



**WORLD HEALTH ORGANIZATION**  
REGIONAL OFFICE FOR AFRICA



**WORLD BANK**  
INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

***BUILDING STRATEGIC PARTNERSHIPS IN  
EDUCATION AND HEALTH IN AFRICA***

**CONSULTATIVE MEETING ON IMPROVING  
COLLABORATION BETWEEN HEALTH PROFESSIONALS,  
GOVERNMENTS AND OTHER STAKEHOLDERS IN  
HUMAN RESOURCES FOR HEALTH DEVELOPMENT**

*Addis Ababa, 29 January – 1 February 2002*

**Report on the Consultative Meeting**

**April 2002**



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## EXECUTIVE SUMMARY

1. The consultative meeting on *Improving collaboration between health professionals, governments and other stakeholders in human resources for health development* was the first meeting ever held in Africa on the crisis facing the health workforce in which a large number of the many and diverse stakeholders met face-to-face to exchange views, examine various dimensions of the problem and initiate processes that could lead to development of solutions. There was unanimity that the issues needed to be addressed soon.

2. The meeting endorsed the following as critical and interrelated issues affecting the health workforce:

- (a) The need to ensure the relevance of education and training of health professionals to the health needs of the population served;
- (b) The importance of forging new partnerships between the health and education sectors, and of continuing professional development of the health workforce;
- (c) The importance of recognizing and defining appropriate roles for health professionals and the organized health professions in health policy formulation and implementation generally, and in the development of health human resource policy and health sector reform specifically;
- (d) The urgency of improving the environment in which health-care providers work in Africa, to facilitate retention and optimal utilization of the health workforce; this includes issues of remuneration, deployment and skilled human resource planning and management;
- (e) The recognition of the impact of the HIV/AIDS pandemic on the health workforce, including deaths and attrition, increased occupational risk, reduced labour effectiveness and massive increases in workloads;
- (f) The critical need to mitigate the impact of HIV/AIDS;
- (g) The impact of globalization, leading to an increasingly flexible and mobile labour market in the health sector, beyond and inevitably therefore within African countries.

3. The phrase 'brain drain' was widely used at the meeting. It refers to the migration of trained African health professionals to other African countries and to third countries, as well as their moving out of the health sector. Participants expressed concern about the deliberate recruitment of African health-care personnel by industrialized countries, and called upon countries to support the proposed Commonwealth Code of Practice for International Recruitment of Health Workers. They recognized the loss of health human resources as a critical problem affecting the ability of African countries to meet their health targets and the Millennium Development Goals. It is a direct consequence of the failure to address key issues impacting on the health workforce. The loss of health human resources was becoming so important that large numbers of participants considered it a crisis. Resolving this brain drain crisis depends on finding solutions to many issues raised at the Addis Ababa meeting.

4. The meeting agreed, overall, on key steps that needed to be taken following the consultation, at the country and at the international level. These actions will contribute to the achievement of the goals of health sector reform, and proponents of health sector reform need therefore to put health workforce issues on their agendas.

5. At the country level, an understanding was reached at the meeting that participants would take the lead in initiating the development of country-specific action plans. This work would take place in the wider framework of the WHO/AFRO regional strategy for the development of human resources for health (HRH). The first step would be to stimulate convening of a meeting of the various country-level stakeholders. At this meeting various facets of the crisis of the health workforce would be discussed and an initial agenda for action agreed. Subsequently, a situation analysis may be in order, to collect information on the workforce, on health training institutions' outputs, curricula, budgets and financing, etc. Specific actions would then follow in phases. Financial support for these activities will be mobilized with assistance of the meeting sponsors and other donors. Several country delegations informed the sponsors that they planned to submit proposals for funding. It was gratifying to note that a number of participants reconvened on their own after the closure of the consultative meeting to start the process of developing country-specific action plans.

6. At the international level, WHO, the World Bank and UNESCO agreed to establish an African health human resource development task force to assist countries in developing strategies and in the mobilization of funds for the required analytical studies and consensus-building. The Rockefeller Foundation and USAID agreed to join the task force and indicated that they might be able to provide financial support for work at the country level. The Norwegian Education Trust Fund, managed by the World Bank, was also available for certain follow-up activities. One possibility was to hold further consultations at the subregional level, or by linguistic groups of countries, but this did not need to hold up action at the country level. The principal conference sponsors were working out the details of these arrangements and follow-up plans as this report was being completed, but this need not hold up actions at the country level. WHO country representatives and World Bank local health staff and task managers are available to work on these matters with country delegations who attended the Addis Ababa consultative meeting.

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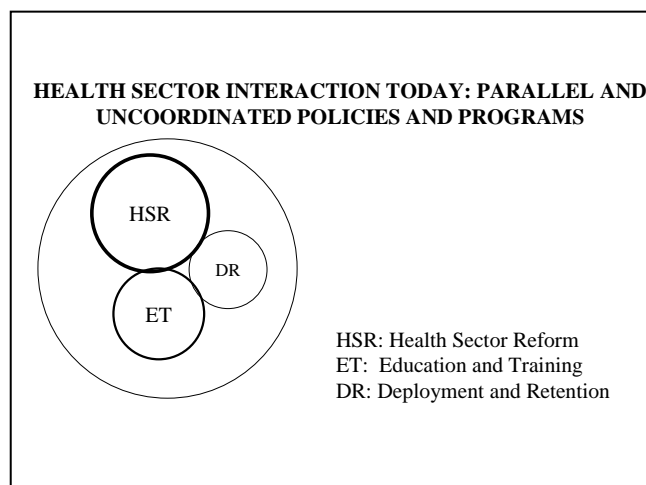
## ABBREVIATIONS AND ACRONYMS

ADB	–	African Development Bank
AMSA	–	African Medical Schools Association
AUF	–	<i>Agence Universitaire de la Francophonie</i>
CESAG	–	<i>Centre d'Etudes Supérieures Africaines en Gestion, Dakar (Senegal)</i>
CIDMEF	–	<i>Conférence Internationale des Doyens de Médecine d'Expression Française</i>
ECSA	–	Eastern and Southern Africa Commonwealth Health Secretariat, Arusha (Tanzania)
ENHR	–	Essential national health research
HFA	–	Health for all
HIVAIDS	–	Human immunodeficiency virus/Acquired immune deficiency syndrome
HRH	–	Human resources for health development
HSR	–	Health sector reform
IOM	–	International Organization for Migration
IRSP	–	<i>Institut Régional de Santé Publique, Cotonou, Benin</i>
MAG	–	Multidisciplinary Advisory Group (of WHO/AFRO on HRH)
MDGs	–	Millennium Development Goals (of the United Nations)
OAU	–	Organization of African Unity (African Union), Addis Ababa
PHC	–	Primary health care
PRSC	–	Poverty Reduction Support Credit (of International Development Association)
SADC	–	Southern Africa Development Community
SWAps	–	Sector-Wide Approaches
UNAIDS	–	United Nations Joint Programme on AIDS
UNDP	–	United Nations Development Programme
UNESCO	–	United Nations Educational, Scientific and Cultural Organisation
UNHCR	–	United Nations High Commissioner for Refugees
USA	–	United States of America
USAID	–	United States Agency for International Development
WCC	–	WHO Collaborating Centre
WFME	–	World Federation for Medical Education
WHO/AFRO	–	WHO Regional Office for Africa
WHO/HQ	–	World Health Organization Headquarters

## INTRODUCTION

### Background

1. The health sector reform programmes that countries are undertaking in Africa have had inconsistent and inadequate approaches towards health workforce issues. Health professionals and organized professional bodies have had little role in health policy formulation. The education and training of health professionals have rarely taken health sector reforms into account. Continuing professional development and motivation and retention of staff have infrequently been addressed by African countries during the preparation and implementation of health sector reforms. The resulting reality was that actions taken in Africa on health sector reform, education and training of health professionals and the deployment and retention of health workers occurred largely independently of each other, as depicted in the figure.



2. There is an insufficient appreciation of the importance of building partnerships between the education sector and the health sector in Africa. Such partnerships would facilitate meeting the dual goals of ensuring the participation of health professionals in the design and implementation of national health policies and reforms and the relevance of health professional education to societal needs.

3. The assessment set out above led the WHO Regional Office for Africa (WHO/AFRO) and the World Bank to organize a joint consultative meeting in Addis Ababa, Ethiopia, from 29 January to 1 February 2002. Financial support for the meeting was provided by the Norwegian Education Trust fund managed by the World Bank, by WHO/AFRO, by UNESCO, and by the World Bank and World Bank Institute.

