Commonwealth Regional Health Community
for East, Central and Southern Africa

REPORT OF THE 38th REGIONAL COMMONWEALTH HEALTH MINISTERS' CONFERENCE

ZAMBEZI SUN, LIVINGSTONE, ZAMBIA.
17 – 21 NOVEMBER 2003.

THEME:

"STRENGTHENING AND SCALING UP HEALTH INTERVENTIONS IN EAST, CENTRAL AND SOUTHERN AFRICA: THE ROLE OF HUMAN RESOURCES".

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Abbreviations.

CRHCS	Commonwealth Regional Health Community Secretariat
ECSA	East, Central and Southern Africa
RHMC	Regional Health Minister's Conference
HRH	Human Resources for Health
HIV	Human Immuno Deficiency Virus
AIDS	Acquired Immune Deficiency
DJCC	Directors Joint Consultative Committee
DG	Director-General
SARA	Support for Research and Analysis in Africa
AED	Academy for Educational Development
USAID	United States Agency for International Development
REDSO	Regional
RD	Regional Director
WHO-AFRO	World Health Organization Africa Regional Office
NCD	Non-Communicable Diseases
UN	United Nations
MDG	Millennium Development Goals
IMF	International Monetary Fund
MMR	Maternal Mortality Ratio
SWAP	Sector Wide Approaches
ITN	Insecticide Treated Nets
ARV	Anti-Retroviral (Drugs)
VCT	Voluntary Counselling and Treatment (Centres)
PMTCT	Prevention of Maternal to Child Transmission
CBD	Community Based Distributors
FP/RH	Family Planning & Reproductive Health
CPR	Contraceptive Prevalence Rate
TFR	Total Fertility Rate
GNP	Gross National Product
RBM	Roll Back Malaria
TB	Tuberculosis
RPF	Regional Pharmaceutical Forum
AHP	Allied Health Professionals
CBO	Community Based Organization
NGO	Non-Governmental Organization
DDT	

EXECUTIVE SUMMARY

The 38th Regional Health Ministers' Conference (RHMC) was successfully hosted and organized by the Ministry of Health, Republic of Zambia from 17-21 November 2003 at Zambezi Sun, Livingstone, Zambia. The Conference was inaugurated by His Honour, The Vice President of the Republic of Zambia, Honourable Dr. Nevers Mumba, MP. It was attended by Health Ministers and delegations comprising senior officials from eleven countries in East, Central and Southern Africa as well as representatives of regional and international organizations and development partners.

Hon. Brig. Gen. Dr. Brian Chituwo, Minister of Health, Republic of Zambia was elected the Conference Chairperson taking over from Hon. Brig.Gen. Jim K. Muhwezi, Minister of Health, Uganda. Hon. Dr. David Parirenyatwa, Minister for Health and Child Welfare, Republic of Zimbabwe was elected the Conference Vice-Chairperson.

Themes and sub-themes

The theme of the 38th RHMC **was "Strengthening and Scaling up Health Interventions in East, Central and Southern Africa: the central role of Human Resources for Health."** The sub-themes included the following:

- Scaling up health interventions
- Health workers and Quality of Health care
- Strategies for improving retention of health workers in ECSA
- Visionary leadership

The conference was organized into eight sessions in which presentations on each of the sub-themes above were made followed by discussions.

Summary of key issues

The conference noted with concern the growing burden of infectious diseases including HIV and AIDS, Tuberculosis, Malaria and other conditions such as non-communicable diseases as well as reproductive health problems. Unfortunately, the region is also facing a human resources for health (HRH) crisis which makes it difficult to adequately address this disease burden.

The human resources for health situation in the region is characterized by the following:

- Inadequate supply of trained health workers

- High levels of attrition of HRH due to the combined effects of illness and death primarily from HIV/AIDS, migration of skilled HRH from the region to developed countries as well as retrenchment and retirement of health workers.

- Ill motivated health workers who are overworked, poorly paid and insufficiently equipped to provide acceptable quality health care
- Poor deployment causing imbalance in the distribution of health workers resulting in fewer workers in rural areas where the majority of the population.

- Inadequate human resource policies on planning and management of HRH.

Recommendations and Resolutions

The Conference resolved that Ministers of Health shall continue to provide leadership in addressing HRH issues in the region. Four priority areas were identified as follows:

- Improve incentives and motivation for health workers.

- Tackle health workforce geographic and skills mix imbalance in order to improve coverage.

- Collect evidence on migration – more knowledge is required on flows and destinations of migrant health workers, monitor recruitment methods and promote ethical recruitment practices.

- Document the impact of HIV and AIDS on the health workforce, develop workplace prevention programmes to protect those uninfected and develop practical strategies for treating those living with HIV/AIDS.

The recommendations were incorporated into the resolutions which were approved and adopted by the Conference of Health Ministers. (Appendix 1).

The Conference was officially closed by Hon. Nalumango, Acting as Minister of Health, Republic of Zambia.

BACKGROUND AND INTRODUCTION

The Conference of Health Ministers provides a forum for Health Ministers, senior health officials and collaborating partners to exchange views and experiences on regional health problems and approaches for addressing them. These forums are held twice a year, one as a side meeting to the World Health Assembly in May and the second full meeting held within the region in November.

The 34th Regional Health Ministers' conference (RHMC) held in Dar es Salaam, Tanzania in October 2001 on the theme "Strengthening Health Systems: Challenges and Priorities in East, Central and Southern Africa", recognized that the key actions to strengthen health systems centred around the stewardship role of government, human resources development and management and provision of quality health care among others. The continuing focus on Human Resources for Health (HRH) and their capacity to support efficient health services delivery for the people of ECSA remains appropriate and relevant.

The Theme of this Conference was thus ***"Strengthening and Scaling up Health Interventions in East, Central and Southern Africa: The Central Role of Human Resources for Health"***.

There is evidence that the ECSA region is experiencing an HRH crisis as a result of limited human resources capacity and ineffective HRH management systems compounded by unprecedented levels of international migration. The expanded disease burden caused by the HIV/AIDS epidemic is also another confounding factor. Measures introduced in some member countries aimed at mitigating the impact of international migration and attrition of HRH have been either ineffective or have had limited impact and sometimes created unforeseen complications. In fact, the weakening HRH status in ECSA threatens to undermine health gains made over the past decades from the health reform processes and programmes such as the Expanded Programme for Immunization (EPI) and Roll Back Malaria. Programmes planned for the future, such as those aimed at expanding the response to the HIV/AIDS pandemic, including increasing access to anti-retroviral treatment are also now threatened by the human resources crisis.

There are often shortages of critical skills in the various disciplines making it difficult to meet the health programme demands. In addition, the ECSA region carries one of the heaviest disease burdens in the world. It is estimated that in some ECSA countries, up to 60% of in-patients in hospitals suffer from HIV/AIDS related illnesses. The prevalence of the infection in the adult populations of member states ranges from 10 to 38 percent. Studies on the impact of HIV/AIDS on the Health Sector are currently being finalized and should reveal, among other things, the magnitude of the HRH crisis in ECSA.

As a result of poor economies and other problems, ECSA member states have been unable to address HRH issues adequately and to avert the looming crisis, whilst on the other hand, the increasing communicable and non-communicable diseases burden demands scaling up of ECSA's response.

