global health workforce alliance

Human resources for health in Africa

EXPERIENCE, CHALLENGES AND REALITIES

MEETING REPORT

DOUALA, Cameroon 6-8 June 2007

World Health Organization

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List of acronyms and abbreviations

ADB	African Development Bank
AFD	Agence Française de Développement (French Development Agency)
AFRO	WHO Regional Office for Africa
AU	African Union
C2D	Contrat de Désendettement et de Développement (Debt reduction and Development Contract)
CAF	Fonds d'Action Culturel (Cultural action fund)
CAR	Central African Republic
CIESPAC	Central African Inter-State Centre for Higher Education in Public Health
DHRS	Directorate of Human Resources for Health
DRC	Democratic Republic of the Congo
ESTHER	Together in a hospital network of solidarity in care and treatment
EU	European Union
FHF	Fédération Hospitalière de France (French Hospital Federation)
FSP	Fonds de Solidarité Prioritaire (Priority Solidarity Fund)
GAVI	Global Alliance for Vaccines and Immunization
GHWA	Global Health Workforce Alliance
GIP SPSI	Groupement d'Intérêt Public Santé Protection Sociale Internationale (International Health Social Protection Public Interest Group)
HRH	Human Resources for Health
ILO	International Labour Organization
JLI	Joint Learning Initiative
MDG	Millennium Development Goals
MFA	Ministry of Foreign Affairs

NGO	Nongovernmental organization
NHDS	National Health Development Plan
NSIS	National Statistical Information System
PDRH	Plan de Développement des Ressources Humaines
PNDS	Plan National de Développement Sanitaire
OCEAC	Organization of Coordination for the Control of Endemic Diseases in Central Africa
ODA	Official Development Assistance
PRSP	Poverty reduction Strategy Paper
HRDP	Human Resources Development Plan
SFPR	Strategic Framework for Poverty Reduction
SWAp	Sector-Wide Approach
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	US Agency for International Development
WAEMU	West African Economic and Monetary Union
WAHO	West African Health Organization
WHO	World Health Organization

Acknowledgement

This Conference has been made possible thanks to the warm welcome and active support of the Government of Cameroon, which has agreed to host it for the benefit of all its participants.

The personal commitment of His Excellency Mr Urbain Olanguena AWONO, Minister of Public Health of Cameroon has been a major contribution to the meeting's success. The active participation, throughout the preparatory period and then during the Conference of Dr Hélène MAMBU-MA-DISU, Resident Representative of WHO in Cameroon and of her team, which was fully mobilized for the event, also calls for a special expression of thanks.

The financial and technical support of French cooperation (AFD and Ministry of Foreign Affairs) have also been important in ensuring the success of the event.

The active participation of the Ministers of Health of the Congo, of Equatorial Guinea, of the Central African Republic and of Chad testifies to their commitment of behalf of human resources for health and gives particular prominence to the meeting.

The presence of the Representatives of the WHO Regional Office for Africa, led by Dr Alimata DIARRA-NAMA, and the participation of WAHO, are a further sign of the commitment at the regional level to assist countries in the field of HRH.

Thanks to the effective participation of official representatives of the 18 countries invited, it has been possible to contribute experience and share thoughts in a working atmosphere that has been both hard-working and friendly.

The representatives of public and private nongovernmental organizations have enriched the discussions with an additional perspective.

Finally, the support team, headed by Millicent AYATA, which has welcomed participants and provided the secretariat, deserves special mention for its unfailing support.

This conference on Human Resources for Health (HRH), which was organized by the Global Health Workforce Alliance (GHWA) and supported by the French cooperation system (French Agency for Development, AFD, and the French Foreign Ministry MAE), brought together representatives of 18 French- and Spanish-speaking African countries, five of whose health ministers were present throughout the conference. It led to the adoption of the Douala Plan of Action which listed 12 priority measures for which it assigned responsibility at the national, regional and international levels for achieving results measurable on a calendar. This plan of action was the fruit of stimulating exchanges among the participants in presentations and workshops, which also constituted a forum for addressing the state of progress in international and African thinking in, and the role and contribution of regional and non-governmental organizations.

The breakdown of different aspects of the crisis are by now well known, as is the particular situation of Africa, which has to deal with the severest shortages in the world while having the highest morbidity rates. To deal with this situation, initiatives have been springing up, creating a fertile political climate for problem-solving.

GHWA has come into being out of a common desire among the main actors in international cooperation to tackle the crisis facing human health resources. It has committed itself to developing the technical and political answers to the international dimensions of the HRH crisis. It has also assigned high priority to countries both as regards their national policies and in support of multisectoral mobilization within an analytical framework that includes every dimension of HRH. To provide countries with lasting support, sub-regional organizations such as WAHO have to receive support for harmonizing training courses and recognition of diploma qualifications. Moreover, setting up the HRH Observatory at the WHO Regional Office for Africa is essential both to improve knowledge of the situation and for developing national observatories. Finally, the African Platform brings together the chief actors involved in HRH, with a view to accompanying regional and country initiatives while continuing to advocate the idea that HRH should be taken into account more effectively.

The descriptions of country situation have made it possible for a range of common characteristic to be distinguished and certain particular features to be identified. A situation analysis has now been carried out in most of the countries that are committed to the implementation of actions assigned priority, often under emergency plans while the national plans for HRH projects are being developed.

Measures assigned priority concern increases in HRH, improved education and training, and salary conditions. Strong incentives to correct imbalances in territorial distribution of posts loom high on the agenda. Certain initiatives such as management by post point the way to improved HRH management, a key to better use of existing resources.

Intervention by non-governmental groups has made it possible to illustrate approaches that meet certain aspects of the crisis. The taking up of rural positions by physicians in rural areas, the creation of regional training programmes for health workers, North-South hospital partnerships to accompany measures for capacity building and initiatives for tackling AIDS are examples of promising initiatives. The involvement of development partners as in the case of France at the national, regional and country levels, is essential if the HRH crisis is to be speeded up.

Regionally, there are several ways of setting about tackling the challenge of improving training capacities, improving quality and extending the range of training programmes. By drawing lessons from previous experience lasting responses are possible through inter-state and national agencies of regional importance.

The present report is not a simple chronological transcript of the proceedings of the Douala meeting. It is set out around themes emanating from the objectives of the meeting. It only evokes the key elements of the presentations by countries and support partners, whereas the proceedings of the discussions and the views expressed in them are lessons in themselves.

Readers seeking further information should click on the GHWA site to review the presentations in their original formats. http://www.who.int/workforcealliance/events/conference_Douala/en/index.htm

If they wish to obtain additional information on the activities and projects, readers may also contact participants from the different countries and agencies whose names are annexed hereto, as well as on the above site, which also includes their contact details.

Participants group Picture

Achievement of the health-related Millennium Development Goals (MDG) calls for mobilization of the appropriate HRH. This problem area, which has been the focus of discussion at three successive World Health Assemblies, receives close attention from African political leaders.

Following the Gaborone Declaration by health ministers of the African Union (AU) in 2005, the Lusaka consultation (4-6 April 2006) and the Brazzaville consultation (12 and 13 December 2006), the Douala Conference (6-8 June 2007), on the subject "Human Resources for Health in Africa: Experiences, Challenges and Realities" organized by the GHWA, has contributed to mobilization on behalf of HRH in order to apply solutions capable of improving the situation.

The health ministers of five countries, Cameroon, Congo, Equatorial Guinea, Central African Republic and Chad, were present throughout the Douala conference, which was also attended by delegates from 18 French-speaking countries, most of them in Central and West Africa, representatives of GHWA, WHO, the French Ministry of Foreign Affairs (MOFA), the French Development Agency (AFD), the African Development Bank (ADB), the United Nations Children's Fund (UNICEF), the WHO Regional Office for Africa (AFRO), the West African Health Organization (WAHO), representatives of health sciences training organizations and non-governmental organizations, the French Hospital Federation (FHF) and GIP ESTHER.

1.1 Objectives, expected outcomes and proceedings

1.1.1 Objectives

- To present the major HRH challenges and the answers provided by the GHWA, the African Platform and the main regional organizations;
- To exchange ideas on experience, research and trends in the HRH field in French-speaking sub-Saharan Africa;
- To take note of and initiate discussion on recommendations from the meeting of health ministers of the African Union (AU) in April 2007;
- To promote the creation at national level of human resources plans, accompanied by evaluation tools and observatories.

1.1.2 Expected outcomes

- Better knowledge of the different dimensions of the human health resources in sub-Saharan Africa;
- An exchange of information around specific examples of solutions at country level and the level of sub-regional groupings;
- A greater commitment from countries concerning the creation and/or improvement of human health resources plans.;
- Partners who are better informed about the health manpower crisis.

1.1.3 Proceedings of the conference

The meeting, which was subdivided into in nine sessions, was consolidated by plenary presentations, group activities held in three parallel sessions and re-submitted to the plenary and a round table on the subject of regional and international cooperation in human resources for health, followed by the Douala Plan of Action, presenting twelve recommendations permitting each country to speed up its progress.

[1] In collaboration with the WHO Regional Office for Africa and supported by AFD and MAE.