### Objectives of the meeting

4. The general objective of the meeting was to define strategies for constructive partnerships between the health professions, governments and other relevant stakeholders to improve their contributions to health sector reform.

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Note: The 'shadow rapporteurs' of the meeting, A. Edward Elmendorf and Seth Acquaaah, prepared this report.

5. The following were specific objectives of the meeting:
  - (a) To review current mechanisms for contributions of the health professions to health policy formulation and to the implementation of health sector reform;
  - (b) To review the relevance and responsiveness of health professional education and training to health needs and to health sector reforms in Africa;
  - (c) To propose human resources management practices that contribute to the retention and motivation of health professionals;
  - (d) To propose a framework for action on health workforce issues in connection with health sector reforms.

### **Opening ceremony**

6. The Honourable Vice Minister of Health for Ethiopia, Dr Demmisse Tadesse, chaired the opening ceremony. In his statement the Honourable Minister stressed the importance of human resources for health development. Shortages of health workers, especially in rural areas, were an important problem in many countries, including Ethiopia. This situation required the formulation of measures to promote retention. It was time, he said, to discuss the problem of developing country health workers now employed in industrialized countries. This was both a national and a local problem.

7. Professor Shabani Juma (UNESCO) expressed the concern of his Organization for appropriate education, development, deployment and utilization of the health workforce in Africa. UNESCO was working with medical faculties in five francophone countries on reviews aimed at community service, and expected to work also on continuing education programmes for medical personnel. UNESCO was extremely concerned at the brain drain of African health workers, and was working with UNDP on a programme for the temporary return of such personnel for teaching purposes. Professor Juma explained that the objectives of the consultative meeting were reflected in UNESCO's work programme and UNESCO wished to contribute to the implementation of the recommendations that may be made by the meeting.

8. In his introductory remarks, Dr O. Pannenberg (World Bank) regretted the absence of health sector professionals at the negotiating table when health sector and other reforms of major concern to the health professions were discussed. Ministries of Finance and Planning, Ministries of Health and multilateral and bilateral development partners are present, but the providers of care who are most directly involved and affected tend not to be represented. Dr Pannenberg said that African governments' health reform teams should include representatives from associations of health-care providers and health-care-provider training institutions and universities. He underscored the importance of cooperation between the health and education sectors on health workforce issues, and pointed out that the education sector was much more advanced than the health sector in engaging service-providers in the substance and process of reform. In associating teachers with the work on education sector reform, the education sector was establishing practices that could be emulated by the health sector. Addressing health workforce labour market issues, Dr Pannenberg expressed

great concern about the brain drain. As a result of the brain drain and other problems confronting health policy-makers, he said, health workforce issues in Africa were reaching a crisis level.

9. In his keynote address, the Regional Director of WHO, Dr Ebrahim M. Samba, reminded participants that health goes beyond the purview of health professionals. He indicated that if health professionals attempted single-handedly to address health without the engagement of others, they were bound to fail. He recognized that the involvement of health personnel and their collaboration with other stakeholders in implementing health sector reforms remained far from the desired level, and pointed to this as justification for organizing the Addis Ababa consultative meeting. He expressed concern about the massive brain drain of health professionals in the African Region, and suggested that there may be more African physicians working outside the continent than within it. He asked participants to produce realistic strategies and a framework for addressing the health workforce crisis in the Region.

### **Officers and organization of the meeting**

10. Officers of the meeting were elected as follows:

- Chairman: Honourable Dr Marie Coll-Seck, Minister of Health, Senegal
- Vice-Chairman: Professor J. P. van Niekerk, World Federation for Medical Education (WFME)
- Rapporteurs: Professor Peter Ndumbe, Dean, Faculty of Medicine, University of Yaounde, Cameroon
- Dr Fatima Simao, Director, CRDS, Maputo, Mozambique
- Dr K. Bessaoud, Institut Regional de Sante Publique, Benin
- Dr R. Ndlovu, Senior Lecturer, Dept. of Nursing Service, Zimbabwe.

11. The first day of the meeting was devoted to gaining a common understanding of the major concepts underlying the linked themes of the meeting - health sector reform and health human resource development. The second day involved an analysis of key issues with an impact on the health workforce, illustrated by selected country experiences. On the third and fourth days, participants worked in small groups. A concluding plenary session completed the consultative meeting.

### **Participant profile**

12. Over 70 delegates from 17 African countries attended the meeting. The country teams comprised deans of medical and nursing institutions, other top training personnel and university administrators, regional and national associations and councils of health professionals, and senior officials from ministries of health and education. An unusual feature of the meeting was that key personnel from core agencies such as finance, planning, civil service and labour were included in the country delegations. WHO collaborating centres and representatives of regional economic groupings also participated. In addition to the main sponsors of the meeting (WHO, UNESCO and the World Bank) a number of major bilateral development partners in Africa were represented, as were regional and international organizations interested in the development of human resources for

health. Several members of country delegations observed in the debates that consumers of health services were *not* represented among the participants at the consultative meeting, and underscored the importance of their representation in the dialogue on health reforms at the country level. The full profile and list of the participants (including electronic addresses, where available, to facilitate contact and networking) is given at Annex 1.

### **Organization of the report**

13. The present report follows the structure of the meeting. It begins with a section of context, on the conceptual framework for health sector reform and the status of implementation in Africa, and on health human resources issues in Africa. It continues with three thematic segments on the main issues brought to the meeting by its sponsors as the three central concerns on the health workforce agenda in Africa:

- (a) engagement of health professionals in the substance and processes of health sector policy-making and reform;
- (b) education and training of health professionals;
- (c) motivation, retention, and deployment of health workers.

14. Each thematic segment of the report begins, as at the meeting, with a brief summary of the conference presentations, and then turns to country experience. The text of the thematic segments draws upon the discussions in plenary sessions and informal working groups. A brief introduction of the group work is included, along with highlights of the wide-ranging discussions in the small groups. A summary of the accomplishments of the meeting against its specific objectives, main points from the concluding plenary session, an attempt to reposition the issues in the light of the consultative meeting, and a vision of follow-up, complete the report.

15. It is impossible in a brief report to fully capture the rich debates and the many ideas presented. Readers are encouraged to use the report and associated materials as a source of ideas for adaptation according to their particular circumstances. Key papers and presentations from the meeting are listed in Annex 3 and are available at the website of WHO/AFRO <http://www.afro.who.int>.

## **HEALTH SECTOR REFORM AND HUMAN RESOURCES FOR HEALTH DEVELOPMENT: CONCEPTUAL FRAMEWORK AND CURRENT STATUS**

### **Health sector reform in Africa**

16. Professor G. Dussault (World Bank) introduced the topic, providing a summary of key health sector reform (HSR) issues to stimulate discussion. The purpose of health sector reform was to improve health sector performance and a typical justification for reform was performance gaps which were often related to ineffectiveness in addressing health problems, low efficiency in the use of scarce resources, high cost of and inequities in access to health services, user dissatisfaction and donor pressure. HSR often involved establishing an appropriate and ongoing process of policy and institutional change. It was a long-term and contentious process. The reform agenda included changes at the level of financing, payment mechanisms, organizational structures, regulatory

process and organizational cultures. Professor Dussault said that so far reform results had been mixed on cost-recovery, with little progress in the handling of financial risk issues and few successes in the implementation of provider-payment mechanisms, reluctance of central authorities to devolve power, weak local capacity, and the ongoing experimentation with the contracting of nongovernmental providers. He said that regulation was not sufficiently used as an instrument for change. Little had been done to enhance the organizational capacities of health-care providers, civil servants and managers. Professor Dussault explained that HSR was difficult to design, hard to 'sell' to decision-makers, and even harder to implement. Partly as a result of this, health human resources issues had been, thus far, a forgotten part of the HSR agenda. Concluding his presentation, Professor Dussault said that HSR involved a combination of art and science. The Millennium Development Goals (MDGs) adopted by the United Nations could provide a framework for future HSR efforts.