The Directors' Joint Consultative Committee (DJCC) meeting held in July 2003 provided a unique forum to share experiences, identify best practices and innovations as well as to establish the critical HRH policy issues that need to be addressed by the Conference of Health Ministers.

These issues and recommendations from the DJCC were presented to the Conference of Health Ministers and were discussed, reviewed and endorsed for action. A number of presentations were made in 6 technical sessions covering a range of issues related to strengthening Human Resources for Health in ECSA, including the disease and health conditions facing the region, scaling up health interventions for HIV/AIDS and other communicable diseases and sustaining the health systems through capacity building and motivation of health workers.

The 7th and 8th Sessions reviewed past resolutions and recommendations and decided on a new set of recommendations and resolutions.

The 38th Regional Health Ministers Conference ended with adoption of resolutions and recommendations for further action.

Hon. Brig. Gen. Dr. Brian Chituwo, Minister of Health, Zambia was elected Conference Chairperson. He took over from Hon. Brig. Jim Muhwezi, Minister of Health Uganda. The 38th Regional Health Ministers Conference was facilitated by Dr. Delanyo Dovlo and Mr. Ummuro Adano, Consultants to the ECSA Regional Health Community Secretariat with assistance of the Regional Secretary – Dr. Steven Shongwe and staff of the CRHCS.

The following report is a summary of presentations and discussions made at the 38th Regional Health Ministers Conference. It also presents the resolutions and recommendations arising from the meeting. The complete set of presentations and papers are available separately from the Commonwealth Regional Health Community Secretariat for East, Central and Southern Africa.

OFFICIAL OPENING

Summary of Remarks:
Dr. Ben Chirwa, DG of Central Board of Health, Zambia, directed the opening ceremonies with m*usical Interludes by Student Nurses from Livingstone Nursing College and a Cultural Troupe.*

Welcome by Hon. Mr. Frederick Mwendapole, Mayor of Livingstone.
The mayor remarked that Livingstone was the tourism Capital of Zambia, with a preserved natural environment. Livingstone was privileged to host the meeting and guests were welcomed to become ambassadors of the beauty of Livingstone to their respective countries.

Remarks by Hon. Chilufya Kazanene, Deputy Minister, Southern Province, Zambia.
Delegates feedback from conference that should include information on Livingstone and Victoria Falls. Many health problems existing in the ECSA region but which hopefully, can be dealt with by utilizing a multi-dimensional approach.

Remarks by Dr. Steven V. Shongwe, Regional Secretary, CRHCS-ECSA
Dr. Shongwe gave a warm welcome to the Vice President of Zambia. He and the people of Zambia were thanked for gracing the occasion and for the excellent location and arrangements made for the conference. The CRH Community was a family with similar health challenges which should be met with a unity of purpose. This conference of health ministers is the highest policy making body of the CRHC and allows ministers to share experiences and best practices and this serves to guide the CRHC Secretariat's programmes through its resolutions and recommendations. Thus the CRHC Secretariat is owned by member countries and is directly responsible to the Ministers of Health.

The theme of the conference (“**Strengthening and Scaling up Health Interventions in East, Central and Southern Africa: the Role of HUMAN RESOURCES FOR HEALTH**”*) reflected the shortages of all types of health workers leading to unacceptable health indicators such as high Infant (IMR) and Maternal Mortality rates (MMR) in the region. Whatever interventions needed to scale up health in the region would depend on Human Resources (HR) and would be directly influenced by the shortages of health workers being experienced by member countries. Hence there was a need for HR to be high on the Health Community's agenda. The Conference would discuss migration and brain drain, review the impact of HIV/AIDS on health workers in Kenya and Malawi, and discuss the resolutions and recommendations of the 36th meeting of Health Ministers in Entebbe in 2002. There was a need to report back on the resolutions; and there was a need to develop monitoring indicators to be able to overcome constraints.*

Dr. Shongwe expressed thanks to the current and outgoing Chairman Hon. Brig. Jim Muhwezi and the incoming one – Brig. Brian Chituwo was welcomed. The support of cooperating agencies and partners were appreciated by name and especially USAID REDSO for its core financial support to the Health Community.

Remarks by Dr. Andy Sisson, Regional Director, USAID-REDSO
Dr. Sisson noted that the meeting dealt with a most important topic especially as during the past decade HIVAIDS had intensified the HR problem and eroded gains made in health. He further noted that "HIVAIDS is particularly devastating on this continent". Indeed two health programme officers in the USAID Office of one country had recently died. HIVAIDS contributes to a fifth of health burden on this continent. Health sector systems need to be strengthened and a key area for this is in HR development. All health sector strategies need to address HRH covering recruitment, expansion in skills of Health Workers, addressing productivity and finally retention and the brain drain including morale and motivation. This requires strong leadership of Ministries and Ministers of Health and a need to develop a conducive environment to support, strengthen and nurture for HRH towards the goal of mitigating HIVAIDS and providing health services to our populations.

Remarks by Dr. Rufaro Chatora, Director – Division of Health Systems & Services Development, (Representing the WHO-AFRO Regional Director)
Reported that the Regional Director was at the time in Ghana for the Executive Committee meeting, the first of its kind to be held in Africa. He reiterated that even for the Ghana meeting the issue of HRH was high on the agenda.

Dr Chatora read the RD's message.

The HRH Crisis in Africa is different from other health problems as it strikes at the heart of health systems. Health Workers also have influence on how the other resources for service delivery are utilized and thus are core to the very existence of health services. Africa has to move beyond talking to taking ACTION as individual countries, regions and with our partners, recognising our interdependence. HR must be tackled comprehensively and not one at a time. HRH has three sides – Policy Planning, Development and Training, Staff management and motivation. All three must remain at the heart of HRH efforts. There is a need to take care of both professional and personal needs of Health Workers including paying a "living Wage". There is also the need to coordinate the various arms of government that influence HRH issues (MO Higher Education, Planning etc).

The Regional Director hoped that discussions at the conference would bring up ideas on how best to move forward. Health Ministers must seize the leadership occasion to steer their countries in the direction of good health development and policies through appropriate strategic management. Ministers should seek the ear of their Heads of State in all such policies. The RD reaffirmed WHO-AFROs commitment to working with the CRHC in attaining health.

Remarks by Hon. Brig. Jim Muhwezi, Conference Chairperson & Minister of Health, Uganda.: *The Chairman thanked the Vice President of Zambia for his presence at the conference and also the Government of Zambia and the Ministry of Health for their hospitality. He noted that "Health knows no boundaries and the partners agree that*

there is value in tackling the various health challenges of the region together". He re-emphasised the conference theme as an appropriate one and emphasised the need to use the forum to analyse and discuss and understand full ramifications of full policy options to mitigate the challenges faced.

2003 saw an exercise on Institutional review of CHRCS finalised and this helped to chart the future direction of CHRCS. He thanked the Task force for a detailed and thorough job. Members of Advisory Committee and the Regional Secretary and staff gave input into final report and provided logistic support. The strategic plan review of the organization brought on board new areas such as health financing, NCDs and the neglected communicable diseases. He praised the secretariat for its good management practice and style. The chairman re-emphasised the importance of the organization and regretted the continued absence of South Africa, Botswana and Namibia. He hoped that the incoming chairman would continue to explore means of bringing them back into the fold.

