"TRIPLE C'S IN OSLO"
CONSULTATION, CONSENSUS, AND CALL-FOR-ACTION

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Overcoming the Crisis:
Taking Forward the Abuja Action Agenda
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Introduction

About 130 participants – leaders from Africa, bilateral donors, multilateral agencies, international financial institutions, global funds and initiatives, non-governmental organizations, academia, and professional councils – came together for two days in Oslo to consult on how to overcome the crisis in human resources for health (HRH) in sub-Saharan Africa. Following the Abuja High-Level Forum on the Health-Related MDGs in December and the recently released report of the Joint Learning Initiative, the Oslo consultation aimed to bring together key stakeholders for sparking follow-up action.

NORAD, the Norwegian development assistance agency, hosted and navigated us through a tightly-packed agenda featuring an opening keynote speech by the Norwegian Minister for Development, Hilde Johnson. Assistant Director-General of the WHO, Tim Evans, reminded us of the processes and constituencies that have built up momentum leading to Oslo, and the African health leader, Adetokumbo Lucas of Nigeria, urged the consultation to focus on country action. This opening was followed by panel presentation of three country cases, eight break-out groups, and sessions on fiscal space and the world health report 2006. On the second day, reports from break-out groups were followed by sessions on financing and platforms for action. The expertly-designed agenda moved us steadily through "consultation" towards "consensus," leading to a final "call for action."

In global health, we are experiencing an unprecedented human resources crisis -- leading not just to a health crisis, but also a development crisis, a security crisis, and a moral crisis. The causes are not new but have fresh dimensions – the HIV/AIDS epidemic, global labor markets, and chronic under-investment. And the consequences are complex -- issues of worker shortages and mal-distribution, public sector reform, health sector reform, HIV/AIDS, donor policies, and political governance.

Despite the bewildering complexity and apparent intractability of HRH, Oslo will be remembered as a landmark event that turned the corner from consultation to action. Norwegians, I am told, have a special aptitude for producing harmony from tension; I understand that there is a Norwegian custom to put two contentious people in a row boat until they achieve consensus! I feel that we 130 participants have been on a Soria Moria row boat for two days! And on this Soria Moria, the Norwegians were able to bring together key stakeholders to generate the "triple C's!" – consultation, consensus, and call

for action. Oslo will mark the acceleration of country-led and country-based action, backed by more coherent reinforcement from the regional and global communities. As Hilde Johnson said at last nights's inaugural dinner: "Overcoming the crisis can be done! Overcoming the crisis must be done!"

These are preliminary personal reflections, as more time will be needed to digest the richness of conference deliberations. Hastily presented at the concluding session in Oslo, this synthesis has been subsequently revised. These reflections should be viewed as complementary to official documents coming out of the Oslo Consultation.

Country Action

Adetokombo Lucas set the consultation tone – country first! Human resources problems are brewed and solved within countries, not globally. Importantly, human resources are not the only determinant of good health; policies, priorities, and good governance also matter. In many countries, much HRH activity is well underway. Although the situation differs from country-to-country, case presentations by Yaw Antwi-Boasiako of Ghana, Simon Mitti of Zambia, and Jorge Fernando Manuel Tomo of Mozambique demonstrated remarkable similarities in strategic approach – recruitment to overcome shortages; training of medical assistants to improve skill mix; introduction of monetary incentives to correct for geographic mal-distribution; and retention strategies including welcoming home the diaspora to counter the draining effects of out-migration. In all countries, HRH was recognized as a multi-faceted problem – technical, financial, and political. As underscored by Erasmus Morah of UNAIDS in Malawi, building human resources requires a long-term approach spurred by emergency action in crisis situations.

Action is necessary along several parallel fronts. First is to revitalize education and training for expanding an appropriate pool of human resources. Second is building well-functioning health systems that both depend upon human resources but also support the performance of workers. Third is to harmonize diverse activities, including the public and private sectors and vertical as well as horizontal programs.