17. Dr M. Kiasekoka (WHO/AFRO) provided an overview of health sector reform implementation in Africa. He gave the following definition of health sector reform, which was fully consistent with Professor Dussault's approach:

*"A sustained process of fundamental change in national policy and institutional arrangements guided by the government and designed to improve the functioning and performance of the health sector and ultimately the health status of the population."*

18. While acknowledging substantial intercountry variations in reform implementation, Dr Kiasekoka considered that some key achievements in HSR were linked to policy and implementation, improved diagnosis of problems of service delivery and access to services by the poor, linkage of reform to credible medium-term economic and financial frameworks, resource shifts to primary level services, increased community participation, capacity-building at the district level in the management of funds and services, and reduction of the incidence of some diseases, including onchocerciasis, measles, tetanus and poliomyelitis.

19. Dr Kiasekoka underscored the following key factors in the successful implementation of HSR: sound government leadership; political stability; good economic performance and availability of domestic financial resources; effective management of the process of change; participation of health workers and other stakeholders; technical, managerial and institutional capacity; adoption of sector-wide approaches (SWAp) to health development; effective coordination of donor support; and availability of a comprehensive strategy on health human resources to address retention issues. For Dr Kiasekoka, challenges to the successful implementation of HSR in most African countries included: definition of the stewardship role of the government; enhancement of national capacity for development, implementation, monitoring and evaluation; increasing poverty; and difficulties in retaining health professionals.

20. Senegal and Uganda were the two country health sector reform experiences presented at the meeting. Uganda had adopted the sector-wide approach (SWAp). Uganda's reform programme was part of the country's poverty reduction action programme. It was being implemented within the medium-term economic and financial framework. Uganda and its health partners had agreed to use the same technical instruments. Methods of work were agreed upon and two joint missions were

held each year. The key factor had been the decentralization of public services across many sectors. Transparency, accountability and focus on priority programmes were promoted and the remuneration of health professionals had been increased.

21. Senegal presented an example of hospital reform. The aim was to revitalize public hospital services with benefits to users and providers. A legal framework for hospitals had been developed. A 'patient charter' (*charte du malade*) had been adopted, along with a programme for mapping health facilities (*carte sanitaire*). A decree creating a joint hospital-university coordination committee had been agreed by the Ministries of Health and Education. Texts were being formulated which dealt with the participation of private providers in the provision of care in public facilities and the modalities for evaluating hospital performance. It was expected that the reforms will shift the focus to improved performance from a purely administrative approach. Constraints to the implementation of HSR in Senegal included inadequate financial and human resources.

22. During the discussion and in the working groups speakers drew attention to many different factors that inhibited health sector reform and to actions that might be taken in their countries to address these factors.

- (a) inadequate collaboration between the health and education sectors;
- (b) resistance to change from consumers of health services, from providers and, sometimes, from top managers;
- (c) absence of the private sector from the process of design and implementation of HSR;
- (d) lack of information or motivation, frequent and contradictory policy changes and uncertain career development and progression;
- (e) artificial human resources shortages created by internal inequity in the deployment of available staff;
- (f) need to place a financial value on the loss of health professionals through brain drain;
- (g) desirability of arrangements with health professionals in private practice and those abroad to permit them to use public facilities to deliver care, and to allow public sector health professionals to have time for private practice;
- (h) importance of developing a global vision for health and the health sector.

23. Several speakers argued that multisectoral reforms originating in core government agencies such as Finance, Planning or Civil Service may hamper the effectiveness of HSR, since there could be inconsistencies between countrywide economic and social reforms and the needs and circumstances of the health sector and its human resources. However, it was pointed out that the process of elaboration of Poverty Reduction Strategy Papers (PRSPs) and Poverty Reduction Support Credits (PRSCs) offered a framework for engagement and harmonization of social sector concerns with macroeconomic and other countrywide imperatives. This could help to overcome the lack of synergy perceived by a number of participants.

24. Participants underscored the importance of political will, and of confidence and trust, among those engaged in reform work. Poor governance was cited as an obstacle to effective reform processes. The importance of basing reform decisions on reliable data was underscored. Regulation of the health professions and accreditation of health-care facilities were considered to be important instruments for use in the reform process. A tool for benchmarks of fairness in health reform was evoked in the debate, along with the need for an inclusive rather than a directive approach.

### **Global overview of human resources for health development**

25. Introducing the subject of human resources for health development (HRH), Dr O. Adams (WHO/HQ) provided a global overview of health human resources as seen by WHO. The World Health Report 2000 states that human resources are “the most important of the health system’s inputs”. The current context for human resources policies in health involved health sector reforms, technological change, socio-demographic transition, and market changes. Against this background, WHO found a clear need for health human resources policy guidance, including an evidence base of methods, tools and best practices, along with policy recommendations. Priority issues included workforce demographics and planning, health labour force movement, staffing distribution and adjustment, quality of health worker performance (and the associated issues of training and access to knowledge), remuneration, skill mix, and a change in the organization of the health workforce. Dr Adams explained that the links between the quality of care and health worker performance were not fully understood. There was need for a framework, instruments and methods to assess the links between health workforce education and practice on the job. There was also a need for instruments and tools to monitor and evaluate continuing education programmes.

26. Dr Adams said that WHO was working at both national and international levels. At the national level, decision-makers were faced with critical choices in setting objectives and defining priorities and plans of action for health human resources development. To guide their choices, they needed to know how human resources could be educated, maintained and deployed to produce the best health system performance and thus the best health outcomes.

### **WHO/AFRO regional strategy for the development of human resources for health**

27. Dr A. Gbary (WHO/AFRO) presented a summary of the WHO regional strategy for human resources for health (HRH) development. He said that human resources served as a catalyst for all other resources and for health sector reform. Efforts were being made to harmonize global and national health policies with the development of human resources for health. Many chronic problems were hampering effective integration, which included poor numerical, spatial and quality distribution of staff and the inability to retain and optimally utilize health staff. The regional human resources for health strategy underscored the generally poor understanding by policy-makers of the importance of HRH and the low priority that they gave to it. Dr Gbary said that there was a contradiction between the adoption of the primary health care approach and the continuation of training and practice according to a hospital-focused medical model. Ministry of Health HRH departments were inadequately structured, skilled and equipped. The private sector tended to be excluded from HRH planning. There was a lack of motivation and incentive systems including appropriate legislation and suitable living and professional working conditions.

28. Against this background, Dr Gbary explained that the WHO regional strategy aimed to contribute to the achievement of the health objectives of the Region by strengthening the capacity of African countries to optimize the use of their human resources for health. By 2004, the strategy expected all 46 countries of the Region to have developed a policy for human resources development for health. By 2007, all the 46 countries were expected to have acquired the capacity to implement their policy. The strategy was based on the following priority interventions: policy formulation and development, planning the development of human resources for health, education and training and skills development, administration and management, research, and regulation of the health professions. At the country level, the strategy proposed that national advisory committees be established to examine the progress of policy, planning and education, administration and management, research and regulation of the health professions. At the regional level, a regional multidisciplinary advisory group (MAG) of experts had been established, and AFRO was seeking partnerships with other institutions. Evaluation was planned every two years in collaboration with the MAG.

29. During the plenary discussion on the global overview and the WHO/AFRO regional strategy and in the working groups, a wide range of HRH strategy problems and possible actions were raised. The highlights were:

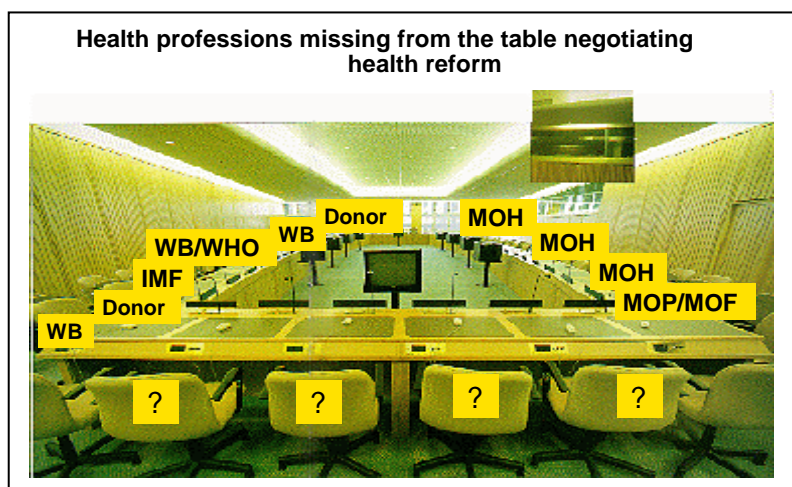
- (a) weak motivation and inadequate sense of initiative among health personnel;
- (b) values and equity issues insufficiently considered;
- (c) lack of coordination between ministerial departments responsible for education and health;
- (d) a need for a balanced assessment of the strengths and weaknesses of use of foreign medical personnel;
- (e) insufficient resources for HRH strategy and inadequate expertise in certain fields, such as public health;
- (f) need for inter-disciplinary evaluation;
- (g) establishment of HRH as a central issue in health sector reform;
- (h) establishment of working groups representative of different professional cadres;
- (i) Ensuring that the education sector was aware of the health sector's quantitative and qualitative requirements, and that the education sector was perceived as a full partner rather than simply a provider.