Remarks by Hon. Brig. Gen. Dr. Brian Chituwo, Minister of Health, Zambia.
The Minister thanked out-going chairman Brig. Jim Muhwezi for work in developing programmes for the CRHC. He noted that countries in ECSA share common health problems and there was a need to share common strategies and plans to resolve the issues. He welcomed the delegates to Zambia and Livingstone.

Inaugural Address by His Honour Dr Nevers Mumba, MP, Vice-President of Zambia.
The Vice-President welcomed all delegates and encouraged them to enjoy the hospitality of Zambia. This meeting afforded an opportunity to put heads together to resolve the huge health problems facing ECSA. Advances in transport and communications have made diseases transmission much wider and hence the need for regional togetherness in meeting the challenges. Health must be considered beyond the public sector alone and should involve private and other stakeholders. The Vice-President expressed his confidence that the forum will discuss health concerns adequately so as to reduce the burden of disease among people. This if successful, will power development of the region.

The high levels of poverty in the ECSA region creates high attrition of Health Workers and pits the diminishing state resources against ever increasing demands by other social sectors. The skilled personnel in the region are too few to meet the high demand for services with a resulting overload and poor delivery of services. The region needs to join hands together to meet its HR needs. Specific programmes need to be developed and aimed at supporting and caring for health staff.

The Vice-President's wish was that the meeting would come with recommendations to governments on how to make policies and create changes to the health of their populations. People were waiting to hear what the leaders gathered in Livingstone will come up with. So were the Heads of States.

The heavy migration of HRH from the ECSA region was because it was predominantly English speaking. The Code of Ethical Recruitment developed by the Commonwealth Secretariat is not binding and thus is not the fool-proof solution. The forum should come up with more tangible strategies. There was a need for systems to care for the carers. A number of declarations have been endorsed by heads of state – Abuja, UN declaration on HIVAIDS, Children Summit declaration and all these have major HR implications.

The Millennium Development Goals (MDGs) have 3 out of the 8 goals being health related and countries need to strengthen HR in order to address these goals. The Vice-President ended by enunciating some of the steps Zambia had taken in this area and formally declared the conference officially opened.

SESSION 1: BACKGROUND OF HRH CRISIS IN ECSA

Presentation 1: Conference Theme, Sub-Themes and Objectives Dr. S. Shongwe, Regional Secretary, CRHCS/ECSA

The theme of the Health Minister's Conference once again highlighted the need for strengthening health systems and HR in particular, in order for health interventions to work in the region. The main theme was – **"Strengthening and Scaling up Health Interventions in East, Central and Southern Africa: the Role of HUMAN RESOURCES FOR HEALTH".**

Four sub-themes were enunciated as –

1. Scaling up health interventions
2. Improving quality of care
3. Strategies for improving Recruitment, Retention and Deployment of Health Workers
4. Leadership

These sub-themes would be covered in 8 sessions along with a review of previous resolutions and progress made on them. There would also be the review, approval and adoption of recommendations and resolutions arising from the current meeting. The Regional Secretary also proposed the methodology for the meeting comprising presentations by Experts and Ministers and discussions in plenary. The conference also had two facilitators to provide technical input and to advise the discussions.

The Keynote Address:

Strengthening and Scaling Up health Interventions in ECSA: The Central Role of HRH. Dr. Delanyo Dovlo

The keynote address, as an overview to the Human Resources crisis in ECSA and Africa, covered three main areas. These were-

[*a]* *The Health Crisis in Africa* represented by reverses in health indicators and increased burden of diseases. Africa shares 26% of the world's burden of

disease though it has only about 10% of its population. Dr. Dovlo outlined 4 broad challenges to HRH in Africa including the following:-

(i) Retention, Deployment and Utility of Health Workers
(ii) Managing Retention and Migration of health professionals,
(iii) Respecting & Valuing the African Health Worker,
(vi) HIV and AIDS and its impact on the health workforce.

[*b]* *Six Key Strategic Options* arising from Experiences were described:

(i) Strengthening HR Policy and Planning systems,
(ii) Proper management of recruitment, retention and migration,
(iii) Improved HR management and administration, reducing bureaucracy.
(iv) Modifying health worker education and scopes of practice and skills,
(v) Utilizing the new donor aid instruments to support HRH.
(vi) Using regional and Inter-country collaboration and agreements to share resources and experiences.

[*c]* *Conclusions and Recommendations* which require that HR polices and plans answer the following questions –

- *What can a country afford?*
- *Which cadres are most cost-effective and efficient?*
- *What staff types will best address our health needs?*
- *What skills will be most required? and*
- *How can we supervise & maintain quality & standards?*
- *What new ideas and innovations are needed?*

The presentation ended with recommendations for a 4-step process that countries can use to work towards resolving HRH issues. These steps consist of the following:

1: Research, Information and Data collection
2: Undertake all inclusive stakeholder consultations and strategic reviews
3: Detailed Strategic Planning of HRH based on strategic policy options.
4: Implementation Plans and Actions

Presentation 3: Scaling Up Interventions: The Zambian Experience.
Hon. Brig. Gen. Dr. B. Chituwo, Minister of Health, Zambia

The Zambian health sector experience was presented and covered the need for decentralization which was seen as important for moving the health sector forward. The challenges Zambia faced included:-

- *The HIV/AIDS pandemic with 16% adult sero-prevalence rate.*
- *Increased incidence of Malaria, TB, high malnutrition levels, etc*
- *A doctor to Population ration of about 1:14000, nurses 1:1000.*
- *Health Indicators: though improvements, Zambia still has very high maternal mortality rates.*

- *SWAP: Basket funding to be extended to support all aspects of district including hospitals.*
- *Insecticide Treated Nets (ITN) – coverage rates still very low at 27%*
- *HIV/AIDS programmes – there is need for a multi-sectoral approach. Zambia determined a need for an institution - the National HIVAIDS Council. There are plans to improve access to ARV for 10,000 patients initially. VCT now scaled up to 106 sites in all 72 districts and PMTCT 74 sites in all 8 districts, 7 provinces*
- *Introduction of rural incentive schemes for doctors. (Nurses and others to follow).*
- *Hospitals with Nursing Training Colleges now bonding nurses;*
- *Increased training of auxiliary staff in invasive procedures and expanding scope of practice,*
- *Introduction of "part-time" arrangements and strengthened in-service training for nurses.*

HRH – Zambia started a policy of recruitment of doctors from friendly countries. There are also incentive schemes for local staff including a car loan scheme, (not discriminatory though salary levels may cause problems with payment), Selling of government housing stocks to sitting tenants, transformation of Enrolled Nurse schools into Registered Nurse schools (Zambia realised this was a mistake and has now stopped).

Zambia is now training "Medical Licentiates" who shall take up some physician roles.

Points from Discussions.
Ugandan perspectives: *International partners have sometimes enhanced the HRH crisis through Structural Adjustment and World Bank dictum of embargoes on recruitment. Divesting government housing has caused more difficulties with placing staff in certain areas and services because of lack of accommodation. Consolidation of pay packages meant the incentives created to individuals by specific allowances was lost.*

Macro-economic policies forced on countries seem to support underpaying staff and has created an internal brain drain, with nurses leaving to go into market trading. University students are no longer keen on training in medicine and whilst workloads are high, only some 30% of work is being done productively. Uganda's previous success with HR now has a new development, the health workers are stronger and are now engaging the government in threatening a strike.

