother of three children who were all born at home.

Email: F.Day-Stirk@internationalmidwives.org

December 2010

BJARNE GARDEN

ASSISTANT DIRECTOR
NORWEGIAN AGENCY FOR DEVELOPMENT COOPERATION (NORAD)
NORWAY

Bjarne Garden is an Asst. Director in the Norwegian Agency for Development Cooperation (Norad), Oslo, Global Health and AIDS Department. The department is tasked with advising relevant embassies of Norway and the Ministry of Foreign Affairs on development issues.

Educational background: health management and administration, social sciences, social work and community development.

Has worked with development cooperation in different capacities since 1978, and served mainly in Africa – Kenya, Somalia, Sudan, Zambia, Congo Brazzaville. Assignments have covered refugee and emergency relief situations, community development, development portfolios in Norway's embassies in Nairobi and Lusaka. Participation in programme development committees and workgroups.

Has worked in public administration in Norway and as a private consultant. Thematic responsibilities in Norad cover human resources for health and health systems development, service delivery and fragile states, capacity development and aid modalities.

OTMAR KLOIBER
SECRETARY GENERAL
WORLD MEDICAL ASSOCIATION
SWITZERLAND

Dr. Otmar Kloiber is the Secretary General of the World Medical Association. He has been an international medical relations and collaboration leader for more than 20 years, with expertise in medical ethics, health policy, government affairs and management of relationships with patients, other health professionals, manufacturers and other medical stakeholders. He has been the chief executive of the WMA since 2005.

Prior to his move to the WMA, between 1997 and 2005, Otmar served as Deputy Secretary General and Secretary of the German Medical Association. During his tenure there, he was selected as a Member of the Study Commission on the Law and Ethics of Modern Medicine of the German Bundestag (Parliament), 14th electoral term.

Between 1991 and 2005, he was also a key liaison to the Standing Committee of European Doctors, the WMA, the International Conference of Medical Chambers, the European Forum of the World Health Organization and individual national medical associations. In addition, for six years, he was the foreign relations adviser to the German Medical Association, focusing on international health and social policy reforms and construction of the German Health Network.

Otmar holds an MD (1984) and PhD (1986) from University of Cologne, was a postdoctoral fellow in the Department of Biochemistry at the University of Minnesota, and was a research assistant a the Max Planck Institute for Neurological Research, engaged in pathophsyiological studies on brain energy metabolism and cerebral blood flow.

In 2006, he was awarded an honorary doctorate by the Victor Babes University for Medicine and Pharmaceutics, Timisoara, Romania. He is Clinical Professor in Health Administration at the Brooks College of Health, University of North Florida.

MAXENSIA NAKIBUUKA TAKIRAMBULE
COMMUNITY HEALTH WORKER
UGANDA

COMMUNITY HEALTH WORKER and founder of Lungujja Community health caring organization (LUCOHECO) a community based initiative and a faith based and indigenous non-governmental organization registered as a non profit entity in Uganda. Lungujja Community Health Caring Organization is affiliated to Kamwokya Christian Caring Community (KCCC) and Uganda Community Based Association for Child welfare (UCOBAC)I am an executive member on the committee organizing the formation of Home Based Care givers' Alliance in Africa. I am a member of the Domestic Violence Coalition of Uganda, a member of the Global network of grassroots organizations operating together in sisterhood Groots International and Huairou Commission based in New York of USA.

This organization was formed in 2005 by Mrs. Takirambule Maxensia after testing herself and was found HIV positive in August, 1999, and thereafter the death of her husband in December, 1999. Maxensia is now survived with four children and 4 other beneficiaries of her brothers and sisters who also died in the AIDS scourge over ten years ago. She is also the caretaker of her 80 years aged mother.

Leadership
Maxensian is the National Women Leader of the Democratic Party of Uganda, I was directly elected L.III Councillor representing Lungujja Sub Parish to Lubaga Division Council 2001-2005 and thereafter as Deputy Speaker Lubaga Division.