## **PARTICIPATION OF HEALTH WORKERS IN HEALTH SECTOR REFORM**

30. Dr Cesar Akpo (Consultant, Faculté des Sciences de la Sante, Benin) introduced the topic. The justification for engaging health workers in the substance and process of health sector reform (HSR) was that they were the main actors in the health system, were most directly affected by HSR, represented the major portion of health expenditures, and were in direct contact with other partners and users. Dr Akpo pointed to the need to develop a country-specific global vision for HSR,

otherwise the HSR activities will be externally driven. There was also a need to build relevant capacity at all levels and among various stakeholders. It was important, he explained, constantly to advocate for the participation of health professionals. They needed to own the reforms.

31. During the country presentations and subsequent discussions, few country teams were able to report a systematic concrete experience showing the participation of health workers in the HSR process. This tended to confirm the hypothesis of Dr Pannenberg in his introductory remarks that the health professions had hardly ever participated thus far in the reform and policy debate. The problems of convening authority, and of inter-agency tensions over mandates, made it particularly difficult to engage health workers and health educators in health sector reform. As an example of the engagement of health personnel, in Cameroon, there were strategies to involve health workers and community members in identifying priorities for intervention. In Ghana it was said that policy formulation and implementation were decentralized, both horizontally and vertically. However, there was minimal involvement of health professionals in the process due to apathy, misconceptions and suspicion. Management teams in Ghana tended to be seen by many health-care professionals as ‘alien bodies.’ New strategies aimed at increasing the involvement of health professionals included involving units and departments in determining priorities for action. Appointing health-care professionals to key advisory bodies would help, and it was important, alone from the standpoint of the government, to engage in substantial consultation with representatives of the principal bodies of



health professionals at the country level. In Senegal it was reported that the Ministers of Education and Health had signed a joint decree providing for consultation and cooperation between the two sectors in the education and training of health professions. Speakers confirmed that the decree had done much to reduce the kind of problems mentioned in Ghana.

32. Highlights of the observations and suggestions made in the discussion were as follows:

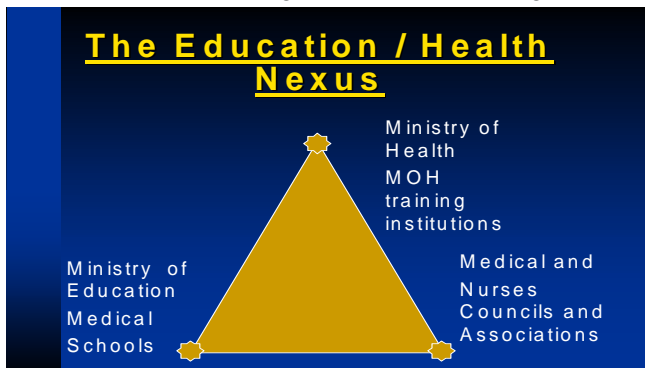
- (a) resistance to change might come not only from those who were targeted by reform but also from those who were responsible for the formulation of policies, who might see the *status quo* as serving their interests;
- (b) people resisted change if it was imposed on them, and it was therefore important to deepen dialogue and build mutual confidence;
- (c) medical educators at the meeting said that they had hardly even been informed of health reforms, not to mention consulted on the substance of government policies and health sector development plans;

- (d) to facilitate the engagement of university-based personnel in the HSR process, there was need for a budget line for health systems research;
- (e) medical, nursing and other health professionals should be encouraged to generate and research relevant HSR topics as part of the process of involving them in health reform;
- (f) essential national health research (ENHR) could provide a framework for the engagement of the health professions in HSR research and subsequently in the broader dialogue on health reform;
- (g) there was a need to involve health professionals from the private sector in policy formulation and implementation;
- (h) in view of the paucity of information on the implication of health workers in health sector reform, it was important to document experiences at the country level;
- (i) a proactive approach by health professionals to their engagement in health reform would help, in lieu of a posture of waiting formally to be invited to participate in the health sector reform process.

33. Both government representatives and speakers from professional associations underscored the importance of engaging professional associations in the substance and process of health sector reforms. This would increase the commitment to reform by health professionals and increase the probability that reforms could be successfully implemented. Capacity-building to strengthen professional associations should therefore be encouraged. The experience of a programme of leadership training for paramedical staff was mentioned as a way to increase confidence, awareness and engagement of these critical groups in the health reform process. It was also argued that there was a need to work out strategies for integrating traditional practitioners in the overall health-care system. Conscious communication strategies and professional communications assistance were evoked by a number of speakers which could be very helpful to the engagement of health workers in health sector reform.

## EDUCATION AND TRAINING OF HEALTH PROFESSIONALS

34. Professor J. Bryant (Consultant, USA) introduced the topic of education and training of health professionals (EHP) in the context of health sector reform. The main focus of health sector reform tended to be on the organization and management and health-care financing. Dimensions of the



education and training of health professionals that needed particular attention, according to Professor Bryant, included organization and management of universities. African medical faculties and university administrators needed to develop new statements of mission and vision. Such statements should commit them to joining with ministries of health to address the serious inadequacies of health care in Africa. Review of curricula and of

other aspects of health professionals' training and development was greatly needed. The process had been initiated in several countries, starting with a self-assessment by the university concerned. In the education of health professionals, Professor Bryant explained that more emphasis was merited on public health and community health. Universities should commit themselves to the care of defined populations and use health-care delivery sites for education and training in the provision of care as well as in health services research. Professor Bryant urged that health sector reform (HSR) teams, health professional training reformers and key local stakeholders establish local task forces to address country-specific issues.

35. Country experiences presented included Kenya and Côte d'Ivoire. In Kenya, several institutions trained health personnel within the context of HSR. Kenya's health sector reform envisaged 'right-sizing' in place of automatic retrenchment in connection with reform. It had proved difficult to handle performance management issues in connection with civil service reform, and the issue had therefore been returned to the health sector. Contracting out and creating semi-autonomous bodies were under consideration. In Côte d'Ivoire it was said that the initial training and continuing professional development of health-care providers had been organized following the exigencies of HSR. Curriculum reform was under way, and an inspection visit by a team from the *Agence Universitaire de la Francophonie* (AUF) had been carried out. Health professional training was state-financed but there were insufficient middle-level cadres and relatively large numbers of specialists. Because of difficulty in managing the student inflow, the medical faculty had greatly expanded, and this had a consequential negative impact on the quality of training and quality of care.

36. Speakers at the meeting underscored the critical importance of the education-health nexus to bring about improvements in medical education and long-term, sustainable success in health sector reforms. Collaboration was needed to engage not only Ministries of Health and Education but also professional associations and regulatory bodies. The agenda for action needed to concern not only those health workers engaged in primary health care but also the entire health professions.

37. Given below are the highlights of the observations and suggestions made in the plenary and group discussions:

- (a) medical education should be problem-based and problem-oriented;
- (b) curricula needed to be reviewed in order to make training relevant to HSR;
- (c) there was need to standardize the framework for training of health professionals;
- (d) training should focus on developing cadres responsive to change;
- (e) intake into training institutions should be guided by strategic human resources plans of the Ministry of Health;
- (f) distance-learning should be systematically expanded;
- (g) the scope of training should be broadened to lay greater emphasis on public health and community medicine, and to enable professionals to understand the overall design of the health sector and the linkages of their future functions to other health interventions;

- (h) there was need for an orientation towards users in education, training and research;
- (i) demonstration districts should be encouraged, as in Niger;
- (j) there was need to introduce or strengthen continuing education for health professionals and to include components on health sector reform;<sup>1</sup>
- (k) WHO should commission a study into the various community-based training programmes that were said to be under way in many countries;
- (l) joint consultative bodies bringing together staff from ministries of Education and Health and health workforce training institutions could greatly strengthen the relevance of training.