A single spine salary structure evolved for Public Service is creating tensions with health workers who feel job evaluations carried out did not grade Health Workers roles adequately.

Kenya has proposed a "Health Service Commission" in the new constitution which is being developed. The idea is to de-link health services and providers from the Civil Services. What are the experiences of countries that have implemented de-linkage and how beneficial has these been? We need to investigate the impact of de-linked health sectors on services and how this stimulates health worker motivation.

HRH Development and Management is a complicated and difficult process that must be well coordinated and orchestrated to avoid interventions at one end that produce problems of another sort elsewhere. The diverse interests that influence HRH must be managed using dialogue and negotiations backed by strong evidence of what works. There is need for sensitivity when handling changes in the systems and this must involve a "give and take" situation with stakeholders.

The HRMC must make concrete resolutions aimed at definite actions. There should be adequate research, advice and development of standardised approaches to issues such as health service de-linkage to inform countries.

HR problems continue in the countries – Zimbabwe's doctors, now on Z$1.5m per month are now asking for Z$30m. Basic PHC Nurses (enrolled category) in Zimbabwe recently are being recruited for old peoples' homes meaning the brain drain is affecting these cadres as well. Agreements with the developed countries are necessary and should be pursued with more vigour.

Is it possible in face of vacancies in rural areas to use the unpaid salaries to top up the wages of the few persons working there?

Lesotho has had no previous experience of clinical officers. The Minister's recent visit to Malawi provided the experience of a 200 bed hospital with 1 doctor and several Clinical Officers which was running very well which gave an insight into what Lesotho could do. The abolishing enrolled nurse training in Lesotho is now much regretted given the severe shortages.

The discussions have not mentioned the community level worker as an HR intervention. These have contributed a lot to care in Lesotho in assisted the MOH in reaching 86% coverage of immunization. The role of traditional healers as care givers also needs to be explored.

Main themes arising from other comments:

- *There is a need to review the abolishing of enrolled nurse training and to re-establish the courses. The region needs them very much.*
- *Experiences gained by countries in the region should be recorded carefully, documented and shared. Examples are – the use of clinical officers, De-linkage of health services from civil services etc.,.*
- *Capacity should be strengthened to negotiate and reach agreements with the developed countries that take the bulk of staff through migration. The "code of ethics" alone is ineffective.*
- *Development Aid from Health sector partners should now include specific proportions aimed at strengthening Human Resources retention.*
- *There should be a more comprehensive approach to strengthening HRH and not the current piecemeal solutions.*

- *De-Linkage of Health Services from Civil service (Health Service Commissions) is an important move and experiences of countries such as Uganda, Zambia and Ghana that have implemented these should be reviewed to find standardised ways for countries in the region.*
- *Regular critical reviews and situation analyses is needed to identify and monitor implementation of the actual needs of human resources.*
- *Countries in the region are facing common problems and should come together to develop home-grown solutions.*
- *Motivation and retention of HRH is an area that member states need to work very hard on.*

SESSION 2: THE IMPACT OF HIV/AIDS ON THE HEALTH WORKFORCE

Presentation 1: An Overview - Prof. SN Kinoti

Prof. *Kinoti remarked that the years 2003-2004 provided a narrow window of opportunity for action on HRH Development especially with the Heads of State declaration of 2004 as Year of Human Resources in Africa and increased international activity on the subject.*

HIVAIDS related demand on the health sector's human resources arises from an increased demand for services which in turn is causing a crowding out non-HIV patients from services, with increased personnel needs in peripheral facilities and quickly worsening health indicators. The effect of the epidemic on health workers includes:-

- *Reductions in Health Worker stock*
- *Reductions in productivity possibly arising from burnout.*
- *Senior level programme managers are being lost*
- *Reductions in entrants into workforce at the training institutions*
- *A real and perceived risk of work based infections.*
- *Some recent data appears to make the additional risk to health workers quite real. Sero-conversion is 15 times higher in surgeons in Africa than in the developed world.*
- *There is debate that sexual transmission alone may not explain hiv infections in Africa (are the conditions in our health systems contributing?)*
- *% of Health Workers with AIDS is rising in Botswana.*
- *20% of health workers in Malawi may die from HIVAIDS.*
- *Staff preparedness: 46% of staff sampled in one hospital – had no education on HIV & AIDS, no counselling skills in HIVAIDS, 40% of doctors in Uganda never talk to patients about HIVAIDS.*
- *There is need to develop costed plans with implications of what delivering full package of HIVAIDS interventions will entail. Countries like Botswana now doing something about this.*
- *Other skills are also needed such as for laboratory testing; counselling.*

- *Workplace prevention programmes are worthwhile and must be introduced. HIVAIDS doubled deaths in workforce in Uganda. In Zimbabwe absenteeism contributed about 40% of costs.*
- *Health Sector Reforms – integrating HIVAIDS into reproductive health services may be useful as 30 yrs of family planning etc has left good infrastructure and services that can be tagged unto.*

Points from Discussions:
Is community based care cheaper or more expensive in terms of the cost of travelling to reach clients in communities? There is a need for further studies to clarify this issue.

The reductions in frontline workers that occurred through abolishing enrolled nurses in some countries etc were now being felt.

The Global HIV/AIDS funding agencies must be influenced to support HRH initiatives. There is a need for each country to make assessments that determine the impact of HIV/AIDS on supply and demand of HRH including quantifying, planning and implementing actions.

The Ministers should be advocates and use the available data to build national stakeholder consensus, support development of innovations, monitor and implement actions.

Presentation 2: Assessment of the Impact of HIV/AIDS on Health Workforce in Malawi - Dr. A. Gonani

Dr. Gonani presented the preliminary results of a study on the impact of HIV & AIDS on the workforce in Malawi. The study was to assess attrition of health workers due to the HIVAIDS epidemic. The study had difficulties getting data on staff numbers and determining full-time equivalences.

A sample of core data presented included:-

- *National adult HIV prevalence rate is 15%*
- *500,000 deaths have occurred in Malawi from AIDS.*
- *2000 HW in MOPH living with HIV & AIDS. This accounts for a high percentage of admissions and increased average bed occupancy of 119%, which adds to workload. The death rate across cadres is 2.2%. Care Assistants show highest death rates at 5%. The 30-39 age group shows highest death rates.*
- *Only 2 % of Health Workers have been tested and counselled.*
- *A rise in resignation and retirement and shifts into non-health work has been noticed.*
- *Absenteeism is mostly among female health workers (carers at home?) and averages 1-5 days with workers ages 25-39 being the highest absentees*
- *The reasons include personal illness, nursing ill spouse or child, also funeral attendance. Funerals account for 18% of absenteeism.*
- *Only 4% of eligible health workers are trained in VCT,*

- *Fear of infection, low remuneration and poor working conditions contribute to the loss of staff.*

Presentation 3: Assessment of the Impact of HIV/AIDS on Health Workforce in Kenya, Mr. B. K. Cheluget

The Kenya study also presented its preliminary results. Before the HIV epidemic, Kenya was clearly improving its health systems '88, '93 ' 99 morbidity and mortality figures showed improvements.

Key Issues Raised:

Sero-prevalence is currently at 9.4%, (urban prevalence 13.8%). Health worker estimates indicate some 3500 are infected and the results show increases in hospital admissions over past few years from 2500 in 1996 to 3500 in 2002 in the selected hospitals. Only 9% of hospital admissions were tested of which 90% were HIV+.