1.2 Opening ceremony

The opening ceremony featured five speeches : the government delegate to Douala City Council, the WHO representative to Cameroon, the French ambassador to Cameroon, the Executive Director of GHWA, and the Cameroonian Minister of Public Health, who each in turn highlighted the following topics:

- The scale of the crisis in sub-Saharan Africa which has made HRH a priority issue for all countries;
- The need to find lasting solutions with the backing of development partners, while exploiting every way of maximizing the use of HRH ;
- The importance of international cooperation and multisectoral mobilization in the search for solutions;
- The need for a better share of global resources for greater equity in accessing health care;
- The creation of a climate favourable to the development of HRH, particularly the level of training and the career prospects for health personnel;
- A concerted effort to encourage increased resources in support of HRH and reduce present losses in human capital investments (misemployment, unemployment, workforce migration, etc.) and defective geographical distribution of posts.

Opening ceremony

2.1 World Health Report 2006

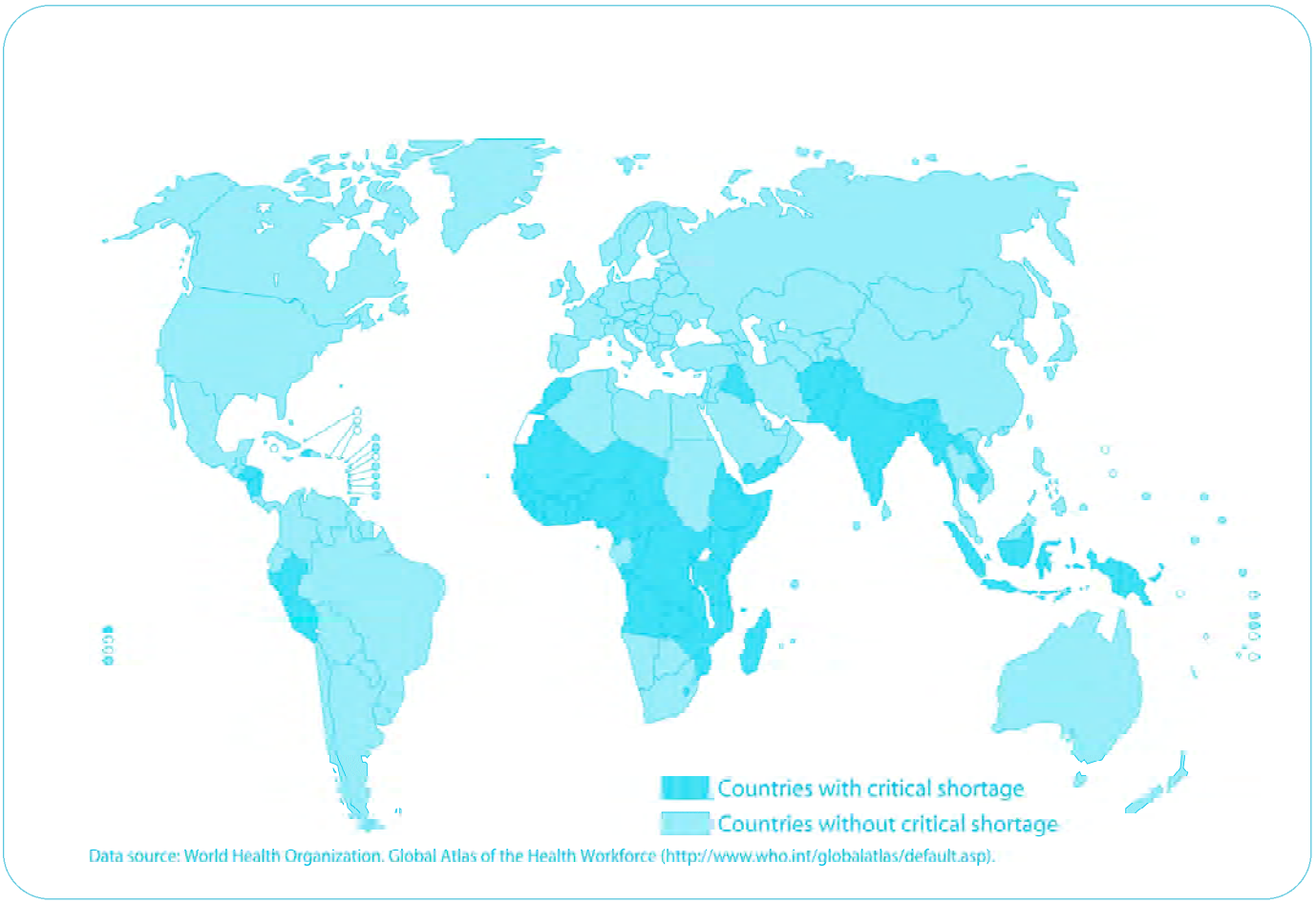
It should be recalled that the report reveals a worldwide deficit, showing major inequalities between North and South, but also, in the South of numerous disparities among regions and even within countries (e.g. the contrast between city and country). In Africa the crisis, which is as much qualitative as it is quantitative, has been exacerbated by structural adjustment policies that have had a grave effect on the production of HRH and curtailed public-service job opportunities.

As an example, "The WHO Region of the Americas, with 10% of the global burden of disease, has 37% of the world's health workers spending more than 50% of the world's health financing, whereas the African Region has 24% of the burden but only 3% of health workers commanding less than 1% of world health expenditure." (C.f. Table 1 and Figure 1, taken from the report),.

Table 1: Global health workforce, by density

WHO region	Total health workforce		Health service providers		Health management and support workers	
	Number	Density (per1000 populations)	Number	Percentage of total health workforce	Number	Percentage of total health workforce
Africa	1 640 000	2,3	1 360 000	83	280 000	17
Eastern Mediterranean	2 100 000	4,0	1 580 000	75	520 000	25
South-East Asia	7 040 000	4,3	4 730 000	67	2 300 000	33
Western Pacific	10 070 000	5,8	7 810 000	78	2 260 000	23
Europe	16 630 000	18,9	11 540 000	69	5 090 000	31
Americas	21 740 000	24,8	12 460 000	67	9 280 000	43
World	59 220 000	9,3	39 470 000	67	19 750 000	33

Figure 1: Countries with an acute shortage of service providers (physicians, nurses and midwives)



The *World Health Report 2006* conveys 5 key messages:

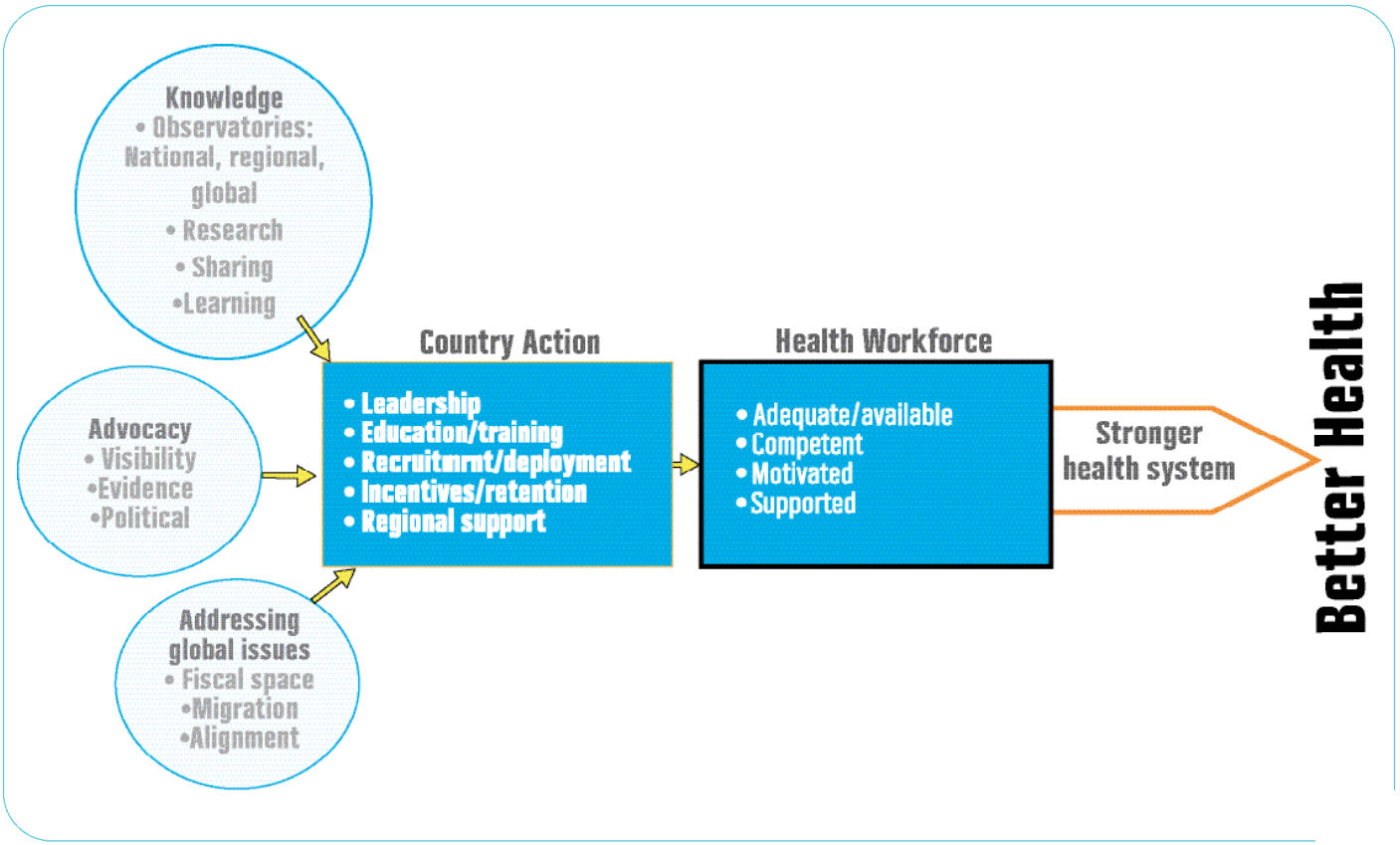
1. Well trained health workers save lives.
2. Support and protection for health personnel is a necessity.
3. Increase the efficiency of personnel at every stage of their professional life.
4. Remedy the inequalities and imbalances at every level.
5. Promote partnerships and place trust in cooperation.