38. During the discussion, a variety of different activities for quality improvement in medical education were evoked. WHO and the World Federation for Medical Education (WFME) had developed tools for the evaluation of health science training programmes and quality improvement in medical education. Both tools were currently in use by WHO/AFRO in collaboration with the African Medical Schools Association (AMSA) in a project for the evaluation of 10 medical and nursing schools in Africa. Comparable initiatives had been started among francophone countries with support from the *Agence Universitaire de la Francophonie* (AUF). It was strongly hoped that the WFME and AUF initiatives could be expanded to other countries.

#### **MOTIVATION, RETENTION, DEPLOYMENT AND THE BRAIN DRAIN OF HEALTH WORKERS**

39. Dr D. Dovlo (Consultant, Namibia) introduced the topic of motivation, retention and deployment of health workers in Africa. He pointed out that in many African countries the challenges of planning human resources for health were compounded by high output lead times, professional interests and turf battles and lack of data. Migration of African health professionals to Europe and the USA had become an acute problem. Both the ‘pull’ factors, attracting health-care providers to recipient countries, and ‘push’ factors, encouraging emigration, were at work. The ‘push’ factors included poor human resource (HR) planning, weak compensation, political insecurity and conflicts, poor working conditions and environment and lack of recognition. African countries were adopting a number of strategies to prevent emigration. These included staff re-profiling, improving the administration and management of staff, bonding of trainees to serve for a period after training, control of certification and intercountry agreements. Other possible actions to promote retention included improving motivation, better selection of trainees and eliciting support from development partners. It was pointed out that some countries were trying to deal with the problem of lost skills by training lower cadres to take some of the workload of care, but that there were practical, ethical and legal limits to such changes.

40. Country experiences presented at the meeting included South Africa. In South Africa health science education was subsidized by the government. Sponsored candidates signed contracts that bound recipients to serve in specific locations. There was a community service programme for

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<sup>1</sup>It was noted that donor support for training under projects oriented to specific diseases tended sometimes to undermine overall continuing education programmes.

health professionals. HIV/AIDS posed a serious threat to the health workforce.<sup>2</sup> Socioeconomic conditions made it difficult to retain staff. A whole class in a nursing school of one African country was recruited by a developed country immediately after graduation. South Africa was pursuing intercountry agreements within the framework of the Southern African Development Community (SADC) and bilaterally beyond it, to address health workforce migration issues. During the discussion it was said that Nigeria produced 1,500 new doctors annually but lost 600 to emigration in one year.

41. The International Organization for Migration (IOM) reported on its work to facilitate the return of African professionals from the diaspora. Bottlenecks in the implementation of the IOM programme included weak recipient government ownership, mismatch between the supply of available returning professionals and local demand, and prolonged job search stemming from lengthy and cumbersome recruitment processes in many countries. Lack of trust in African governments among African professionals in the diaspora was also an important factor. The IOM considered that African governments needed to see their citizens in the diaspora as a valuable resource. There was also need for aggressive policies for attracting and retaining migrated brains back into the home countries. There should be active involvement of the private sector in this drive. The IOM representative argued that a paradigm shift was needed in the environment of globalization, from emphasis on retention at home to managed mobility of health workers.

42. Many speakers, including those from USAID, WHO/AFRO and the World Bank, drew attention to the overall situation of the health workforce in Africa. The effects of the brain drain, losses to HIV/AIDS and poor personnel management cumulated into a multifaceted health workforce crisis.<sup>3</sup> A draft report on the health sector human resources crisis in Africa was made available by USAID. It was mentioned that a study on migration of skilled health personnel commissioned by WHO/AFRO was under way in six African countries. The delegate from CESAG referred to the migration study in Senegal, undertaken by CESAG as part of the six studies commissioned by WHO/AFRO. Speakers suggested that African governments should meet on the brain drain crisis and find possible solutions to the problem. Some proposed that there should be more structured arrangements to control emigration of health professionals.

43. Data in the background papers for the meeting and the evidence produced at the meeting helped to give a quantitative appreciation of the health workforce crisis in Africa:

- (a) medical doctor vacancy rates in the public sector in 1998 were reported to be 43 % in Ghana and 36% in Malawi;
- (b) the nurse vacancy rate in the public sector in 1998 in Lesotho was reported to be 48%;
- (c) only 30% of the recipients of WHO fellowships from Lesotho in 1994 were reported to have returned home;

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<sup>2</sup>See the separate draft paper on this subject submitted to the conference by USAID, 'Impact of HIV/AIDS on the Health Workforce' available on the WHO/AFRO website.

<sup>3</sup>The health workforce crisis is highlighted in the press release issued jointly at the end (Annex 2).

- (d) in Namibia 50% of the doctors in public service were reported to be expatriates;
- (e) in Cameroon there was no public recruitment of health personnel for 15 years;
- (f) data from Ghana, Zambia and Zimbabwe suggested that the annual losses from public sector health employment continued to be between 15% and 40%;
- (g) Africa was the only WHO Region to show a decline in the doctor: population ratio from 1980 to 1996.

44. The consultative meeting strongly emphasized the need for basic working conditions that would enable health professionals to do their work with fresh personal commitment, and for provision of special incentives to attract health professionals to underserved rural locations. Improvement in compensation for public sector health workers in some countries was being provided in the form of higher allowances; this made it possible to remain within the overall civil service framework. Empowerment of health-care providers through making them responsible for and accountable to patients and communities rather than to a bureaucratic hierarchy was suggested as part of a programme to increase professional satisfaction and reduce 'push' factors. It was thought that promoting a code of ethics should be put on the agenda of countries as well as of bilateral and multilateral organizations. Delinkage of public service providers from the civil service (Zambia) and introduction of recruitment and contracting authority at the local government level (Uganda) were also mentioned. In Kenya, it was observed that terms and conditions of service for public sector health-care personnel were being improved.

## **WORKING GROUPS**

45. Following the plenary sessions on the principal topics, participants broke into working groups to examine potential strategies to address major issues, based on the lessons learned and experiences gained in their own and other countries. On the final day of the consultative meeting, participants again worked in small groups to outline a framework for action that would form the basis for concrete country strategies to be formulated when they returned home. The group work was meant to give participants opportunities for informal contact and exchange among themselves on issues raised in the plenary sessions. The group-work sessions were also intended to assist in the identification of key issues, proposals for action and resources for HRH development in Africa. Plenary reports summarized the work done in the small groups. The results of the group work, and the highlights of the discussions at the plenary presentations of the groups, are taken into account in the thematic segments of the report set out above and especially in the conclusions, recommendations and follow-up at the end of this report.

46. Key observations and proposals made by the working groups are summarized below:

- (a) communication, and communication programmes, form the critical components of any systematic effort to address the issues raised at the Addis Ababa meeting;
- (b) health-care providers were hardly informed, let alone consulted, at the key stages of HSR – conception, implementation, and evaluation;

- (c) lack of synergy between HSR and overall public sector reform programmes created problems for both;
- (d) working group representatives of different categories of the health workforce were needed;
- (e) increasing use of the tools of regulation and accreditation was recommended in exercising the stewardship role of the State;
- (f) best practice documents on reform experiences were widely needed;
- (g) the lack of internal and external review of educational institutions and programmes needed to be addressed;
- (h) use of data for compelling advocacy on HRH issues;
- (i) make HRH a central theme in health sector reform debates;
- (j) establish governance conditions that overcome patronage and nepotism and re-establish equilibrium between urban and rural areas and guarantee suitable working conditions for health workers;
- (k) establish an inter-sectoral working group at the international level to address issues raised at the meeting;
- (l) to ensure an adequate data base and monitoring of follow-up, a task force at the level of the African Region might be helpful.

## **CONCLUSIONS, RECOMMENDATIONS AND FOLLOW-UP**

47. The consultative meeting needs to be understood as the beginning of a much larger and longer process of cooperation and consultation while addressing the critical issues of health workforce that confront Africa today.

### **Concluding plenary meeting**

48. At the concluding plenary session speakers emphasized the importance of follow-up. They recommended that the Addis Ababa meeting should not be treated as an isolated event but as the start of a larger process of new thinking and engagement of many stakeholders to address the issues of the health workforce in Africa that were increasingly developing into a crisis. Representatives from WHO/AFRO, the Rockefeller Foundation, the World Bank and USAID committed their organizations to pursue the meeting's agenda with African countries and other development partners. It was pointed out that country-level stakeholders had been seized of the problem, they were aware that health and health care were produced by the people, and that health sector reforms in Africa had thus far produced only mixed results.