Some Malawi Workload determinants.

Intervention	*No of Staff*	*Average number of Clients*	*Ratio of provider to Client*
VCT	*32*	*1116*	*1:349*
PMTCT	*14*	*784*	*1:560*
HBC	*6*	*100*	*1:166*
STI	*37*	*235*	*1:64*
TB	*21*	*420*	*1:200*
ARV	*2*	*20*	*1:100*

VCT: for example, Health Worker to client ratio is 1:349 per month though the estimated ideal should be 1:150

Non-Death Attrition of health workers

Intervention	*No of Staff*	*Average number of Clients*	*Ratio of provider to Client*
VCT	*32*	*1116*	*1:349*
PMTCT	*14*	*784*	*1:560*
HBC	*6*	*100*	*1:166*
STI	*37*	*235*	*1:64*
TB	*21*	*420*	*1:200*
ARV	*2*	*20*	*1:100*

Retrenchment encouraged by World Bank has not helped the situation. The leading cause of attrition among health workers is death at 31.4%. HIV aids related deaths constituted 52% of Health Worker deaths that had their causes determined. Nurses were highest at death rates of 10% of total. Only 8% of deaths were tested for HIV/AIDS and of these 80% were positive.

Absenteeism, caused by personal illness is a major problem. The 2nd highest reason is attendance of funerals. Vacancies levels have remained constant for doctors for past 5 years despite training supply and these must be related to the increased workload discussed earlier.

Main Discussion Points.

Is there an increased risk to health workers or simply a reflection of the level of infection in the community? Care must be taken not to instil unnecessary fear among health workers.

The "call" to become a health worker is no longer there and fewer people coming into the professions are there with a feel for the job.

ARV treatment is important as a public health need to "hit the reservoir" and reduce viral loads. Previous African suggestions of ARV intervention made to donors were actively discouraged. Treatment serves both a preventive as well as curative measure and assists to protect the community. There is need to be more aggressive with this epidemic. HIV-AIDS is creating a lack of social support by destroying families and creating orphans which may contributes to the region's social crisis and wars.

We must consider ourselves as "commanders" in this war for health and on HIV/AIDS with the "troops" dying in the field. What are we doing about it?

We must not come out of this conference giving an impression that we are losing the war. We need to spend more on the health worker for him/her to survive.

Clearly the attrition rate of health workers is too high, the working environment is not conducive– the troops are getting fed-up and leaving the service (or either retiring or being absent from work frequently.

There are ethical issues that should be tackled squarely;
Health Workers are precious and this conference needs to take major decisions about how to conserve them.

Chairman of sub-Session – Hon. Dr. M. Phooko, Minister of Health and Social Welfare, Lesotho

Presentation 4: Human Capacity Development for Effective Response to *HIV/AIDS.* Mr. Ummuro Adano

The presentation discussed a framework for human capacity development (HCD) created by the MSD project that is helping to bring interested parties together beyond the Health sector. HCD involves "developing the will, skills, abilities and Human Resource systems to respond effectively to HIV/AIDS and other health concerns".

The Goal of HCD (Human Capacity Development) is to "strengthen the ability of the workforce and communities to lead, plan, implement, and monitor, its interventions. This makes HCD a much more comprehensive strategy encompassing HRH development. Human Resource Management is a key ingredient and building block for developing HCD in a comprehensive way.

4 components of HCD mentioned are:-

- *Legal, policy and financial requirements – civil service reform, health sector reform, personnel mgmt rules and resources allocations.*
- *HR Management Systems - Trained and experienced hr managers and staff. HR planning and data systems, good recruitment/retention strategies; and appropriate compensation policies*
- *Leadership: Visionary leadership to address local and global implications of interventions at all levels! It includes critical workplace behaviours of managers show they value people and performance.*
- *Partnerships – linkages with Private Sector and civil society groups, empowered community networks, linkages to service provision, resource allocation and policy development.*

An overarching need in countries is to look at issues of poverty and how this relates to treatment with ARVs (Will a hungry client benefit from ARVs?).

3 spheres of action are necessary, i.e, Individuals, their families; the community.
Requirements for success must include mobilising resources and policies and providing sustained leadership and multi-stakeholder involvement. The session ended with key questions designed to focus on developing clear leadership intentions.

The critical insights include:
The need for vision and leadership at all levels; This means creating support for health workers through changing the organizational environment within which they work, especially as we want foster scaling up of interventions. The climate at the workplace must change

Presentation 5: Leadership in the Health Sector – NEPAD Perspective. Prof. E. Buch

Africa Union's NEPAD Initiative provides a vision for revitalising the continent's development. It represents a declaration of the need for bold and imaginative leadership. The key leadership challenge facing NEPAD is resources and the $42bn shortage from what is required to achieve sustainable health development on the continent.

Strong leadership is required in meeting some the targets of the declarations such as the Abuja Declaration aimed at increasing expenditure on health to 15% of country budgets.

Health Ministers can also show leadership by inviting the NEPAD peer review mechanism to help ascertain whether countries are achieving what they really could with the resources available.

A "Reality Check" is that we have to work harder to show that even with the current resources available, we are achieving the optimum with these despite the remaining shortfalls.

The industrialized countries appear content to continue bleeding Africa of its human resources in health. But we also need to find ways to evolve a cadre of Health Workers who are motivated and have a caring ethos, ***Ministers must be out there personally, visiting and motivating their staff in rural areas.***

Issues raised include:-*:*

- *Ensuring relevance of training curricula to service needs*
- *Developing a pool of African experts whose skills are embedded in local experience.*
- *Rebuild and strengthen centres of excellence to be shared in the region.*
- *Addressing HRH alone will not help but this must be linked with strengthening health systems as a whole – (there is no point in having health workers without drugs and logistics to perform with).*
- *The regional Commonwealth countries are a grouping which is in a unique position to unite in dialogue with the developed countries that take most of their staff.*
- *Ministers could support NEPAD by taking its Health Strategy to the World Health Assembly.*
- *Leadership is needed in expanding cooperation in areas of common concern – eg; drugs registration and quality assurance,*
- *The ultimate evidence of leadership is to show success!*

Discussion Points:
Are we about to see history repeat itself? Tanzania articulated a health policy and an HRH policy but Development partners were only ready to support overall health policy but not HRH. Has the situation changed?

SESSION 3: SCALING UP HEALTH INTERVENTIONS: HUMAN RESOURCES IMPLICATIONS.

Presentation 1: The HIV/AIDS Treatment Emergency: Achieving the 3 Million Target by 2005. Dr M. Banda, WHO

Dr Banda presented on WHO's "3 by 5" INITIATIVE aimed at people living with HIV-AIDS: In Africa, 75000 people are estimated to be on ARV treatment currently and this constitutes just about 2% of people estimated to be needing treatment. This is an emergency which must be resolved to create a balance between our treatment and prevention measures to complement each other. The target of "3by5" is to provide treatment to at least half of the people needing it (the about 3 million people needing treatment) by 2005. This gap was declared a global health emergency by UNAIDS and WHO this year and ECSA's citizens constitute some 50% of the being people targeted as requiring treatment

A 2-pronged strategy has been adopted involving well planned responses to epidemic and development of simplified guidelines and procedures for scaling up treatment with ARV.