Other Portfolios
Church Leadership
Maxensia was the Head of Justice and Peace Lubaga Cathedral Parish and Coordinator Justice and Peace Lubaga Deanery for the past 10 years. I am the Secretary General of the Council of the Laity Kampala Archdiocese (Catholic fraternity)

I am a Commissioner Ministry of Women affairs environment and people with disabilities of the
Buganda Kingdom

As an Activist

I am the founder and Chief Executive officer of Lungujja Community Health Caring Organization (LUCOHECO) an outreach of Kamwokya Christian Caring Community.

This initiative provides awareness, primary health care, treatment, care and support to the communities in the home settings of Lubaga Division more especially to people infected with or affected by the HIV/AIDS pandemic, the orphans and vulnerable children as well as women, by providing psychosocial, spiritual and economic support to the terminally ill patients and their affected families.

I influence institutions and organizations like the Church, Cultural institutions, NGOs and others to network in order to make strong advocacy teams on HIV/AIDS and Human Rights.

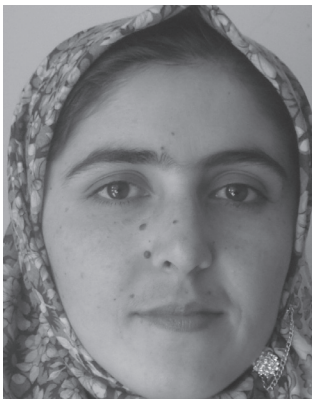
SALMAN RAWAF

PROFESSOR OF PUBLIC HEALTH
IMPERIAL COLLEGE LONDON
UNITED KINGDOM

Salman Rawaf qualified in medicine with subsequent training in paediatrics and public health. Professor Rawaf until January 2009 was the Director of Public Health in NHS Wandsworth, London: a post which he held since 1988 in South West London. He is currently Professor of Public Health and Director of WHO Centre at Imperial College London, Hon. Professor of Public Health at the Middlesex University, Hon Professor of Primary care at Ghent University Belgium, and Senior Lecturer at St George's University of London. He serves on many national and international committees and groups. He has published more than 120 scientific papers, 2 books (Assessing Health Needs RCP Publishing Group, and Health Improvement Programmes RSM Publishers) and many international reports. He is the Founder and Editor-in-Chief of the journal Public Health Medicine and a member of other editorial boards. He is well known for his international work and his contribution to global health. He is an adviser to the WHO on primary care, public health, health system and medical education. He has been invited to undertake many international assignments in many countries around the world.

Professor Rawaf is a Fellow of the Royal Colleges of Physicians London and the UK Faculty of Public Health and Member of the Faculty of Public Health Medicine Ireland. He is the Chair of the International Committee, Faculty of Public Health UK, Executive Member of the International Committee of the Academy of the Royal Medical Colleges, Council Member of Chelsea and Westminster Hospital Foundation Trust, Member of WHO Advisory Committee for Health research, and Programme Leader of the Postgraduate Diploma/MSc in Family Medicine Middlesex University. His contributions to public health and primary care in research and service delivery are well documented. Among the many innovative approaches are young people and addictive behaviour and Staying Healthy: a programme to assess risk factors for chronic diseases in community settings and enable individuals to engage in their own health. Since started his work in 1988 in South West London as a Director of Public Health, he and his team received many awards and recognitions for the works to improve health. At International level is well recognised in his work supporting countries in strengthening their health system including primary and public health. He runs well renowned training programme of health system development both in and outside the UK.