2.2 Global Health Workforce Alliance

Launched on 25 May 2006 in the wake of the report by the Joint Learning Initiative, the Oslo Conference, World Health Day 2006, and in answer to the call by the World Health Assembly, GHWA is a new worldwide partnership[2] seeking rapid solutions to the present crisis. It brings together and mobilizes the main stakeholders in the field of world health to help countries to improve their organization, education/training and health manpower. The GHWA also raises the prospect of practical approaches to urgent problems that result from factors that the countries cannot cope with.

[2]This partnership is hosted by WHO with technical and financial support from bilateral (Canada, France, Ireland, Norway and United Kingdom), multilateral (EU), and private (Gates Foundation) partners.

Figure 2: General GHWA strategy



GHWA concentrates its activities on five priority lines of action aimed at:

1. speeding up work at country level, by drawing on support from regional bodies;
2. harmonizing the activities of contributors of all categories and promoting alignment by them with national policies;
3. developing knowledge, factual tools and simulating learning;
4. disseminating information and communication to strengthen arguments in favour of HRH;
5. handling the repercussions of a globalized labour market for health professionals;

GHWA encourages countries to develop a strategy resting on seven pillars:

1. a multisectoral national team fully recognized by the authorities;
2. a health development plan (HDP) in line with priorities under poverty reduction strategy papers (PRSP);
3. a strategic plan for HRH development that provides backing for the HDP;
4. an observatory that monitors HRH situations and reports on them annually;
5. coordination between the national, regional and international levels;
6. on-going advocacy for strengthening the HRH;
7. improved leadership and managerial performance in the HRH

However, to ensure that the countries do advance, it is essential to underscore the importance of good governance, against a background of strong political will, which takes the form of financial commitment and of efforts by all the various national actors to overcome the main obstacles, in particular the institutional ones.

2.3 Gaborone Resolution, African Union

A technical consultation bringing together participants with a role in the development of health systems, was held in Gaborone during the month of March 2007 under the auspices of the AU.

This consultation revealed the requisite synergy among all the various institutional and private actors for developing plans to strengthen the HRH around five priorities:

1. Performances, postings and migration of health personnel
2. Increasing the numbers of health workers
3. Better identification of the status of health personnel
4. A sustainable approach to funding of personnel
5. Governance and lasting partnerships in the management of personnel.

To give substance to this political will, every country must develop budgeted HRH development plans, integrated into medium-term expenditure and which have an annual appropriation line in the state budget. These plans must be consistent and must complement the PRSP's and NHDP's. The role of the private sector in providing health care must also be taken into account more systematically.

These key priorities were set out in statements directed at the G8, and largely centred on the question of human resources. In conjunction with the question of the HRH the insufficient funding for the health care system has also been presented as a major obstacle to its strengthening. The implementation of social welfare mechanisms will help increase resources for funding HRH.

2.4 The African Platform

The African Platform, an initiative for the promotion of action at national, sub-regional and regional levels, is intended as a regional network that will help develop, share and organize a common African position and voice on problems of the HRH .

The African Platform intends to develop on the basis of consensus. Its operating principle is therefore to persuade parties to join without any desire to force its members to take on particular responsibilities or undertake specific action.

Lively discussion during coffee break

Box 1 - The functions of the African HRH platform

- Supporting actions at the country level
- Research, sharing and coordinating lessons and experience garnered
- Resource mobilization and intervention
- Forming networks and partnerships

Source: presentation of the African platform at the conference.

Its ta skis to strengthen national, sub-regional and regional actions in the HRH sphere, to help improve the performance of health systems, and to promote regional cooperation to help African countries to attain the MDG's.

Affiliation is free and open to all parties interested in the evolution of HRH in Africa, and above all to public administrations (ministries responsible for health, of finance, civil service ministries and ministries of education), regional and subregional organizations, divisions of networks responsible for Africa, associations, agencies and universities as well as to any other organizations – whether public or not – involved in the HRH sector in Africa.

In order to carry out its activities, the Platform, which has a steering committee, will establish a permanent secretariat with the assistance of GHWA.

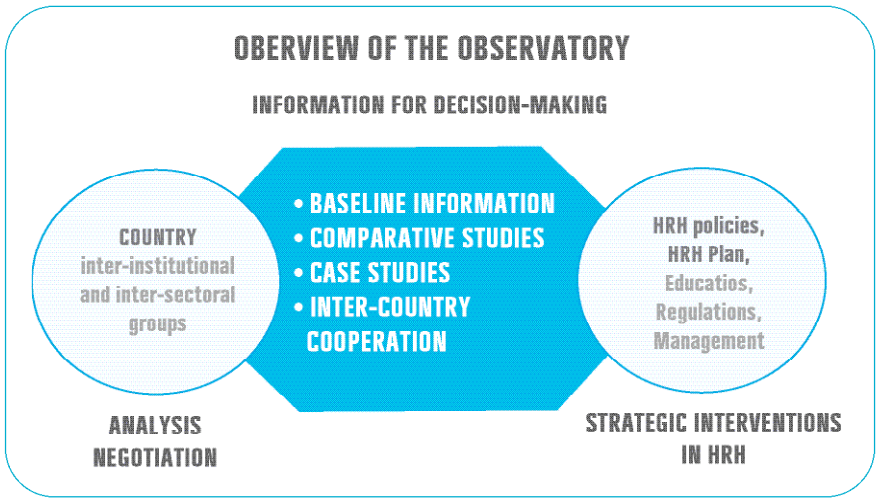
2.5 The African HRH observatory

The assessment made by the WHO Regional Office for Africa of the human resources shortage specifically points to the following features:

- the problem of data reliability;
- the weakness of health information systems;
- the limited technical resources available properly to use information systems;
- the poor quality of the data collected (poor definition);
- poor quality and insufficiency of data collection methodologies;
- low level of comparability of data between countries.

To address these challenges and draw up a map of HRH and of needs in countries, and following the recommendations of the July 2005 consultative meeting in Brazzaville, an observatory, hosted by AFRO, has been set up thanks to funding from GHWA.

Figure 3: Presentation of the observatory



The Observatory operates as a common network of countries and stakeholders for the purpose of: (i) producing recommendations, (ii) improving collection of high-quality data and (iii) developing national monitoring and evaluation capacity.

The functions to be assumed by the regional observatory and relayed by the network's national observatories hinge around the following activities:

- Information and monitoring of HRH
- Analysis and research
- Sharing and dissemination
- Promotion of national and inter-country networks
- Reinforcement of HRH skills.

The role of the secretariat is to foster and carry out advocacy, to ensure coordination and monitoring-evaluation, and to identify matters of general interest and good practices.

The first results have already been registered:

- Organizational development– a focal point is initiating and directing the work of the observatory, an organizational working group has been set up, together with national observatories (South Africa, Ethiopia, Ghana, Mozambique and Tanzania);
- Technical development – data on HRH have been collected in all the countries and are currently being analysed: a regional data base has been established and the web site has been set up (www.afro.who.int/hrh-observatory/index.html).

Harmonization of terminology (in order to collect consistent data in the different countries, with a view to consolidation and standardization) is one of the Observatory's priorities. In addition, it also plays an important role in helping countries wishing to set up or improve their own national observatories.

Box 2 - Principal activities of national observatories

- Stakeholder analysis
- Evaluation of the country's HRH
- Collecting and sharing data and the results of studies available in the country
- Research into HRH at country and inter-country level
- Promotion of a national HRH agenda
- Setting up an accessible framework for information sharing
- Drawing up and regularly updating the country's HRH profile .

The creation of the Observatory has opened a debate on the boundaries of its field of action in order to improve the information available for decision-making. Concern only for human resources without addressing the improvement of infrastructures, planning, the involvement of ministries of finance to ensure payment of salaries etc., seems insufficient for some, who press for an observatory of health systems. Moreover, it would be important for the Observatory, which is at present accessible only in English, to be translated into the official languages of AFRO.

The African Platform and the Observatory link up perfectly: the first is the structure providing strategic guidance and supervision, while the second is a technical tool at the service of the Platform and of countries.

2.6 The West African Health Organization

The mission of WAHO, which is a specialized agency of ECOWAS, is to ensure the most comprehensive health coverage possible for the community's 280 million inhabitants. The fifteen Member States of WAHO belong to three language groups: English (5), French (8) and Portuguese (2).