Key elements also included:

- *Policy and financial commitments by a, countries, b, international arena*
- *Coordination and leadership mechanisms*
- *Ascertaining continuous availability of treatment and ARV,*
- *Capacity/capability of the health services*
- *Monitoring, evaluation and operations research*

The next steps proposed included –
A release of the new strategy and next steps on World Aids Day and creating linkages and coordinating with various partners. The WHO Missions in the countries will have important roles to play in implementation support and follow up. Further information will be available in the World Health Report 2004

Presentation 2: Expanding PMTCT Services. Ms. Nomajoni Ntombela

The presentation described issues related to mother and child transmission of HIV/AIDS and the HRH implications. Some statistics were provided including the fact that HIV/AIDS now accounts for 7.7% of all children deaths in sub-saharan Africa and this represents a clear need for political support in order to be able to meet the Millennium Development Goals

Lessons learned from pilot studies show that the proposed interventions are viable and should be expanded to meet a wider clientele. It is proposed to use a 4 – prong approach including HR needs determination and a PMTCT plan and its implementation.

The presenter suggests that PMTCT could catalyse changes in health systems especially in strengthening clinical health aspects as an entry point. There is need for a firm strategy, planning and implementation to achieve the objectives.

Main Discussion Points:
Zimbabwe disclosed the country's local production of generic ARV which it is hoped will create opportunities for other countries in the region.

The terminology used on orphans from aids was discussed – use of the term "children orphaned by aids" is preferred to "AIDS orphans.

We have to be careful so that the HR capacity limitations the region faces does not becomes an absolute conditionality for introduction of ARV.

Are there specific HRH plans to create the capacity that will be required for WHO's 3x5 strategy?

All technical programmes lay claims to being a channel for strengthening health systems, and this may rather lead to new vertical systems strengthening. There is need to develop indicators to monitor health systems performance and improvements that arise from projects. The WHO is developing guidelines to assist countries to plan how to scaling up ARVs.

Presentation 3: Access to Reproductive Health Services with Special Focus on FP: Hon. Dr. D. Parirenyatwa, Minister of Health and Child Welfare, Zimbabwe
Family planning in Zimbabwe was in the past vertical and not well integrated. Specialised cadres were even created to deliver services. Certain HRH Implications now arise concerning family planning services which includes-

- *Increased demand for services in relation to Health Worker numbers ,*
- *A need for "skills diversification" to enable staff to take on additional tasks*
- *In-Service and on-the job training systems needs have become paramount.*
- *Incorporation of FP into the pre-service curricula is needed for all core health professionals.*

The challenges to meeting family planning objectives in Zimbabwe include:-

- *The Brain Drain – internal and international*
- *Increasing disease burden,*
- *New settlement areas arising from the land reforms and peri-urban communities which have limited access to services.*
- *Continuing effects of poverty and the need for empowerment of women,*

The country has coped mainly through using community based distributors (CBD), and utilising village health workers in its programmes.

Presentation 4: Improving Access for FP/RH in era of HIV/AIDS: Challenges & Opportunities: Dr. N. Maggwa

Contraceptive Prevalence Rate (CPR) remains relatively low in the ECSA region with quite high unmet needs and most women appear to use methods that do not protect against HIV/AIDS. There is a phenomenon also, of high HIV/AIDS prevalence districts in Kenya still having high total fertility rates (TFR) and the country may be beginning to lose some of the gains made earlier on. Population growth rates in the region still outstrip GNP growth in most countries.

HIV/AIDS and Family Planning have the similar target populations and both interventions can be readily integrated to good effect. However there is a fear of competition for resources and whether the health workers can contain the raised workload this will entail. Men and the youth who are not usually attracted to family planning services are however attending VCT services and this gives another opportunity for family planning services to be integrated with VCT services.

Problems with capacity remain and for example, in Kenya, most VCT staff have not been trained in family planning service provision which means integration will require significant training to be done.

Main Discussion Points.

Can the Community Based Distributor (CBD) approach be used for HIVAIDS prevention in communities?

It is important to integrate Family Planning and HIVAIDS prevention interventions as clearly poor FP intervention can only expand the orphan problem.

The conference needs to give serious consideration to integrating Family planning and VCT and HIVAIDS prevention.

Chairman: ***Hon. G. Konchellah – Assistant Minister of Health, Kenya****.*

Presentation 5: Scaling Up Malaria Prevention and Control: Dr. G. Upunda CMO Tanzania.

The presentation described Tanzania's health system and its 21 administrative regions and 121 districts. It outlined the Health Sector Reforms and the malaria strategic plan and described implementation lessons. Tanzania's involvement in HSR since 1996 and its adoption of Sector Wide Approach (SWAPs) created long term partnership and support for the sector.

An essential package of health interventions has been determined which has assisted districts in planning. Malaria is the number 1 priority in terms of morbidity and deaths of

in-patients. 93.7% of the country's population is at risk from malaria. The goal of the strategy is to reduce malaria incidence to level where it is no longer a major public health obstacle to social and economic development.

Key elements of the strategy are -

- *The home as "the 1st hospital" for treatment and care.*
- *Improved case management is the primary strategy and this includes the Tanzania Food and Drug Administration's quality control on the drugs used and monitoring their efficacy.*
- *Chloroquine resistance is now up to 50% - but mismatch a between scientists and policy makers means treatment policy is yet to be changed.*
- *There is continual demand for building capacity of health workers and strengthening referral systems.*
- *The Tanzania ITN Target: by 2007 50% of children and pregnant women should be sleeping under an Insecticide Treated Net (ITN).*
- *A national voucher system for receiving subsidised ITNs is to be introduced for pregnant women. The voucher system will hopefully accelerate reaching the Abuja targets.*
- *Other elements include prevention in pregnancy; prevention & control of malaria epidemics; regional cooperation through East African surveillance for malaria epidemics.*
- *HSR, IMCI, PRSPs and partner commitment and involvement provides opportunities for success.*

Presentation 6: Review of Policies and Programmes on Malaria in Pregnancy Dr. Q. Q Dlamini

Dr. Dlamini presented a study prepared on behalf of the CRHCS including a desk review conducted on member countries' malaria plans and strategies.

11 of 12 ECSA countries did have malaria in pregnancy as part of National Health policy (exception of Mozambique). The study examined a variety of factors taken from the policies and interviews with programme managers.

- *These included intervention methods used by countries which varied significantly. Mauritius is almost at the point of eradication of malaria.*
- *The magnitude of malaria in Pregnancy (MIP) varied in countries from quite low in Botswana to high in Mozambique, Uganda and Tanzania.*
- *Surveillance – Countries used surveillance systems of variable strength. The situation is the same with monitoring systems such as ITN uptake.*
- *Finding recent coverage data in many countries was quite difficult.*
- *Quality Assurance facilities were good in Botswana, Kenya, Malawi (none though in Mauritius)*
- *Summary: The region had a mix of high, medium and low transmission countries in equal measure with Mauritius almost at the point of eradication.*

Presentation 7: Scaling Up TB Prevention and Control: Hon. Dr. M. W Phooko, Minister of Health and Social Welfare, Lesotho

The presenter described Lesotho's 18 health "service areas" which are the units for health service delivery. Lesotho's health data included population of 2,2m with a 2% growth rate; maternal mortality ratio (MMR) of 419/100,000 and Infant Mortality Rate (IMR) of 74/1000. 54% of rural households lived in poverty.