May 2009



SAIRAM SAADAT
PROGRAM COORDINATOR
COMMUNITY MIDWIFERY SCHOOL
AFGHANISTAN

Sairam Saadat belongs to Badakhshan province of Afghanistan which has the highest maternal mortality rate in the world in 2004. She attended Najeebullah Shaheed High School in Faizabad (the capital city of Badakhshan). In 2005, she decided to get into the Community Midwifery School which had been jointly established by the Aga Khan Development Work (AKDN) and Ministry of Public Health in collaboration with USAID. It was the time when parents were reluctant to educate their daughters because of the stigma attached to it. Sairam's mother (father had already passed away) decided to accept this as a challenge and encouraged her daughter to go and attend the community midwifery school. According to Sairam, "When I started going to the midwifery school, everyone gazed at me strangely with an enigmatic smile. Some people thought I would a traditional birth attendant and clean all women at the time of delivery. Some had a fear that I might interact with male doctors and nurses in the hospital and give society a bad name". Sairam was among eighteen other girls who got the honor to be the first graduated midwife of the Community Midwifery School in Badakhshan. She stood first in her class and received the best student award. After graduation in July 2006, she was deployed at the community midwifery school as a midwife trainer. In 2008, she was raised to the position of course coordinator. In 2010, she resumed the responsibility of a Program Coordinator.

Since 2008, Sairam is a member of Afghan Midwife Association (AMA) and just recently, she started leading the association in Badakhshan Province. Sairam has attended many international seminars and workshops. She attended the Regional Asia- Pacific Midwives Conference in Hyderabad India in November 2009.

She has been involved in many research studies and has carried out several needs assessment surveys in Badakhshan, Badghis and Hirat provinces on behalf of Jhpiego. She has received many excellence awards and appreciation letters from MOPH and provincial government. She also organizes and conducts trainings for all graduated midwives in Badakhshan in order to build their capacity

SHEILA DINOTSHE TLOU

DIRECTOR
UNAIDS REGIONAL SUPPORT TEAM FOR EAST AND SOUTHERN AFRICA

Dr. Sheila D. Tlou is the Director of the UNAIDS Regional Support Team for East and Southern Africa. She joined UNAIDS on the 1 of October, 2010.

Dr. Tlou is a former Member of Parliament and former Minister of Health of the Republic of Botswana (2004-2009). She is a Professor of Nursing at the University of Botswana and former Director of the WHO Collaborating Centre for Nursing and Midwifery Development in Primary Health Care for Anglophone Africa. She has been involved in the fight against HIV and AIDS right from the time the epidemic started in Botswana in 1985. She was HIV/AIDS Coordinator at the University of Botswana from 2002- 2004 and facilitated the formation of the Students Against HIV/ AIDS Society (SAHA). She is the founder of the Botswana chapter of the Society of Women and AIDS in Africa (SWAA).

Dr. Tlou holds a PhD in Nursing Sciences and post graduate Certificates in Women's health and Gender studies, from the University of Illinois at Chicago. She has published on numerous gender-related topics, including HIV/AIDS, Older Persons, Menopause, and community- based approaches to HIV and AIDS prevention. During her term as Minister of Health, Dr. Tlou contributed to the improvement of global health care, especially for women and girls. She led a successful HIV/AIDS prevention, treatment, care and support program in Botswana whose achievements are still some of the best in Africa. As Chairperson of SADC and African Union Ministers of Health in 2005, Dr. Tlou provided leadership in the adoption of the SADC Malaria Eradication Program, the SADC HIV/AIDS Plan of Action, and the adoption of the Maputo Plan of Action on Sexual and Reproductive Health and Rights. Dr Tlou also represented Eastern and Southern Africa in the Board of the Global Fund for AIDS, Tuberculosis and Malaria. She has received several national and international awards, among them the 2003 Florence Nightingale Award from the International Red Cross Society, the 2002 Botswana Presidential Order of Honour, the 2007 Woman Leading Change Award from the World YWCA, the 2004 Emang Basadi Award for Leadership in HIV/ AIDS, and the 2002 Anna Reynvaan Award from the Amsterdam Medical Centre. She is the United Nations Eminent Person for Women, Girls, and HIV/AIDS in Southern Africa.

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