49. It was emphasized that a new vision of the way to improve health in Africa was needed to maintain the values enunciated at Alma-Ata, combined with a rethinking of the modalities of implementation. This would call for much analysis and dialogue, with growing attention being paid to demand variables and to private and NGO providers of health care. Speakers pointed out that

professional communities and networks needed reinforcement and investors in health and health reform needed to recognize and engage themselves on the issues in a long-term perspective of at least a decade. The Chairman strongly urged participants to pursue the issues raised at the meeting upon their return home, with the formulation and implementation of country-specific action agendas.

### **Review of meeting outcomes against objectives**

50. The general objective of the meeting was set as defining strategies for constructive partnerships between the health professions, governments and other relevant stakeholders to improve their contributions to the health sector reform process. Participants made no specific assessment of the accomplishment of this objective. However, their observations and the material on the achievement of the specific objectives set out below permits the conclusion that, overall, this objective was achieved, but that the road ahead is long and difficult and will require persistence and perseverance by all stakeholders.

51. The four specific objectives of the meeting, and the assessments of participants, are reviewed below:

**(a) To review current mechanisms of contributions of health professions to health policy formulation and to the implementation of health sector reform**

52. In the evaluation forms completed at the end of the consultative meeting, seventy-eight per cent of the participants rated achievement of this objective at four or five on a scale of 1-5, 5 being the highest. This was the highest rating given by participants to the achievement of the meeting's objectives. Nonetheless, it was also evident during the meeting that the contributions of the health professions to health policy and health reform in Africa were inadequate. It was probable that this was the case because the mechanisms and the will on the part of stakeholders were themselves inadequate. Despite the elaboration of a paper by Professor Akpo, relatively little information was available at the meeting on existing mechanisms for engagement of the health professions. Further exploration of mechanisms and modalities that have successfully engaged the health professions in the processes and substance of health policy and health reform was desired. The meeting sensitized participants to the need for a greater use of existing mechanisms, for the creation – where needed – of new mechanisms, and for stakeholders to seize the initiative to engage the professions. Documenting of successful experience was strongly recommended.

**(b) To review the relevance and responsiveness of health professional education and training to health needs and health sector reform**

53. Seventy-one per cent of the participants rated achievement of this objective at four or five. The general opinion was that while some progress had been made in making health professional education and training increasingly relevant to health needs, most African countries had a long way to go in this respect. Furthermore, because of the lack of involvement of health educators and trainers in the processes of health policy formulation and definition of health sector reforms, it was widely felt that action was only beginning to be taken to link the substance of education and

training of health professionals in Africa with health reforms. Participants at the meeting strongly endorsed the initiatives taken by the World Federation for Medical Education (WFME) and the *Agence Universitaire de la Francophonie* (AUF) to work with African medical faculties on internal and then external evaluations. It was hoped that this work could be adapted and the approach extended to institutions that train nurses and other health workers. It would also be desirable to ensure that such evaluations made explicit links with the health sector reform processes and agendas. Finally, conceptual and practical linkages were needed between the work undertaken in countries belonging to different language groups.

**(c) To propose human resources management practices that contribute to retention and motivation of health professionals**

54. Fifty-one per cent of the participants rated achievement of this objective at four or five. This was the lowest achievement rating of the meeting objectives. While a large number of possible actions to contribute to the retention and motivation of health professionals was mentioned in the background paper by Dr Dovlo and by various speakers in the plenary sessions and in the working groups, the relatively low rating reflected the difficulty of the problem. It also reflected the widespread sense among participants of a crisis affecting the African health workforce that required actions that went beyond improved health human resource management practices. But this did not absolve the health sector of its responsibility to adopt a proactive approach. Actions at the level of the health sector – and at the level of individual health care facilities - were necessary but not sufficient. Strengthening of the Ministry of Health departments responsible for human resources issues was strongly recommended.

**(d) To propose a draft framework for action on human resources development components for the implementation of health sector reforms**

55. Sixty per cent of the participants rated the achievement of this objective at four or five. This appeared to reflect a feeling among a number of participants of both satisfaction and a desire to be more explicit on this point. It was evident from the country presentations and informal discussions that there was enormous variety and differentiation among country situations. Thus there would be risks involved in proposing a framework for action that would suggest a common set of actions by individual countries. In the circumstances, the following elements of a framework were proposed at the meeting:

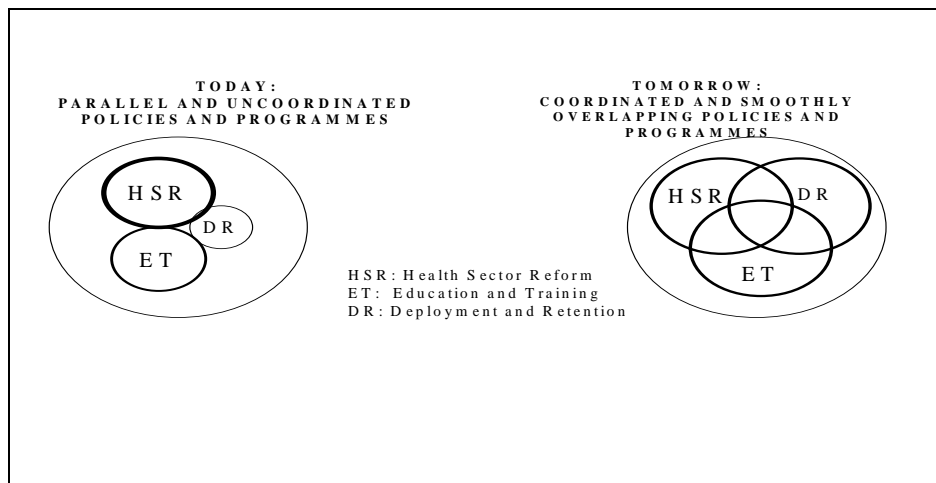
- (a) bring all the interested parties and stakeholders in health professional education and training, in health workforce deployment and retention, and in health sector reforms together in dialogue and debate at the country level;
- (b) undertake country-specific analysis of the health workforce situation so that action is based on evidence rather than only perception;
- (c) act together to ensure that no new programme of health sector reforms is approved without consideration of the education and training of the health workforce and the deployment, management, motivation and retention of health workers;

- (d) organize country-specific mechanisms and modalities that institutionalize contact and collaboration among the stakeholders in health professional education and training, health workforce deployment and retention, and health sector reform;
- (e) create networks of continuing consultation among stakeholders at country and international levels; the contacts made at the Addis Ababa meeting and their addresses in Annex 1 can contribute to further contact and communication;
- (f) begin the work with a forum for the restitution of the Addis Ababa meeting at which participants broaden the dialogue to larger numbers of stakeholders with a briefing and consideration together of next steps at the country level.

**Rethinking the interaction of education, training, deployment and motivation of health professionals with health sector reform in Africa**

56. At the beginning of the meeting, there was a widespread feeling among the organizers and participants that there was little contact and interaction among the people and ideas associated with education and training of the health workforce in Africa, with the deployment, motivation and retention of health professionals, and with health sector reform. Actions in the areas of education and training of health professionals and the deployment, motivation and retention of health workers can contribute to the goals of health sector reform. Therefore, proponents of health sector reform need to ensure that health workforce issues figured prominently in their future agendas. Participants in the meeting developed a vision for the future of a harmonious balance combined with close interaction among these three themes and groups. This is captured in the figure below.

**Health Sector Interaction**



## Future actions

57. An understanding was reached that participants would take the lead in initiating the development of country-specific action plans at the country level. The first step would be to stimulate convening of a meeting of various country-level stakeholders. At this meeting various

### **Chairperson-Senegal Minister of Health on follow-up of Addis Ababa meeting**

*Speaking as Minister of Health of Senegal, the chairperson summarized ten key action points for herself and personally confirmed her intention to pursue the agenda outlined by the participants upon her return home at the level of the government as well as with individual ministers. She urged all participants to undertake advocacy activities at their own level on their return home.*

facets of the crisis of the health workforce would be discussed and an initial agenda for action agreed. Subsequently, a situation analysis may be in order to collect information on the workforce, on health training institutions' outputs, curricula, budgets and financing, etc. It was reported at the meeting that some such studies were planned or were under way. Careful coordination of this work was needed among internal and external

stakeholders. A tool could be prepared to assist in this work in the form of model terms of reference for such studies for subsequent adaptation and application at the country level.<sup>4</sup> Specific action plans would then follow in phases. Financial support for these activities could be mobilized with assistance of the sponsors of the current meeting and other donors. Several country delegations informed the sponsors that they planned to submit proposals for funding.