The health services are highly subsidized and delivered free of charge for diseases perceived to be of public health importance e.g. Tuberculosis. Ante-Natal care is free and NGOs and other partner providers are reimbursed for each patient diagnosed and treated for TB. TB and HIV/AIDS are among the top three adult causes of morbidity.85% of population live within 10km of a fixed health facility. Lesotho utilizes 6000 community health workers and TBAs.

In year 2000, 9946 TB cases were reported indicating a tripling of rates over previous 3 years. There is 69% TB treatment success rate but 54% of the cases are also HIV+. Human Resources Needs includes:

- *Skills for DOTS treatment,*
- *Laboratory and radiography services*
- *Training and supervision of staff*
- *Monitoring and evaluation of the services*
- *Skills in IEC, contacts follow-up and advocacy.*

Lesotho has a strong and committed management team, and continued training of TB coordinators supported by regular supervisory visits is essential. There is a need to link national TB programmes with the HIV/AIDS programme and joint VCT/TB centres have been proposed.

Discussion

Uganda developed a pack of malaria drugs – distributed to homes to be kept for treatment of malaria (when fever sets in children under-5.) Systems also link community health workers with the formal health system to ensure early referral.

TB programmes represent another area where integrating into VCT services will be very beneficial.

SESSION 4: IMPROVING QUALITY OF HEALTH CARE – HUMAN RESOURCES IMPLICATIONS.

Presentation 1: Improving quality of pharmaceuticals and other commodities procurement. Dr. M. Bura and Dr. M. Thuo

This presentation examined the ECSA response to the challenge of inadequate access to pharmaceuticals and medical supplies and described focus areas of possible collaboration between member states. The key problem is that the communicable diseases in the region such as TB, Malaria all require effective drug treatment and supply systems. This raises Issues of:-

- *Quality*
- *Procurement and storage*
- *Distribution*
- *Stock control*
- *Controlling Irrational prescribing*

Pharmaceuticals and medicines constitute the second largest costs in health care after human resources and it is proposed that the region should re-establish a regional pharmaceutical forum for collaboration. This is even more important given the new foci of HIV/AIDS, RBM and TB.

The Regional Pharmaceutical Forum (RPF) will be a body of experts /committee to advise the Regional Health Ministers Conference through the DJCC on matters of medicines and pharmaceuticals. A 1st meeting was held in Kampala last year and the RPF is now viable. Its main areas of concern will include-

- *Legislation and regulations*
- *Quality controls*
- *Formularies*
- *Training of staff*
- *Manufacturing*
- *Preventing counterfeiting*
- *Clarifying private and public sector roles*

The RPF will coordinate management systems and create pooled procurement opportunities for sensitive medications and also share information sources and standards of medications. It will utilize technical working groups to provide technical assistance to member states to ensure that pharmaceutical products meet quality standards set for the region. RPF will support coordinated informed buying thus linking countries to prices and sources

Main Discussion Points

The CHRCS was encouraged to Include surgical supplies as part of the RPF system including anaesthetic drugs etc.,

Uganda is also considering the local production of ARVs and RPF may play a role in coordinating the regions approach to this.

The RPF needs to keep in mind the production of pharmacists, pharmacy assistants and supplies professionals to handle the systems for ARV expansion.

The RHMC should advocate for special protection of local suppliers and producers to enhance their capability within the ECSA region.

Presentation 2: Improving Quality of Care through legislation and regulation. Mrs. Eleanor Msidi.

Mrs. Msidi reviewed the purposes and responsibilities of professional self regulation and described a case study of Zambia's nursing profession. Self regulation was described as a collective privilege given to a profession.

Most of ECSA practiced similar means of internal regulation carried out from within the profession. Their roles include

- *Protection of public from unsafe practices*
- *Ensuring quality standards*
- *Fostering the profession's development;*
- *Confer accountability on practitioners,*
- *Accredit training and set standards and qualifications.*
- *Monitoring continued competency of professionals*

Zambia revised the Nurses and Midwives act recently and broadened the scope of practice for nurses and midwives, setting new standards and competencies.

The nursing curriculum was also reviewed using multi-disciplinary teams. Indeed many of the curricula had not been reviewed in 5-10 years. The review also developed a set of monitoring and evaluation tools and systems.

Presentation 3: Improving Quality of Care through Legislation & regulation. Mrs. E. Oywer Registrar – Nursing Council of Kenya.

Regulation is an integral part of the overall health sector vision of Kenya. This led to the creation of a department of standards and regulation in the Ministry of Health in 2001.

The role of Nursing and other councils in Kenya are similar to Zambia's and those of other countries in the region. The strategies adopted included developing supportive supervision, integrating traditional medicine into the health system, and establishment of research and ethics committees for all professions. The department holds an annual congress of quality in health care and serves to harmonize the health laws and regulation that cut across professions.

Another aspect of the department's focus is "the Kenya Quality Model" which involves developing evidence based practices and the promotion of community involvement and participation in quality monitoring (patient partnerships). A "Master checklist" with a

scoring mechanism (including staffing numbers and types) is now in use. Components include, aspects of Structures, Processes, and Outcomes or results.

Quality is everyone's business and its leadership is a must with all staff as a most important resource in this process.

Motivation, high workload, attrition from brain drain and deaths among staff remain significant problems. Kenya MOH will be training 2 inspectors for every district to implement the Quality Model (KQM). Quality improvement issues must also be included in training curricula at all levels.

Presentation 4: Quality of Care through Regulation of Allied Health professions. Mrs. O. Munjanja

The 30th RHMC in Seychelles had recognized the input of allied health professions into health systems in the region and asked CRHCS to strengthen the contribution of these allied professions. A study was commissioned to identify actions to be taken by countries and the secretariat. Mrs Munjanja provided feedback from the study which looked at issues covering the following:-.

- *Recruitment*
- *Training*
- *Career*
- *Deployment*
- *Continuing education*
- *Licensure*

AHP were regulated in a variable manner in the region with advantages and disadvantages of various models. The study was conducted with support of COMSEC London has produced a report and fact sheet which have been circulated to participants of this conference. The presenter urged Ministers and delegates to review the fact sheet and report in order to decide actions that countries may need to take.

A summary of issues arising-

- *There is a need to work with countries to establish or strengthen AHP regulations in countries.*
- *Allied Health Professions need to be advocated for starting with the Ministers.*
- *The AHPs should be supported to form their own professional associations that can help address their peculiar concerns of professional development.*

Main Discussion Points

- *The Kenya example of a Department of Standards and Regulation which pooled all professions together is a challenging and important systems that will facilitate the professions working together.*

- *Observation was made that there is a changing scope of nursing which is increasingly the front line health worker, This important roles need to be*

accepted as positive change and not seen as changing a rigid definition of nursing.