The strategic plan, which is the fruit of the work of the Ministers of Health of the Member States and of foreign partners, (USAID, UNAIDS, etc.), has highlighted nine priorities, two of which concern HRH (institutional development and training). This has led WAHO to engage in regional review, in particular of training - both basic and in-service - of health professionals. In this respect, high priority has been assigned to harmonizing training in order to improve its quality and foster a sub-regional response to staffing requirements. In order to achieve this objective, in 2004 an expert committee was set up and organized a series of consultations which culminated in the approval for the harmonization of specialized medical training curricula.

Between 2005 and 2006, the principal medical specialties were reviewed in order to have proposals ready for adoption in October 2006. Harmonization resulted in a consensus on the classification and length of training, conditions of recruitment and content of training, evaluations of training and programme development and content.

Box 3 - WAHO: harmonization of specialized medical training curricula

1st session: surgery, internal medicine, paediatrics and gynaecology – obstetrics
Bamako 5-7 September 2005

2nd session: anaesthetics-intensive care, ophthalmology, psychiatry and public health
Ouagadougou 9-11 March 2006

3rd session: anatomy-pathology, medical biology (biochemistry, bacteriology-virology, haematology-immunology, parasitology), dermatology, ENT, maxillary-facial surgery and radiology

Dakar 10-12 May 2006

WAHO has now set itself the task of harmonizing nursing and midwifery training and is setting up, in conjunction with AFRO, a data base on HRH staffing levels in Member States.

Several countries (Benin, Cameroon, Congo, Equatorial Guinea, Mauritania, Niger, Central African Republic, Democratic Republic of Congo, Rwanda, Senegal and Chad) presented their own experience, focusing special attention on certain areas where they had tried to provide solutions corresponding to their priorities.

They all share a common conviction that human resources development is an essential component of a health system and that it should henceforth figure among the essential priorities. The conclusion draw from the presentations was that countries face similar situations and problems, albeit with specific features deriving from national circumstances.

3.1 Overview of the country situation

3.1.1 Similarities

- Structural adjustment budget policies have reduced the number of training courses and limited recruitment.
- The majority of training institutions are public.
- The countries benefit from varying levels of international assistance, although its volume means that development partners are involved in solving problems.
- The countries have national health programmes and plans and are committed to poverty-reduction programmes.
- Coordination among the main ministries concerned by HRH is frequently limited and rarely formalized.
- In terms of public service staffing levels, health often ranks second behind education.

3.1.2 Specific characteristics of countries

- HRH development plans have reached different levels of maturity depending on the country. Pending the implementation of a human resources development plan, some countries have opted for an emergency HRH plan in order to adopt concrete measures, in particular in terms of increased staffing levels and the provisions for training.
- Within ministries of health, the HRH function is assigned different levels of importance: certain countries have authentic and fully operational departments, while others assign responsibility for HRH to a unit located within a much bigger department.
- The impact of decentralization on the leeway allowed to local authorities to manage HRH, including recruitment, has been varied,.
- The importance and nature of the private sector varies considerably from country to country, as regards both the distribution of health care and the dialogue with the authorities.

Table 2: Staff distribution in Cameroon

Cameroon: the size of the private sector

Private-public sector distribution (Source : MSH report 2004)

JOBS	Public (20.068 beds)	Private (17.999 beds)	Total (38.067 beds)
Total staff	15.025	11.802	26.827
Of which physicians	1.794	1.172	2.9660
Of which non-medical staff	13.231	10.630	23.861
N° of total staff in hospitals	7.366	5.334	12.700
N° of total staff in OHC and HC	7.659	6.468	14.127
Bed ratios per1000 inhabitants	1,192	1,069	2,261
Ratios of health workers per 1000 inhabitants	0,89	0,70	1,59
HW/bed rations	0,748	0,655	0,704

3.2 The main challenges

Box 4 - DRC: major problems in HRH

- Non-existence of staff planning;
- Poor geographical distribution of staff;
- Shortage in certain categories in relation to norms;
- Unsuitability of training with regard to needs;
- Absence of protection for health staff from the HIV/AIDS epidemic
- Lack of staff motivation to tackle the increased workload caused by HIV/AIDS; Inappropriate organization chart with no post descriptions (profiles);
- Failure to comply with regulations on human resources management;
- Lack of autonomy to hire staff and health-care staff managed by the ministry responsible;
- Poor living and working conditions of health-care staff;
- Lack of a framework for coordination among the those who train and those who employ health personnel;
- Heavily centralized management of health personnel;
- Non involvement of professional associations in HRH planning, training and management.

Consequences of these problems:
Low staff productivity, poor motivation, brain drain, absenteeism, poor timekeeping, surfeit of staff in towns and shortages in rural areas.

These affect all countries, although their importance varies from one to another. For example, HRH development plans will assign a different place to each of the elements described below and their implementation will imply a scale of priorities that reflects this relative importance.

3.2.1 Availability of HRH

Despite the efforts made by some countries, knowledge of the actual numbers of HRH is approximate because of the inadequacy of information and management systems.

In all countries, HRH are unsatisfactorily distributed. Their heavy concentration in the capital cities and major towns contrasts with often deserted rural areas. This divide is also reflected in the presence of larger numbers of staff in referral facilities than in front-line ones.

In all likelihood the shortage will increase in the next few years, because the large numbers leaving (career changes, migration, retirement, death) will hardly offset by the arrival of newly-qualified staff. Besides, with sustained population growth, in order to maintain the staff/population ratio, it will be necessary to increase the number of staff by the same percentage, i.e. from 2 to 3 % annually depending on the country.

3.2.2 Development of HRH

Basic training calls for significant support if it is to meet the challenges in terms of numbers and quality. In some countries, private training is developing with the tacit or explicit agreement of the authorities. In others, priority has been given to building up the training capacity of public institutions, occasionally at the cost of disregarding the vitality of the private sector. In all cases, the content of training needs to be adapted in conjunction, where necessary, with reorganization of the training system.

Although in-service training is an important activity, it is often conducted without a standardized framework. It is rarely used in support of career development. Moreover, in-service training often upsets the organization of health services because it is usually decided at the last minute and does not always correspond to services' priorities. There is considerable room for improvement of the way in which the quite considerable efforts made by development partners in favour of in-service training are channelled.

3.2.3 Performance of HRH

The working environment and working conditions are factors that restrict proper use of the available human resources.

- Facilities, equipment and consumables are generally in short supply in health services.
- The isolation and lack of public services (in particular colleges) are some of the reasons why it is difficult to assign health personnel to disadvantaged areas.
- The absence of individual career tracking means that individuals spend a great deal of energy defending their interests and preserving their rights, to the detriment of full dedication to their profession.

Existing incentives are either inadequate or used in a manner that fails to maximize their potential to mobilize human resources.

- Salaries and bonuses are still below the level that would allow professionals to maintain a decent standard of living; consequently, they take on other jobs instead of devoting themselves wholly to their work.
- A system of remuneration that is dissociated from merit encourages the "free rider" strategy.
- Exercise of the profession does not always carry sufficient prestige, and this limits commitment to serving the profession.
- When career prospects are limited, there is little reason to do your best in your daily work.
- The absence of a system of evaluation and reward discourages emulation, which might encourage workers to progress.

When overall figures are analysed, the productivity of HRH often seems insufficient; however a more detailed analysis frequently proves impossible: information and management systems are unsophisticated and incapable of providing a true idea of staff productivity, which also requires a good match between jobs and training. Assignments are not always made with this in mind.

3.2.4 Management of HRH

As far as countries are concerned, the issue is to move on from personnel administration to human resources management. In most cases, this shift is a major challenge:

- How is it possible to move on to this dimension of strategic management when administration is often already not up to scratch? The existing legal framework is characterized by inflexibility, which hardly favours the development of a managerial approach. Moreover, grey areas and areas where the law is not applied exist side by side, fostering arbitrariness.
- The heavily centralized nature of the public service discourages assignment of responsibility to the local level.
- There is a lack of HRH planning to serve as a guide to decisions.
- The lack of analytical tools (tasks, workload) and of management (and computerized) tools makes the job of HRH departments difficult.
- The vagueness of post descriptions and fields of professional competence opens the way to personal interference in job-assignment mechanisms.
- The lack of HRH management skills at all levels is of no help in developing and implementing tools to rationalize HRH management.

3.3 National initiatives to take up pressing challenges

Some countries have chosen to take initiatives without waiting for a human resources development plan to be introduced. They count on significant and visible improvement of the situation in these particular areas to create a favourable dynamic for dealing with the other constraints. The examples below, which are drawn from the country presentations , do not cover all the approaches described, but they do emphasize some particularly important aspects.