Education and training should be urgently accelerated to produce appropriate human resources for health. Although quantification is imprecise, all agree with the diagnosis of massive worker shortages. An ambitious proposal was presented by Barbara Stilwell of WHO recommending a major continent-wide expansion of the workforce. Such education and training, however, must consider dimensions far beyond simply quantitative growth. What type of workers should be prioritized? To this question, conflicting viewpoints were articulated. Some like Eric Buch of NEPAD considered the "massive increase of auxiliary and village health workers … as the single most critical choice for African countries." Others like Bente MacBeath of the Norwegian Red Cross believe that briefly-trained non-exportable workers may not be viable over the long-term. A ministry official from Malawi observed that "village volunteers" failed to take hold in his country. Clearly, an early task of national HRH stakeholders is to gain consensus on the type, number, and quality of workers to be prioritized in education and training.

A well functioning health system is key for enabling health workers to perform effectively. Francis Omaswa of Uganda, S.N. Modukanele of Government of Botswana and Bjorn Foerde of the UNDP in Botswana emphasized the importance of maximizing existing resources rather than excessively concentrating on more money. Such optimization in countries can be enhanced through productive application of sector-wide planning and management, as noted by Jorn Heldrup of Denmark. Performance can be improved through applying best practices achieved through technical exchange and assistance. Dela Devlo of Ghana presented a new initiative called "The Connection" that would network together HRH technical capabilities within and beyond Africa.

HRH should not be viewed separately from health systems performance; all HRH work should be geared to improving health systems outputs and outcomes. After all, as noted by Nils Dulaire of the US Global Health Council (himself a member of the Norwegian diaspora!), many health systems are inefficient because they are actually producing whatever they are structured to produce – often not related to health! Expanding the pool of human resources under such circumstances may simply replicate inefficient practices. That is why "reprogramming" of unspent donor funds or bridging compensation gaps must always be considered as simply one component of broader systems realignment for obtaining greater efficiency, quality, and equity from the workforce.

Harmonization of public and private sectors and vertical and horizontal programs is key in all countries. Managing HRH for health systems performance requires linking strategies to health outputs and outcomes -- monitored by tracking key indicators of HRH performance, as suggested by Neil Squires of the European Commission. And such management must navigate labor markets of both the public and private sectors, including exercising instruments such as information, regulation, and public finance. Several expressed worries about damaging flows across sectors, for example Debbie Palmer of the UK Department for International Development expressed concern over the "leakage" of skilled workers from the public into commercial, NGO, and international jobs. In many countries, non-profit NGOs are of growing importance in advocacy and service provision. HRH work in health systems should explicitly recognize these non-profit actors, providing them policy space and umbrella mechanisms for fostering cooperation.

A challenge for all health systems is how to harmonize vertical-horizontal efforts. Hilde Johnson said at the conference dinner – "vertical no! horizontal yes!" One way forward may be illustrated by GAVI which began investigating "systems constraints" several years ago, and now plans to devote up to 50 percent of its funds for systems-wide improvement. Julia Lob-Lyvt, the director, cited GAVI's plans to set aside operational and innovation funds. David Weakliam of Development Cooperation Ireland suggested that all global initiatives should develop systems-wide goals, align their work to national plans and budgets, finance HRH investments, and develop metrics to monitor their impact on HRH, thereby holding them accountable for developing sustainable HRH systems.

Financing Country-Based Action

Ok Pannonberg of the World Bank presented the cooperative arrangement between his institution and WHO. The joint WHO-Bank proposal attracted some commentaries but did not emerge as a center of gravity of discussions. Ok noted that HRH and health systems reform require cooperation beyond the ministry of health to the ministries of finance, education, and civil service. It is important, also, to adopt a long-term financing perspective; IDA-14, for example, will extend loans and grants for 7-35 years periods. While HRH may be finally gaining recognition by the health community, it has barely emerged on the radar screen of economic policy-makers. Indeed, active resistance may be expected if exceptional budgets are proposed for health. Advocacy must extend beyond health into the broader development community.