58. A few possibilities for follow-up at the country level raised by country delegations were the following:

- (a) In Kenya, actions were currently under way to substantially increase the compensation for medical professionals, which should make an important contribution to the resolution of the retention problem. Monitoring and analysis of the impact of these actions in Kenya, for the lessons learned, would be a typical potential follow-up action on the Addis Ababa meeting at the country level.
- (b) In Uganda it might be possible to establish new partnerships on the issues raised at the Addis Ababa meeting with the participation of the Rockefeller Foundation.

59. At the international and regional levels, WHO, the World Bank and UNESCO agreed to establish an African health human resource development task force to assist countries in developing strategies, to monitor actions taken in response to agreements reached, and to facilitate mobilization of funds for the required analytical studies and consensus-building. The many and diverse international and nongovernmental organizations that participated in the meeting were encouraged to disseminate its message within and among their diverse constituencies. The Rockefeller Foundation and USAID agreed to join the international task force and indicated that they might be

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<sup>4</sup>Work on a model scope of work for a country case assessment was initiated with USAID sponsorship after the meeting.

able to provide financial support for work at the country level. The Norwegian Education Trust Fund, managed by the World Bank, was also available for follow-up activities that would bring the education and health sectors together at the country level. WHO/AFRO planned to raise health workforce issues and follow-up on the consultative meeting in appropriate forums. Human resource issues will be put on the agenda of the OAU Ministers of Health meeting and the next WHO/AFRO Regional Committee meeting which brought together African ministers of health.

60. As this report was completed the principal conference sponsors were working out the details of these arrangements and follow-up plans but action at the country level could be initiated independently. WHO country representatives and World Bank local health staff and task managers were available to work on these matters with country delegations who attended the meeting. For long-term investments in curriculum reform and related development of education and training institutions and programmes for health workers, the traditional modality of donor-financed projects could be considered. The World Bank, for example, was financing higher education projects in some African countries, such as Nigeria and Mozambique, with funds for innovation that might be tapped within the framework of follow-up of the present meeting.

61. While it was evident that many different forums and sets of activities were needed at country, regional and international levels to respond to the agenda and vision outlined by the meeting, WHO/AFRO had already established mechanisms that could assist. The WHO/AFRO Multi-Disciplinary Advisory Group of Experts (MAG) on health workforce issues mentioned in the presentation of Dr Gbary provided a fertile environment for discussion. Its next meeting was planned for July 2002. The group, of course, will be briefed on the outcome of the Addis Ababa meeting, and participants in the latter meeting will be informed of the actions taken by the MAG. The Joint Consultative Committee of the East and Southern Africa Health Community (ECSA) also provides a forum that could be useful for dissemination of the messages of the Addis Ababa meeting. The participants and other stakeholders could undoubtedly identify further opportunities. The sponsors are available for consultation and cooperation to make it possible to address the workforce crisis that threatened to undo Africa's health achievements.

## **ANNEXES**

## ANNEX 1

### PARTICIPANTS

Over 70 delegates from 17 African countries attended the meeting. Organized as country teams, they represented the many and highly diverse stakeholders in the inter-related issues discussed at the meeting. Participants included deans of schools of medicine (7) and nursing (4) and senior staff (18) from health professional training institutions in African countries; representatives of associations of health professionals (9); senior officials – including two ministers - of ministries of health (25); representatives of ministries of education (5); and representatives of ministries of planning, finance, local government, and labour, as well as civil service commissions (8). In addition to the major sponsors of the meeting (WHO, the World Bank and UNESCO), several major bilateral partners of African development were represented, who included France, Ireland, Italy, Portugal and USAID. A large number of regional and international organizations interested in human resources for health participated in the meeting. These included the two WHO Collaborating Centres in South Africa (University of South Africa and University of Natal), *Agence Universitaire de la Francophonie* (AUF, Canada), African Association of Medical Schools (South Africa), *the Centre d'Etudes Supérieures Africaines en Gestion* (CESAG, Senegal), the *Institut Régional de Santé Publique* (Benin), the Eastern and Southern Africa Commonwealth Regional Health Community Secretariat (ECSA, Tanzania), the International Confederation of Midwives (Holland), the International Council of Nurses (Switzerland), the International Organization for Migration (IOM), the Organization of African Unity (Ethiopia), the Rockefeller Foundation (United States), the United Nations Joint Programme on AIDS (UNAIDS) and the UN High Commission for Refugees (UNHCR). The list of participants is presented in the table below:

### LIST OF PARTICIPANTS

No.	Name of participant	Designation	Address
1	<b>ALGERIA</b> Mrs Fatima Attoumi Kahla	SAGE-FEMME	Secteur Sanitaire de Bejaia 06000 Tel: 213-34201220 Fax: 213- 34201220
2	Dr Abdelhak Saihi	ENSP Algeria	35320 El Marsa Bordj El Bahri Tel: 00213-21861975 Fax: 0021321862569 E-Mail – <a href="mailto:ensp@ibnsina.ands.dz">ensp@ibnsina.ands.dz</a>
3	Mr Ali Chaouche	Directeur d' Etudes	Ministère de la Santé et de la Population Tel: 0021321279980 Fax: 213 21 279194

4	<b>ANGOLA</b> Honourable Dr A J Hamukwaya	Minister of Health	Ministry of Health, Luanda
5	Dr E J Fresta	Director, HRD MOH	Ministry of Health, Luanda Tel: +39 46 50 or 091 201 435 E-mail: <a href="mailto:Frestang@nelangola.com">Frestang@nelangola.com</a>
6	Mr R V Chipeio	Director of Cabinet	Ministère de la Santé, Luanda
7	Mr Ladislau Gui Iherme	National Association for Nursing	Tel: 092607447 P.O.Box 1201, Luanda
8	Mme Luzizila Helena	Professeur/Directrice	Universidade Agostinho Neto, Luanda Tel: 441898/091212341/091502300, Fax: 370888 E-mail: <a href="mailto:luzinpanda@hotmail.com">luzinpanda@hotmail.com</a>
9	Maria Fernanda Carlos	Secretary, Ministry of Health	Tel: 00244 391281/338052 E-mail: <a href="mailto:gobminsau@smet.co.az">gobminsau@smet.co.az</a>
10	<b>CAMEROON</b> Dr Moampea Mbio.n.c	Directeur des Ressources Humaines	Ministère de la Santé Publique, Yaoundé
11	Professor P. Ndumbe	Dean, Faculty of Medicine	Faculty of Medicine, University of Yaounde P.O.Box 8445, Yaounde Tel: 237-2312051 Fax: 237 2311224 Email: <a href="mailto:pndumbe@yahoo.com">pndumbe@yahoo.com</a> / <a href="mailto:pndombe@inccnet.cm">pndombe@inccnet.cm</a>
12	<b>CHAD</b> Mr Mahamat Adjid Oumar	Directeur de la Planification et de l'Formation	Ministère de la Santé publique BP 440 - NDjaména Tel: 51 58 17 Fax: 51 86 48
13	Mr Ahya Chirere	Directeur Adjoint	Ecole Nationale des Agents sanitaires et sociaux(ENASS) B.P. 418 - NDjaména Tel: 522271
14	Dr Djada Djibrine Atim	Ophtalmologiste et Enseignant	FACSS – Université de NDjaména, E-mail : <a href="mailto:djada@intnet.td">djada@intnet.td</a>
15	Mr Harba Klanus	Directeur du Plan/Economiste	BP 286 - NDjaména Tel: 235 – 51 82 67 Fax: 235 – 51 51 85

**Annex 1**

	<b>CÔTE D'IVOIRE</b>		
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18	Dr Rosalie Assi Gbonon	Directeur de la Pharmacie et du Médicament	BP V 5 Abidjan Tel: (225) 21357313 Fax: (225) 21356958
19	Mr Koffi Kouakou Christophe	Directeur la Programmation et du Contrôle des effectifs	Tel: (225) 20219262 Fax: (225) 20219262 BPV 93 Abidjan
	<b>ETHIOPIA</b>		
20	Dr Adem Ali	President, Medical Association	Tel: 251-1-521776/533742 Fax: 251-1-533742 E-mail: <a href="mailto:ema.emj@telecom.net.et">ema.emj@telecom.net.et</a>
21	Dr Kello Abubaker Bedri	Dean	Faculty of Medicine, Addis Ababa University Tel: 156146 Fax: 525817 E-mail : <a href="mailto:Abubakerbedri@hotmail.com">Abubakerbedri@hotmail.com</a>
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*Annex 1*