3.3.1 Geographical and expertise bonuses in Mauritania

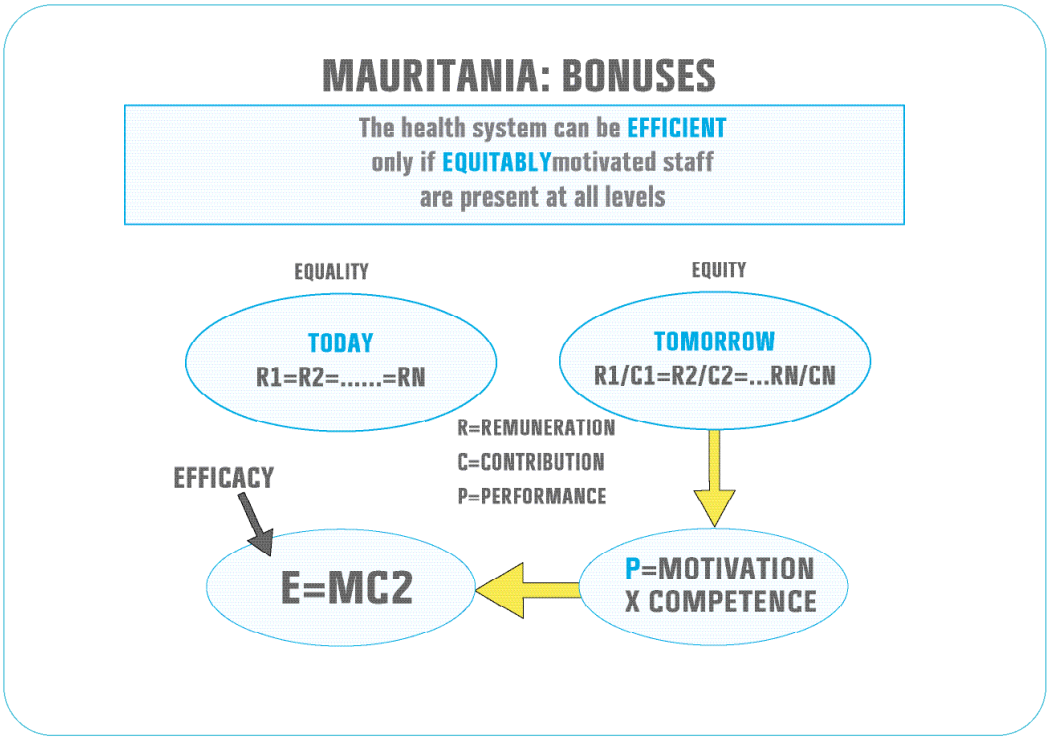
The principle

In order to attract staff away from the capital and from Nouadhibou, Mauritania has adopted a system of bonuses based on two parameters: the location and the field of expertise.
The country has been subdivided into four areas to reflect the isolation of the main town from the capital. These areas have been further subdivided to rank localities in relation to the main towns.

The field of expertise is a means of identifying certain specialities in particularly short supply, for which an additional bonus supplements the area bonus paid to all health workers.

[3] www.who.int/workforcealliance/events/conference_Douala/; see, Annex II

Figure 4: Bonus system in Mauritania



Introduction

In order to set up such a system, it is important to control the resource mobilization circuit on which the payment of bonuses depends. A means of monitoring and evaluation should be designed from the outset in order to keep track of the system's impact.

Lessons drawn from experience

A monitoring system has been set up, taking care to ensure that local structures are involved and that the process is transparent. If there is no such monitoring, there is a strong risk of paying bonuses to ghost workers. Moreover, there is no way of measuring the efficacy of the approach (number of vacant posts filled), or its efficiency (cost of filling a vacant post in a remote area). The aim is also to make it possible better to take into account the contribution made by staff to the results with the objective of finding a formula capable of stimulating motivation and competence in the interest of efficacy.

3.3.2 Multifaceted actions to retain staff in Cameroon

The principle

A career plan and financial incentives were introduced to retain staff in areas where there are staff shortages. Thanks to a precise count of the number of posts and the cost per post, it was possible to estimate the budget needed to introduce this measure, based on a combination of an installation grant and a loyalty bonus

Introduction

Specialized knowledge of national law is needed in order to set up the system of bonuses in conformity with the texts in force and, when necessary, to formalize any changes that might be necessary. A national workshop bringing together the ministries of health, of the public service and of finance will then approve the mechanism.

Lessons drawn from experience

In order to ensure support for such a mechanism, it is important that funds are available to recruit staff potentially concerned by the incentive mechanism and to make up for retirements which create a strong pull towards the most attractive assignments. When countries receive debt cancellation credits, they may use them to fund jobs that need to be created. In addition, the existence of extensive possibilities for training, including in the private sector, makes it possible to respond. Finally, by focusing on training for professions unlikely to be affected by the brain drain (e.g. specialized nurses), the country is assured of a sustainable response.

3.3.3 Adoption of management by post in Niger

The principle

In a country characterized by an acute shortage of HRH, extremely unequal distribution, the absence of reliable data and a huge area with poor communications, it was decided to replace employee-based management with position-based management so as to link assignments to a physically identified post.

Table 3: HRH distribution in Niger

Niger: concentration of HRH in the capital

	Niamey	Outside Niamey	Total	% NY
POPULATION	***1 000 000***	***12 000 000***	***13 000 000***	***8%***
Surgeons	21	16	37	57%
Physicians	341	215	556	61%
Pharmacists	105	20	125	84%
Midwives	432	416	848	51%
Nurses	812	1 605	2 417	34%

Introduction

The introduction of post-based management is part of a broader approach designed to (i) better control the evolution of human resources in terms of numbers and quality; (ii) ensure employees' rights; (iii) devolve human resources management; and (iv) interest staff in the results achieved.

Lessons drawn from experience

The adoption of this approach meant a change in outlook based on strong political support and funding for incentive measures. Consequently, success depends on a systemic approach backed up by national assessment of the results.

3.3.4 Establishment of a HRD in the Ministry of Health in Senegal

The principle

The Ministry identified difficulties deriving from the dispersal of responsibility for HRH activities among several departments (general management, research and training). As a result, training programmes were unsuitable and human resources management was not based on planning tools. The low level of responsibility of the units responsible for personnel was partly responsible for neglect of the HRH factor.

Introduction

Introduction of an institutional framework grouping all HRH activities in a single department was preceded by a feasibility study. Moreover, in order to enable this department to operate satisfactorily, additional studies were conducted. A high-level political decision was also needed because the creation of such a department also required a far-reaching redefinition of the areas of competence of all the Ministry's other departments

Box 5 - Senegal: establishment of a HR directorate

The following studies were conducted to help set up the HRD:

- directory of job profiles
- career management for health personnel
- staff mobility and redeployment
- human resources management planning
- improving the skills of human resources staff
- computerized HRH management system.

Lessons drawn from experience

The first benefit of this change has been the integration of the training mechanism in support of the HRH development policy. New training programmes have been created to meet the needs for personnel. In addition, a series of measures have been decided on to make it possible to re-open health services that had been closed down for lack of staff.

Debating is going on after session ends

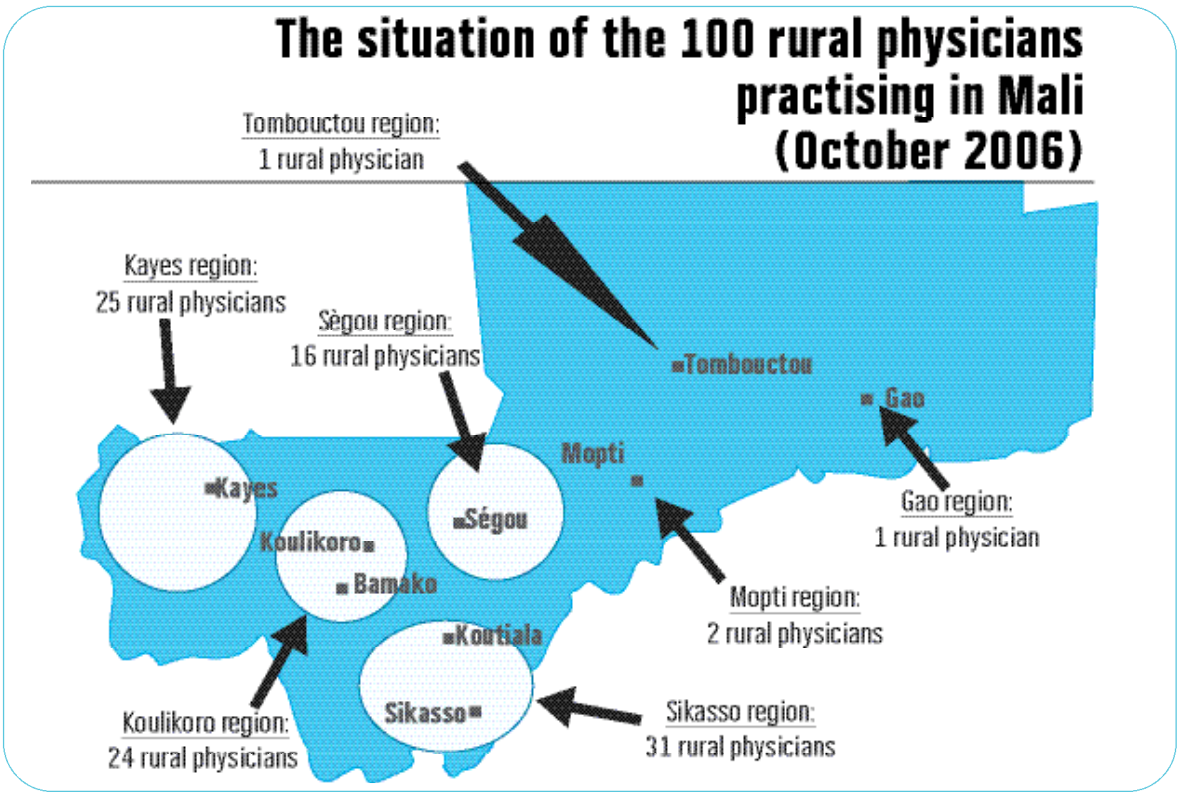
4. Regional or international initiatives

A number of initiatives show that in spite of the scale of the crisis, the lack of resources and the deficient organization of HRH, action is possible.