Mobilizing the support of financial institutions is critical because of sobering data on overseas development assistance presented by George Scheiber of the World Bank. Although foreign aid shows modest increases, the amount required for achieving the MDGs is nowhere within reach. In crisis countries, moreover, overall health expenditures are increasingly being dominated by foreign aid especially those targeted to single diseases. Equally important are insufficient donor predictability, durability, and sustainability, including failure to provide flexible funds so that countries are able to absorb better external resources. One modality suggested by Hilde Johnson is to develop "medium-term personnel plans," thereby matching medium-term expenditure commitments.

Peter Heller of the International Monetary Fund illustrated the challenge of mobilizing public revenues through time trend data from Ghana, Zambia, and Mozambique. Limited potential exist for expansion of domestic revenue from higher taxes and other fiscal maneuvers. The only viable route for fiscal expansion for HRH is via external grants or concessionary loans, with the attendant dangers of "Dutch disease," appreciation of local currency that affects the balance of trade. Irrespective of the option adopted, priority action should focus on macroeconomic stabilization, fiscal governance, and longer-term reliability of donor funding. This IMF prescription was not left unchallenged. Emily Sikazwe of Women for Change in the Zambia debated that "people are dying," and we face the moral challenge of making excuses for not doing enough. Eric Buch asked whether given this pessimistic fiscal picture, should we publicly admit that the MDGs cannot be reached? On a more positive note, Debbie Palmer complimented the cooperative approach of the IMF in working through the macroeconomics of the ample DFID grant for HRH in Malawi.

A convincing case for exceptionalism for HRH has yet to be made. Indeed, Trond Augdal of NORAD noted that what is "exceptional" is not altogether clear! Is it a health threat like HIV/AIDS? Or exceptional action for the health sector? Or, are we seeking exceptional public financing? Roland Msiska of UNDP in South Africa presented an analytical approach to exceptionality. Clarity is needed on what is exceptional, why

exceptional action is necessary, and what will be the implications of urgent exceptional action on the sustainability of long-term efforts.

The single most important exceptionality is outstanding national leadership! All successful stories are associated with exceptional national leadership. The Zambian presentation showed a political mapping of actors according to institutional power and progressiveness of reform. Interestingly, many actors (including some here in Oslo) are classified as neither progressive nor powerful. Effective champions on HRH and health systems reform in Zambia included some "like-minded donors" (many here), as well as one single "non-likeminded donor" (USAID is also here!).

Call for Action

Oslo achieved consensus that the key to HRH is country-led and country-based action. Much is already going on, but much more and much better are needed. Every encouragement should be offered to accelerate country-based action. These coming months offer a window of opportunity for greatly accelerating progress, noted George Brown of the Rockefeller Foundation. Providing an impetus for followup is the Oslo "Call for Action" concluding statement prepared by an informal group coordinated by Andrew Cassals of the WHO.

Two strategies to support country action, still unresolved, were contrasted. One which I call "country first" argues for nurturing organic processes within countries generating demand for secondary regional and global reinforcement. Another which I call "proactive engagement" argues that regional reinforcement and global support should be urgently augmented as country processes are accelerated or hindered by powerful international forces. Organically grown in-country processes are desirable, but one cannot expect these to be effective in a continent of three dozen countries with varying capabilities; the country cases presented in Oslo were the "usual favorites," which are more likely to launch country initiatives. Country coherence also may be difficult to achieve in some countries confronting a multiplicity of powerful international actors. Proactive engagement can drive an accelerating agenda but carries the risk of heavy-handed interference that fails to build sustainable local capacity. Clearly, space should be created for both approaches, fine-tuning the balance shaped to unique national circumstances.

Enthusiastically endorsed was the concept of "platforms for action" at both the regional and global levels. The regional and global platforms would advance the twin objectives of reinforcing country action while harnessing regional or global resources for international problem-solving.