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**WORLD HEALTH ORGANIZATION**  
REGIONAL OFFICE FOR AFRICA



**WORLD BANK**  
INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

## **HEALTH WORKER CRISES THREATEN TO UNDERMINE HEALTH IMPROVEMENT IN AFRICA**

Speaker after speaker at a World Health Organization-World Bank meeting that concluded today in Addis Ababa, Ethiopia, drew attention to an emerging crisis of health manpower in Africa. The situation threatens to defeat the efforts of African governments, private health care providers, NGOs, and donors for health improvement. Training programs unsuited to changing health conditions, inadequate cooperation among the many parties concerned, and the losses of staff to opportunities outside Africa risk making Africa's health care facilities barely able to function for lack of qualified, motivated doctors, nurses and other health workers. This situation is made even worse by the AIDS epidemic, which reduces further the availability of trained health workers by staff deaths and increases the demand for care. These were the principal findings at a Consultative meeting on improving collaboration amongst health professionals, government and other stakeholders on health workers issues. The meeting opened on 29 January, with statements by the World Health Organization Regional Director for Africa, Dr Ebrahim Samba and His Excellency, Dr Demmisse Tadesse, Vice Minister of Health of Ethiopia.

The Chairperson of the meeting, Honorable Dr. Marie Coll-Seck, Minister of Health of Senegal, told participants of her personal commitment to ensure that health labor force issues are high on the agenda of her Government. Dr. Samba explained that, while reliable data are extremely hard to obtain, preliminary information available to WHO suggests that there are tens of thousands of African doctors and nurses outside Africa, and more leaving every day, making it increasingly difficult to furnish patient care in African countries. He appealed to African Ministers of Health to take the initiative to address the issue with other members of their Governments, with professional associations of doctors, nurses and other health workers, with private sector health care providers, and with donor countries and institutions. Dr. Ok Pannenberg, Director of the World Bank's work on health in Africa, placed the problem of African doctors and nurses in the global context of an increasingly flexible labor market, which facilitates migration of high level African manpower to other countries. He noted that Uganda was making progress in addressing the problem, and stressed that each country had to find its own solutions.

## *Annex 2*

Meeting participants underscored that doctors, nurses and other health workers who provide patient care are the most important health system input. The consultative meeting found that health sector reform strategies have failed thus far to adequately address this critical health system component. The importance of forming new partnerships between Ministries of Education and Ministries of Health for the education of Africa's future doctors and nurses was stressed by numerous speakers. Action taken in this area by Senegal was highlighted. Appropriate policies and plans to address health workforce problems, such as in Botswana, exist in few African countries. Dramatic events such as the recruitment by a European country of an entire graduating nursing class in one African country exacerbate the problem of staff losses, and add a new sense of urgency. Indeed, without urgent action there is a risk that the moneys soon to be committed in Africa by the new Global Fund to combat AIDS, tuberculosis and malaria will not even have a serious possibility of achieving their goals. Participants at the WHO-World Bank consultation recognized that new funding initiatives such as debt relief through the HIPC (heavily indebted poor countries) program and the global HIV/TB/malaria fund, combined with heightened awareness of the issue amongst Africa's development partners, provide new opportunities to address the health manpower issues in all their various dimensions.

WHO, the World Bank, and other partners (including USAID and the Rockefeller Foundation) have agreed to establish a joint secretariat to support actions by African countries to address the health manpower crisis in Africa. Participants undertook to widen the dialogue on the issues at home, and identified individual, country-specific measures that they could take, including review of training curricula and establishing country-specific benchmarks for fairness in health reform. Decisions on specific actions and the execution of country-specific work programs will take place, with support from the joint secretariat, in the months ahead.

The joint consultative meeting was organized by WHO/AFRO and the World Bank, and co-sponsored by WHO/AFRO, the World Bank and UNESCO, with financial support from the Government of Norway. Participants came from 17 African countries - Algeria, Angola, Cameroon, Chad, Cote d'Ivoire, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Niger, Nigeria, Senegal, South Africa, Tanzania, Uganda and Zimbabwe. Senior officials attended from ministries of health, higher education, labor, planning and finance - giving participants a unique opportunity for consultation across institutional barriers that are frequently difficult to bridge. Health educators were also prominent at the meeting, including deans of medical and nursing schools, and representatives of a wide range of professional and other non-government institutions.

**KEY DOCUMENTS, BACKGROUND MATERIALS AND PRESENTATIONS  
AVAILABLE AT THE WEBSITE OF WHO/AFRO**

Note: In order to limit the length of this report, the materials included in the report are limited. Key background materials cited, *and mentioned in italics*, are being placed on the website of WHO/AFRO (<http://www.afro.who.int>) and can be downloaded from there in their entirety. These materials in italics are *not* included with the report because of their bulk and separate availability on the website of WHO/AFRO.

1. Statements at the opening ceremony
  - *Keynote speech by Dr E. M. Samba, WHO Regional Director for Africa*
  - *Presentation by Dr C. Ok Pannenborg, World Bank Health, Nutrition and Population Sector Leader for Africa*
  
2. Health Sector Reform in Africa
  - *Health Sector Reform: Why? What? How? Professor Gilles Dussault, presentation at the Addis Ababa meeting*
  - *Health Sector Reform Implementation in the African Region, Dr Miguel Kiasekoka, presentation at the Addis Ababa meeting.*
  - *Sector-Wide Approaches in the Context of Health Sector Reform in Uganda, Dr E. M. Kaijuka, presentation at the Addis Ababa meeting*
  - *Reforme hospitaliere, presentation (in French) by Senegal at the Addis Ababa meeting*
  
3. Participation of Health Sector Workers in Health Policy and Health Sector Reform
  - *Professor Cesar Akpo, Participation of Health Workers at the Formulation and Implementation of the Policy of Health Sector Reform*
  
4. Human Resources for Health Development
  - *Adams, Global Overview on Human Resource Development: WHO Perspective,*
  - *R. Gbary, The WHO/AFRO Regional Strategy for Human Resources for Health Development,*
  - *Regional Strategy for the Development of Human Resources for Health, World Health Organization, African Regional Office, September 1998.*

### Annex 3

#### 5. Education and Training of Health Professionals in Africa

- *John H. Bryant, Education and Training of Health Professionals for the Emerging Challenges of Africa*
- *Report of the Consultative Meeting on Nursing and Midwifery Education and Practice in Africa, 3-7 April 2000, Durban, South Africa, WHO/AFRO Division of Health Systems and Human Resources Development.*
- *Dr Boaz L. Mujera Health Sector Reform Policy in Kenya*
- *Professor B. Kouassi, Education et Formation des Professionnels de Sante en Cote d'Ivoire (French)*
- *Politique et Methodologie d'Evaluation des Programmes d'Etudes Medicales et des Facultes de Medecine, (in French) made available at the Addis Ababa meeting (in French) by the Conference Internationale des Doyens de Medecine d'Expression francaise (CIDMEF)*
- *Process for the Evaluation of Health Care Training Programs, WHO/AFRO Division of Health Systems and Services Development, Human Resources Development, no date, processed.*
- *Quality Improvement in Basic Medical Education, WFME International Guidelines, World Federation for Medical Education, University of Copenhagen, Denmark, 2001.*

#### 6. Deployment and Retention of Health Workers and Professionals in Africa

- *Dr Delanyo Y. Dovlo, MD, CH.B, MPH, MWACP, Retention and Deployment of Health Workers and Professionals in Africa January 2002*
- *Dr Delanyo Dovlo, The Retention and Deployment of Health Workers and Professionals in Africa*
- *The Health Sector Human Resource Crisis in Africa: An Issues Paper (DRAFT), USAID, Bureau for Africa, Office of Sustainable Development, November 2001*
- *The Impact of HIV/AIDS on the Health Sector in Sub-Saharan Africa: The Issue of Human Resources (Draft), USAID, Bureau for Africa, Office for Sustainable Development, November 2001*
- *Dr Stephen N. Kinoti, Impact of HIV/AIDS on Health Workforce*
- *Dr Ashraf El Nour, Addressing the Brain Drain in Africa: The IOM Experience*
- *Dr Yaw Antwi-Boasiako, Retention and Motivation of Health Professionals in Ghana*
- *Dr Rose Mdlalose, Motivation, Retention, Deployment, and Brain Drain, Country Experiences – A South African Response*