4.1 Provision of Medical Services in Rural Areas in Mali

Provision of Medical Services in Rural Areas in Mali is a national initiative which has nevertheless spread into several other countries (Guinea, Madagascar, etc.).
The Santé Sud NGO and its partners have designed an innovative project which associates primary health care and family medicine. In a situation where the number of trained physicians who fail to find jobs in public health facilities is increasing, the aim of this initiative is to improve access to quality medical care for Mali's rural populations. It involves a mechanism to help rural physicians set up surgery and the creation of the Association of Rural Physicians (AMC), which makes it possible to practice individually without being isolated from other professionals.

Figure 5: Implementation of rural physician in Mali.



This experience has made it possible for more than one hundred physicians to set up surgery, frequently in areas remote from the capital. A study of the activity of the health centres has shown that health-care coverage has considerably improved thanks to the presence of physicians. Moreover, the organization of an AMC has made it possible to introduce an in-service training programme together with networked research activities to improve clinical case management. The initiative has also provided an illustration of how to develop a public health service on the basis of private medical practice.

AMC's assertion of its identity is a challenge to be taken up in the coming years. It has actually become difficult to dissociate Santé Sud Mali from AMC; hence the need to clarify their respective roles in order to ensure the sustainability of the system that has been set up.

4 Santé Sud is an NGO of health professionals organized into a network to improve the quality of health services for underprivileged populations through international solidarity. This is a sustainable and not an emergency development project, which is carried out in partnership with local actors (public or private), in order to make the most of local skills on the basis of what has already been achieved by them and which sets individuals at its heart.

4.2 Training for health managers

The *Ecole inter-états des cadres supérieurs, professionnels de la santé et du social* (Inter-State College for Senior Health and Welfare Professionals) (EICAPSS) is a school with a regional vocation, based in Burkina Faso; its objectives are:

- to improve the skills of African health and welfare professionals to enable them to manage or head training schools, oversee projects and provide training;
- to offer a career plan – and consequently additional motivation – to encourage health professionals to continue to work in Africa;
- to foster the creation, in French-speaking Africa, of training colleges for health and welfare professionals;
- to make it easier for health and welfare professionals to study university curricula;
- to contribute to changing health and welfare practices, both by training health professionals and by carrying out actions in the field in conjunction with associations of patients or disabled persons.

The school offers a degree in education science and a professional master's qualification. As soon as it opened in 2004, its intake included students from six French-speaking countries (Benin, Burkina Faso, Côte d'Ivoire, Mali, Chad and Togo). The training is fee-paying and in most cases the fees are paid by scholarships from the students' countries of origin.

The motivation behind this initiative, which is jointly run by Handicap International and the university of Lyon II, is provided by:

- the opportunity to provide HRH for the health evaluation process;
- the value of developing joint action between health and welfare services;
- the need to develop a career plan to offer professionals the opportunity for permanent career development;
- the need to improve the quality of care to improve the quality of life and to involve disabled persons in the choices that concern them.

[5] Handicap International is an international NGO specialized in the field of disability. Non-governmental, non-religious, non-political and non-profit making, it works alongside people with disabilities, whatever the context, offering them assistance and supporting them in their efforts to become self-reliant. Since its creation, the organization has set up programmes in approximately 60 countries and intervened in many emergency situations. It has a network of eight national associations (Belgium, Canada, France, Germany, Luxembourg, Switzerland, United Kingdom, and USA) which provide human and financial resources, manage projects and raise awareness of Handicap International's actions and campaigns.

4.3 Mobilization of hospital partnerships

The Fédération hospitalière de France (FHF) provides support for partnerships between hospitals which formalize relations between French hospitals and establishments in Sub-Saharan Africa. These hospital partnerships, which receive financial support from French Cooperation, make it possible to carry out tailor-made actions to attain specific objectives:

- professionalization of interventions;
- institutionalization of relations between hospitals;
- incorporation of activities into existing cooperation;
- a vision of activities that covers several years and seeks to ensure their sustainability;
- diversification of the fields of intervention.

The actions carried out concern capacity-building, mainly via the contribution of expertise or by carrying out training activities. The approaches adopted involve support in various forms (on-the-spot training, internships, technical support, etc.) and fields (medical techniques, nursing care, administrative management, technical maintenance, hygiene, etc.).

The actions, which employ means originating from different sources (French cooperation, GIP ESTHER, local authorities or associations) are designed to be mutually beneficial and give pride of place to compagnonnage (buddy training). This approach makes it possible for personnel from the North to make a contribution as well as making work in their own country more attractive to health professionals in the South. Although its impact is qualitative rather than quantitative, the health professionals involved have declared themselves highly satisfied with it.

Nevertheless, it is hard to draw up a balance sheet for these partnerships, particularly as regards their impact on the health of the populations. The difficulties experienced in scaling them up and the absence of a monitoring and evaluation system make it difficult to present concrete results for them.

Box 6 - Prerequisites for successful hospital partnerships

- Mobilization of the beneficiaries
  - Involvement in defining the actions
  - Selectiveness regarding requests
  - Critical analysis of offers
- Heightened interest from donors
  - Making the most of potential for cooperation
  - Providing better support for actors' actions
  - Defining more precise objectives
- Organization of the hospital sector
  - Working more closely together
  - Developing joint activities

→ *Organize a hospital association*

The new context of cooperation, the increased financial pressure on hospitals, the global human resources deficit and the lower priority given by countries to the problems facing hospitals all constitute new challenges facing an approach which has not yet reached maturity.

In order to build on the dynamic that has been set in motion, it is important to multiply the number of interventions in a single country (e.g.: Burkina Faso, Niger and Senegal) by focusing on national priority issues leading to the attainment of quantified and time-limited objectives.

In order to draw maximum benefit from this approach, it is also important that countries mobilize in order more precisely to circumscribe actions, capture the attention of donors and organize the response from hospitals through a national federation or association.

4.4 Tackling the HRH crisis in the context of AIDS

In order to improve the capacity of developing countries to treat people with HIV/AIDS, GIP ESTHER provides support for actions intended to organize case management around hospitals and societal networks. Given the shortage of HRH, which limits the expansion of case management for patients with AIDS, its intervention is directed at the three fronts identified as having priority in the World Health Report (Treat, Train, and Retain).

Treat by preventing accidental exposure to blood and training in hygiene and ensure case management without discrimination.
Train thanks to a major in-service training effort (5000 persons over 5 years) locally and abroad, the introduction of training for trainers and of training leading to a diploma in inter-university cooperation.
Retain by improving working conditions, introducing financial and non-financial incentives and providing personalized post-training support.

ESTHER works to provide community case management, to expand the supply of care in the community and is thus capable of forging a strong link between the public and private sectors. By the end of 2007 an analysis of the projects supported by ESTHER will be complete and the lessons drawn from this experience will be made available to all.

4.5 Support from development partners

The representative of ADB said that his organization used applications from States as a basis for financing projects deemed to have priority and which are PRSP compliant.

For French cooperation, the problems of HRH are essential, although the development of HRH calls for political will at the country level in order to obtain increased government budgets and ODA. Any diagnosis of the shortage should stress the quality of resources, which are occasionally available in sufficient numbers, together with governance and bad management which hamper already deficient systems.

The strategies proposed by France involve action on different levels:

At the the international level
Helping to mobilize all actors in order to determine and finance strategies (members of GHWA, collaboration with all UN agencies, favoured partnership with the European Commission).

At the regional level
Galvanizing the potential for regional collaboration, enhancing training capacity (especially as regards training for staff with responsibilities involving several areas, such as managers and planners).

At the national level
Press for an approach that includes all stakeholders, and in particular private players. Assistance also concerns the establishment of national HRDP, using different methods (C2D, SWAp, etc.) while preserving the objective of linking health system improvement to the development of human resources as their common foundation.

France also wishes to become involved in supporting innovative policies, such as North-South partnerships and networks, the development of twinning arrangements and of decentralized cooperation, private-sector involvement, and the development of training and remote technical support.