Attractive to all participants are stronger regional activities in Africa; yet, no single proposal commanded consensus. Based on a recent Abuja workshop, Lola Dare of Nigeria suggested that a regional action-learning network be facilitated by ACOSHED, a health NGO. Eric Buch of NEPAD endorsed an AFRO "HRH observatory," provided

the program is not "ring fenced" and engages a range of African organizations. In addition to "observing," the African observatory should explicitly build capacity in African institutions.

Various donors – Canada, European Union, Germany, Ireland, Netherlands, Sweden, USAID, UNDP, and Rockefeller Foundation – all expressed interest to work with African and global stakeholders to strengthen regional and global platforms. Although Oslo was not billed as a donor pledging meeting, the session on a platform for global action, chaired by Tore Godal, achieved consensus to establish an informal working group for launching an open, inclusive, and participatory platform that would enable existing international organizations and new actors to join together for tackling HRH in health systems. Guidance of platform work would be shared among key stakeholders, reporting perhaps to more democratic political bodies. Operations could be based and facilitated by an existing international body, such as WHO. Rather than debate the structure of the platform, Neil Squires suggested that its form should follow its function, and Eric Buch underscored that the financial and human resources committed to the platform should be adequate to accomplish its mission. Half-way measures compelled by compromises among divergent viewpoints could create an airplane that cannot not fly!

Ultimately, the global platform will perform only as well as the dedication, skill, and motivation of the people it is able to attract. Platforms are not organograms, but the heart and spirit of an endeavor driven by real people contributing blood, sweat, and tears. In generating that spirit of dedication, I call on the key officials here to open platform space to NGOs, academia, and professional groups so that they are able to contribute their maximum potential. Indeed, the vitality of NGOs is absolutely critical for success in a field like HRH. Likewise, I also call upon the NGO community to get behind the global platform, recognizing the pre-eminent role of governmental institutions because HRH depends upon the legitimacy of good governance in democratic societies.

Shaping of the platform has benefited enormously from the wisdom of Adetokumbo Lucas and Tore Godal, two global health leaders who have produced three generations of global institutions. Beginning with the Tropical Disease Program, moving through GAVI and public-private partnerships, this third generation of global institutional arrangement will try to harness the power of existing organizations while promoting the participation of new actors – all within the functional capabilities of existing institutions! The advantage of a platform is its openness, but for it to meet urgent gaps and to exploit emerging opportunities, the platform will need to incentivize the behavior of participants towards synergistic action.

Next Steps

Action emanating from the global platform should be immediate! There is no more time for delay! A small informal working group should get platform activities moving as soon as possible, reporting back to (but not slowed down by) the next High-Level Forum at the end of 2005. In the meantime, several HRH challenges demand urgent attention. The

first is developing practical guidelines for the hemorrhaging of professionals out of Africa, as demanded by health ministers in the May 2004 World Health Assembly. This is a "crisis of globalization," and positive solutions are the responsibility of both the North and South. Another is better harmonization of global initiatives and health systems. GAVI's invitation for developing commonly-shared and jointly-operated harmonization guidelines should be accepted and followed up.

These actions, both immediate as well as long-term, are ultimately based on global solidarity in health, galvanizing our shared commitment for global health equity. And in this case, that solidarity is with and for health workers around the world. Day-in and day-out, millions of health workers toil in dedicated service. We salute the dignity, sacrifice, and nobility of all health workers around the world.

Oslo's triple C's: consultation-consensus-call for action was nurtured through meticulous preparation, smart planning, and perfect execution by our Norwegian hosts. We thank the NORAD staff for this demonstration of Nordic efficiency, hospitality, and generosity. Every event was timely, and every document was immediately reproduced for distribution. The genius behind the Oslo Consultation was Sigrun Mogedal -- who conceived, planned, and directed the entire effort. Heroically and tirelessly, she worked to pull together a truly remarkable event. To Sigrun, we offer our admiration, praise and thanks. As someone who tried to help along the way, I would be happy anytime to share a row boat with Sigrun! Now all of us must work together to implement the call for action on HRH for equitable health and development. Thank you.