5.1 Group I: How can management of existing resources be optimized?

Before making formal proposals, Group I addressed several topics to underscore the importance of:

- qualitative analysis of HRH data via regular surveys. Data bases from national censuses could serve as a starting point, and the results should be widely disseminated;
- differences between the public and private sectors for HRH analyses;
- supervisory tools for HRH management activities;
- the administrative and legal framework that needs to be set up for HRH. For example, the institution of a correlation committee which monitors careers from day to day to identify malfunctions and alert those responsible in the relevant ministries as quickly as possible;
- linking the national HRH observatory with the national health information system (SNIS). The crea tion and/or reinforcement of DHRH also requires clarification of data base development (rather than develo ping 3 bases, develop a single one, accessible by DHRH, NSIS and the observatory);
- the process of building a HRH support mechanism. Should we formalize a policy for the development and rational management of HRH befo re setting up the DHRH or rather begin with the DHRH, which will then participate in the development and implementation of this policy? (Might they be set up concomitantly?);
- assigning clear missions to DHRH within the ministries of health to enable them effectively to steer HRH policy in the country;
- the distinction between incentives for individual staff and those adopted nationally in support of a personnel policy. While complementary, these approaches are based on different rationales. Measures (both institutional and political) at the country level are intended to solve problems such as the training of too many staff in relation to the labour market (Cameroon) or the imbalance betwe en numbers of staff in rural and urban areas, etc.;
- strong political will (affirmed or reaffirmed) regardless of a country's state of governance;
- flexibility in setting the remuneration of health workers, taking local circumstances into account. This is particularly feasible as part of an approach based on the results achieved by health facilities (e.g.: in Rwanda, in addition to improving the wage scales, bonuses were introduced on the basis of the activities carried out for health actions assigned priority);
- the value of replacing management of persons by management of posts. This technical measure is particularly effective in limiting pressure from clientelism;
- the importance of social policies. These support measures may concern housing, free care and pro tection of HRH (for example, from HIV/AIDS), etc. Such measure affe ct the State budget far less than wages measures and may be an alternative means of improving the living conditions and purchasi ng power of HRH.

Preparing work group

Table 4: Proposals by Group I

Level	Indicator(s)	Timeline
Country Level		
1. Situation analysis of HRH (private and public sectors)	Number of countries in which a document with a situation analysis is available	June 2008
2. Preparing the strategic HRH development plan	Number of countries with an HRH development plan	June 2009
3. Set up/strengthen DHRH; decentralize management of HRH	Number of countries with an operational DHRH	Dec. 2007
4. Gradually assign 15% of the State budget to the health sector and increase the share of HRH therein as a matter of priority	% of the State budget assigned annually to the health sector	Dec. 2010
5. Optimize HRH management in referral hospitals using results-based management	Number of countries that have rationalized HRH management in their hospitals	Dec. 2010
6. Contractualize HRH performance within the framework of decentralization	Number of contracts signed in each country	June 2009
7. Involve the diaspora and civil society in the management of health systems	Number of partnership agreements signed by each country	June 2009
8. Encourage development of a formal and regulated private sector (for-profit and non-profit) which pursues national health priorities	Annual growth rate of the private sector with regard to the health map	Dec. 2010
Regional level (sub-regional organizations; AFRO)		
1. Regional mapping of HRH	Number of maps available per region	June 2009
2. Ensure regional frameworks f or coordination on HRH are operational (norms, advocacy, regulation, etc.)	Number of meetings organized annually Number of norms adopted and implemented by countries	June 2009
International level (WHO, AU, ILO, GHWA, etc.)		
Support the HRH development process	Number of countries receiving support to permit the implementation of their HRH development plan	Dec. 2009

5.2 Group II: What skills are required to perform which tasks?

Group II focused its attention on four questions, before formalizing a number of proposals.

5.2.1 Regulating the practice of health professions in African countries

The State plays a key role in regulating professions. In some countries (e.g.: Congo), the reforms under way have made it possible to review a legal arsenal dating from the colonial period and to make a start on drafting ad hoc statutes for several categories of personnel. A presidential decree on the specific status of public servants working for the public health service was adopted in 2001 in Cameroon. The different professional councils also play a role in developing regulations. The influence of unions varies: it is considerable in countries such as Senegal, Côte d'Ivoire and Cameroon. In some State there are councils responsible for regulating the profession (e.g.: Congo). In Rwanda and Niger, the State helps different professional councils to operate. Benin has adopted a different approach involving a private association which is responsible for regulating the practice of the health professions. The association negotiates with the administration and proposes its own regulatory measures.

In spite of the disparities that exist between the different countries within WAEMU, the situation is identical everywhere: there are serious shortcomings in the different regulatory agencies, the main cause of which is corporatism. The agencies are inadequately structured, as a result of which the State frequently signs a multitude of agreements - as for example in Burundi, where it has signed one with each health facility – rather than with a single professional group.

5.2.2 Classification of health professionals and of the corresponding professional skills

There is a real need to harmonize training policies via curricula reform. This would facilitate free movement of health professionals within sub-regional spheres. In this respect, ECOWAS is making a major effort to harmonize curricula. However, while free movement of personnel exists in French-speaking countries, the reform does not really make free movement between the French- and English speaking ECOWAS countries possible.

As a rule, the shortage of HRH creates a de facto delegation of responsibility as a result of which health professionals find themselves practising without having received appropriate training. Occasionally, physicians receive a few months' training in caesarean sections as part of emergency obstetrics training. This is also the case of traditional midwives or nurses who are trained in a hurry to perform emergency surgery (45 days in Niger). The gap between the procedures performed and the level of formal qualifications is a source of tension. In such circumstances, recognition of professional qualifications on the basis of the experience acquired is vital. Countries have adopted two approaches to this: they either ignore the issue or adopt criteria for incorporating professionals on the basis of recognized experience (e.g.: Chad).

5.2.3 Matching the training provided by training institutes (both in-service and basic) to the skills needed to satisfy health needs

To put it differently: does the training provided make it possible to offer quality care? In several countries, the training system operates on the basis of its own criteria, without taking into consideration the evolution of the organization of treatment for patients. A number of countries share the same difficulties, with training colleges over whose curricula they have no control. This situation is part of a bigger picture characterized by poor coordination between trainers and employers.

5.2.4 Making the most of the skills of health-care staff

In almost all countries, health professionals have become somewhat disenchanted with health-care activities. There are several reasons for this: since 1985, the recruitment freeze and drastic salary cuts have forced health-care staff to turn to administrative tasks, or more lucrative jobs outside the health sector. In some countries, the proportion of physicians assigned to administrative tasks is as high as 40 %, which is nothing other than a waste of the investment made in their medical training. In order to reverse this trend, priority should be given to enhancing the prestige of professional practice, for the benefit of patients.

Table 5: Proposals by Group II

Level	Recommendations	Indicators	Timeline
Country	1. Strengthen the role of and funding for professional regulatory bodies (councils, professional associations, congregations, etc.), including in private practice	1.1 Evaluate the regulatory system 1.2 Reform the regulatory system 1.3 Include or increase the item in the budget 1.4 Study of regulatory systems by the HRH observatory	12 months 2 years 2 years 2 years
Country Global	2. Enhance the prestige of the skills acquired by offering more attractive salaries and career prospects	2.1 HRH development plan 2.2 Development of a system of reference for skills and a professional directory 2.3 Advocacy directed at international financial institutions	2 years 12 months immediately
Country	3. Establish a framework for coordination among training institutions, public and private employers and patients' associations	3.1 Existence of patients' associations 3.2 Introduction of the framework for coordination and organization of a minimum of 3 annual meetings	12 months 12 months
Pays	4. Preferably assign administrative and technical tasks to professionals trained to perform them. Reassign health professionals to their core professional tasks	4.1 Measurement of the ratio of administrative and technical tasks performed by appropriately trained personnel	every 12 months

5.3 Group III: Education and training of HRH

The discussion centred on definition of terms ("education" and "training"). To avert any confusion between basic training and in-service training, it was decided to use the term «education» solely for training leading to a diploma issued by officially recognized bodies.

5.3.1 Education

Constraints

- Mismatch between training and the priorities of countries and regions (curricula need to be extensi vely revised and continually adapted);
- the legal framework within which training organizations operate is not always suitable (especially as regards the responsibilityof the supervisory body) and rarely fosters an effort to adapt and aim for quality;
- training for trainers is insufficiently organized (it needs to be harmonized at the regional level) and it is not systematically provided;
- there is no reliable HRH data base or any HRH development plans, both of which are essential tools for proper planning of training;
- there is still no systematic evaluation of the teaching provided (no quality label or accreditation);
- there is no inventory of the training on offer and there is a lack of training for certain specialists, the need for which calls for a sub-regional response (needs are too low to justify a national response);
- regional and international partnerships are insufficiently developed and full use is not made of the possibilities available through e-learning.

Opportunities

- medical faculties exist in most countries, offering the possibility of harmonizing training courses along degree - masters - doctorate lines (DMD);
- there is an inter-state college and a nursing studies centre (in Burkina Faso and in Cameroon).

5.3.2 In-service training

- In a situation characterized by the presence of emerging and re-emerging diseases, knowledge and skills need constantly to be refreshed in order to ensure the quality of care.
- In many countries, the lack of an in-service training policy and plan is a serious handicap to a systematic approach to in-service training.
- There is a lack of continuity in refresher courses for health personnel: there are no individualized training plans; staff enrol for training - which is not always suitable, when they have an opportunity to do so.
- Because budgets rarely make provision for in-service training, training is provided by donors through a multitude of actions related to the activities supported by them.

Table 6: Proposals by Group III

Recommendations	Indicator(s)	Timeline
Sub regional level		
Harmonize HRH training curricula	Harmonized curricula available in the ECOWAS/CAEMC sub-region	by July 2009
Global level		
Assign resources (financial, human and material) to approved training institutions	1. Health within official development assistance; the share allocated to training institutions increases by X % annually 2. 90 % of training provided by training institutions	annually, as from 2008

6.1 Position, role and support mechanism for regional groupings (political, economical and technical) to put human resources back on a sound footing

In respect of training, approval of courses (ECOWAS) and regional consolidation of training help to ensure that the training available responds to countries' needs.

The ending of State contributions and often weak political will have resulted in bankruptcy for several regional institutions. If it is to be sustainable, the regional cooperation model requires strong political will and institutions that ensure a degree of sustainability .

Regional projects above all concern infrastructures, although as part of the effort to control avian influenza, ADB has encouraged joint regional actions between WHO and the ministries of agriculture and health.

Sub-regional experience

The mission with which OCEAC is entrusted expanded between 2001 and 2003. In this economic area, joint programmes receive a proportion of customs revenue. For example, resources are directly assigned for the operation of this organization's structures (automatic financing).

The Central African Inter-State Centre for Higher Education in Public Health (CIESPAC), a regional training institution located in Brazzaville (Congo) has experienced vicissitudes on account of the political situation, which led to its temporary closure until the States decided to reopen this regional cooperation training tool.

Through its Regional Office, WHO fulfils a normative and a technical support function. It undertakes advocacy directed at ministries of health and signs agreements with regional organizations to further the health agenda.

Attention should be drawn to the important role of the African and Malagasy Council on Higher Education (CAMES), a regional organization which evaluates and accredits teachers. Its existence is noteworthy against a background in which national training establishments without the authority to validate their own diplomas are proliferating. The role of the other bodies, such as the International Conference of Deans of Medical Faculties (CIDMEF) and of the Francophone University Agency should also receive greater consideration in connection with the evaluation and accreditation process.

Clarification of the roles played by these different regional organizations is all the more important because there are some countries in which several ministries are directly involved in training HRH. For example, in Cameroon this is the case of the ministries of basic, secondary, technical and higher education. Currently, higher education is in most cases sidelined, as can be seen from the investment projects supported by the development partners.

In this context, only a mutually agreed plan for the development of HRH will possess the necessary credibility to attract support at all levels of the education system and sufficiently to mobilize the regional organizations referred to above.

6.2 What type of training should be provided regionally in the referral centres or inter-State colleges, and what are the requirements for their success?

The case of WAHO is significant. Previously, there was a surfeit of actors in the field of HRH training, resulting in divergence and dispersion of efforts against a background of acute need.

WAHO has made it possible to support a diploma harmonization process. This process is now complete where physicians are concerned, but is still under way for pharmacists, health economists, nurses and other health professions. Harmonization of diplomas is determined by needs.

In West Africa there are English, French and Portuguese-speaking areas, with specific training and procedural features. Examples are the West African College of Surgery and the West African College of Nursing which train, evaluate and issue diplomas that are recognized worldwide. In contrast, where the French-speaking countries are concerned, CAMES evaluates but does not train. This makes it necessary to come up with means of ensuring harmonization to make it possible to accredit centres of excellence and inter-State training centres. To do so, it will be necessary to set minimum requirements based on clearly determined and recognized criteria.

The approach adopted by WAHO affords sub-regional complementarity while avoiding overlapping of efforts. In addition, it makes it possible more intensely to concentrate efforts in three linguistic areas. When facilities are set up, this makes it possible to ensure geopolitical equilibrium.

The example of CIESPAC provides an occasion to raise the issue of the management capacity of training institutions. The systematic appointment of physicians to direct them is not always the right solution, in terms of assuring the specific skills required to run a training institution.

The high costs of training and the scarcity of HRH should incite us to slow down the establishment of national colleges in favour of initiatives with a sub-regional or regional vocation.

Two main trends may be discerned: national colleges with a regional vocation and inter-regional colleges – without it being at all clear whether this is one training model with two facets or two different models. In any case, observance of the provisions of the international agreements and accords signed by these countries is a prerequisite for the sustainability of these institutions.

It will be necessary rapidly to consider questions regarding competence for accreditation and evaluation of training colleges in order to provide a long-term solution. In this regard, it would be desirable to establish regional and national commissions to determine, in an apolitical manner, the requirements for the creation of such establishments.

6.3 What contributions (nature, level and form) are expected of GHWA?

GHWA is expected to provide know-how, advocacy and responses to global problems.

As regards know-how, GHWA emphasizes the following:

- the consensus regarding the creation of regional observatories (Africa, Asia, etc.);
- support to help regional organizations set up training courses at this level;
- sharing of experience among all continents, in order to consider, at the global level, a solution to this multifaceted crisis (identification of « national champions », development of inter-country sup port).

The Alliance must take on the role of initiator and facilitator, in order to galvanize the regional and international agendas. However, GHWA will never be a major source of funds.

As regards advocacy, we should stress the need for political commitment and support. This is an essential prerequisite which incites GHWA to encourage the states associated in the Alliance to act within the framework of their sub-regional political theatre. As regards the African point of view on the brain drain, GHWA has brought the issue to the attention of the major bodies. The Alliance thus plays a role in facilitating, activating and implementing the international agenda for the development of human resources for health.

7. Adoption of the recommendations / Douala Plan of action

The presentations by the countries and the different institutions present, together with the results of the workshops and the discussions during plenary sessions and the round table led to the formulation and adoption of the «Douala Plan of Action» (see Annex I). The Plan highlights the measures to which all participants agree priority should be assigned. The Plan of Action identifies the levels of responsibility (national, regional, global) for implementing measures and a timetable for ascertaining the progress made.

Monitoring the implementation of the Plan of Action is a priority for GHWA as part of its dialogue with countries in order to mobilize partners to bolster assistance on behalf of HRH.

Finalizing the Douala plan of action

LEVEL	RECOMMENDATION	INDICATORS	TIME SCALE
Country Regional International	1. Commit to a strong advocacy effort in favour of developing human resources for health (HRH) actions/solutions	Number of press conferences and articles	Immediate & ongoing
Country Regional International	2. Make the HRH issue a priority on the political agenda to mobilize more resources from the national budget, development partners and global health initiatives (GAVI, Global Fund, etc.)	% of rise of national budget allocated to HRH Amount of mobilized international aid	Immediate & ongoing
Country	3. Identify priority HRH issues demanding urgent measures	List of priority issues identified	August 2007
Country	4. Set up a multisectoral committee for HRH promotion	Terms of reference for the creation of the committee	September 2007
Country	5. Set up or strengthen an office of HRH Director and enable them to play a strategic management role	HRH Director's office set up % of rise in budget of existing offices	June 2008
Country	6. Elaborate/revisit a national HRH strategic plan with an MDGs perspective (2015)	Strategic plan available	December 2008
Country Regional	7. Set up a national health system observatory which covers all information pertaining to HRH	Functional Observatory	December 2008
Country Regional	8. Create a compendium of competencies and a directory of health professions	Compendium & directory available	December 2008
Country Regional	9. Strengthen the training of health managers and their optimal use.	Number of training programmes opened % of posts occupied by trained managers	December 2008
Country Regional	10. Evaluate and accredit institutions and HRH training programmes	Number of evaluation reports available Number of training institutions accredited	December 2008
Country Regional	11. Revise and harmonize HRH training curricula	Number of revised curricula	December 2008
Country Regional International	12. Accelerate the training of various HRH cadres according to country needs	% of rise in students in relevant catergories	Immediate & ongoing

Countries present at the conference: Benin, Burkina-Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Gabon, Guinea, Mali, Mauritania, Niger, Senegal, Rwanda, Togo.

Annex II - List of presentations

Presentations are in French on www.who.int/workforcealliance/events/conference_Douala/

- Benin: Présentation Pays: Bénin [pdf 562kb]
- Cameroon: Présentation pays: Cameroun [pdf 275kb]
- Mauritania: Présentation pays: Mauritanie [pdf 198kb]
- Niger: Présentation pays: Niger [pdf 411kb]
- CAR: Présentation pays: Rép. Centrafricaine [pdf 466kb]
- DRC: Présentation pays: R.D. Congo [pdf 227kb]
- Rwanda: Présentation pays: Rwanda (en anglais) [pdf 91kb]
- Senegal: Présentation pays: Sénégal [pdf 758kb]
- GHWA: Présentation: AMPS [pdf 499kb]
- French Cooperation: Présentation: Coopération Française [pdf 101kb]
- Regional School of Ouagadougou: Présentation: Ecole régionale de cadres (EICAPSS) [pdf 258kb]
- ESTHER: Présentation: ESTHER [pdf 252kb]
- French Hospital Federation: Présentation: Fédération Hospitalière de France [pdf 120kb]
- HRH Regional observatory: Présentation: Observatoire des RHS (OMS/AFRO) [pdf 1.08Mb]
- WHO-Afro: Présentation: OMS [pdf 1.05Mb]
- WAHO: Présentation: OOAS [pdf 447kb]
- African platform: Présentation: Plateforme Africiane pour les RHS [pdf 86kb]
- Mali: Présentation: Santé Sud (Mali) [pdf 387kb]
- GHWA: Présentation: Travaux préparatoires (AMPS) [pdf 146kb]

CONFÉRENCE

"Human resource for health in Africa: Experience, challenges and realities"
Hôtel Méridien Douala, Cameroun 6-8 juin 2007

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