- *The division of labour/roles for councils etc in terms of training and education matters as well as continuing education and curriculum development appears to make the councils responsible for everything. Councils should avoid becoming a player, umpire and others at the same time.*

- *Those in a profession who do not change but remain are as bad as those who leave as this constrains the development and enriching of the profession. Passing a law is one thing but issues such as workload create conditions which make it difficult for staff to undertake continuous education.*

- *The integration of traditional medicine into the standards system in Kenya is very interesting. How is Kenya handling this difficult area? what can other countries learn from this?*

- *Does our situation make it possible to enforce laws that make health a human right when we can not provide adequate access?*

- *Regulation of nurses in private practice can be a problem. In Zambia this was not permitted until all the regulations and laws were put in place.*

- *Professional codes of conduct - Can the region harmonize the regulatory laws rather than working separately as countries?*

- *Exchanges of professionals between countries and having reciprocity of qualifications to enhance recruitment between countries in the region proposed.*

- *There is a need to establish a regional body to ascertain certificates of professionals arriving from some countries (especially in Asia etc) so that the region creates a system for ascertaining such qualifications.*

- *The presenters reiterated the fact that it was critical to involve all other health care professionals in developing the legislation for nurses as well as other professions.*

- *Councils avoid providing continuous education but monitors continuing improvement of their wards.*
- *Some harmonization has been drafted for nursing especially in training and scopes of practice. With Allied professionals this has been much more difficult as 44 different cadre types were identified in the region. Seven of these have been prioritized for future accreditation of training etc.*

- Assessment of candidates for medical professions should be holistic in order to get better quality entrants into the different professions.

- Emphasis to be put on Continuous Medical Education (including laws). CME is considered to be a **Must** for all health professionals. However, workload may hinder staff ability to access CME.
- Laws and Regulations alone are not enough to ensure quality of care.
- Regulation of Traditional practitioners must be undertaken. Multi-sectoral approach, both local and international should be the strategy of choice to regulate traditional practice.
- Setting up of Associations of Medical Councils of the region can facilitate interstate movement of medical professionals within the region.
- Scope of practice of health professionals cannot be too rigid where there is a lack of trained professionals.
- Harmonization of curriculum is a prerequisite for cross-country accreditation.

Presentation 4: Improving Quality of Life through NCDs prevention and Care: Hon. Ashok Jugnauth, Minister of Health and Quality of Life, Mauritius

NCDs constitute a great challenge to Mauritius. The improved economy with GNP in excess of $3000 per capita has led to increase in diseases of affluence such as obesity, heart and endocrine diseases. A notable rise in NCDs was noted since 1987 in that 1 in 5 Mauritians have type-2 diabetes. High elevated cholesterol prevalence increase by 80% since 1987. Smoking and drinking risks are common. Some 50% of deaths are caused by cardio-vascular diseases and Mauritius has the second highest prevalence of diabetes in the world. The minister considers it a primary leadership role to ensure safety of the people from these diseases

.

Actions taken have been based on decentralization of NCD control to each of 5 regions of the country with the following components.

- *Establishment of Regional NCD registers*
- *Facilitating training of staff*
- *Assisting health centre staff*
- *Dissemination of relevant information*
- *Participation in research.*
- *Follow-up of defaulters*

Mauritius uses mobile caravans to screen people for NCDs and to promote preventive measures. Tests results are given on spot except for breast and cervical cancer. Caravans also perform referrals to hospitals.

Home support teams have also been constituted in each of 5 regions with community physicians trained in the core areas. Also a central level committee was formed to coordinate affairs.

NCD and health promotion is now a major point at all health sector meetings and is aimed at inculcating the need for Mauritians to change behaviours and lifestyles. Centres have been opened for eye, cardiac and neuro-surgery. Foreign surgical teams

have been invited to perform the more complex operations within the country. A bill has been prepared to parliament for the transplant of human tissue, and to ban tobacco.

There is a need for additional financial resources to upgrade facilities and hence a need for financing reforms as part of health sector reform. A health insurance scheme is being studied for implementation.

Presentation 5: Addressing the HRH Crisis: The Importance of Infection Prevention and Control – Mrs. O. Munjanja.

The presentation was on a joint venture study between the CRHCS, WHO and JHPEGO. The key importance is for reasons of –

- *Quality of Care*
- *Prevention of Hospital HIVAIDS and other hospital infections, and*
- *to share the current existence of better evidence of what works in infection prevention and control.*

New evidence suggestion that significant aspects of HIVAIDS epidemic may be due to poor IPC practices. Hospital acquired infections and the perception of risk are contributing to migration and loss of health workers. There is therefore a need to upgrade the daily practices of health workers for their own sakes as well as the client's. The region must ensure that IPC must become part of the usual practice of every person with roles and needs for advocacy, policies, performance improvement approaches, and inculcating IPC in educators of health workers.

The manuals and guidelines by CRHCS, WHO and JHPIEGO should be multiplied by member countries and made available to all health workers.

Discussion

A huge NCD problem exists in the region but is not being addressed and may be hidden by the focus on communicable diseases.

Mauritius has consistently led in advocacy for NCDs. NCDs like AIDS also hits middle level professionals such as health workers who we cannot afford to lose.
A regional workshop on NCDs was hosted in Mauritius in September 2003 and plans have been developed for situational analysis to prepare action plans for the silent epidemic.

Zambia has now started an open heart surgery centre and hopes to work on other NCDs later.

Research is needed into the extent of infection control within the region as we seem to be using just proxy information.

Mauritius has studies and tools in the area of NCDs which can be made available to member countries. The last RHMC decided to collate information, but what process can be put in place to do that?

It is important to quickly prepare a baseline and analysis of NCD status in the region to calculate how much effort and cost could go into control programmes.

Cancers of breast and cervix are the most worrying NCDs for some countries. Prostrate cancers in men is becoming a prominent problem!! Mobile clinics work in Mauritius but may be difficult in other countries. Women at risk could be targeted at FP and Reproductive Health clinics but tackling the cases of men can be a lot more difficult. Disability caused by NCDs can be devastatingly costly to countries.

SESSION 5: STRATEGIES FOR IMPROVING RECRUITMENT, RETENTION AND DEPLOYMENT OF HEALTH WORKERS.

Chairman: Hon. P. Pillay, Minister of Health, Seychelles

Presentation 1: Migration of the Health Workforce - Dr. R. Chatora

Dr. Chatora defined migration as movement of professionals within and beyond the boundaries of the country (which is a normal occurrence especially if it does not harm the countries). Movements occur between urban and rural areas, public and private sectors, and from health to non-health professions. A WHO study on migration was presented and this focused on health professionals that moved across borders to other countries.

Brain Drain was identified in the study as "the loss of skilled persons that are required by their countries". Thus not all movement of professionals is brain drain. These precise distinctions are necessary as developed country counterparts tend to focus on the areas of professional loss other than the fact that these are losses of persons required in the countries.

From the study, there were 5 top international destinations of health migrants however within Africa, a few countries in the south are also recipients of some staff.

Migration or movements within the country are considered as one that will still serve the country though outside the public sector. The study provided data on projected shortfalls expected in UK and USA according to their own staffing standards which showed that by year 2020 some 800,000 nurses will be needed in USA alone. Also recent data show an exponential growth of overseas nurses working in the UK.

The study discussed the relative importance of some push and pull factors which is thought useful in designing appropriate interventions. The 4 main factors coming from feedback from emigrants were –

- *Social Conflict*
- *Further training*

- *Poor working conditions*
- *Low salaries and working conditions.*

Reasons given by health workers still in countries but intending to leave indicate that their perceptions about their working conditions is very critical in decision making.

Other key findings:
- *Proportion of workers wishing to emigrate ranged from 26 to 68%.*
- *Pay rates are very low ranging from $50 to about $1500.*
- *% of staff who are worried about contracting HIV aids ranges from 48.3% to 85.3% (though 80% are ready to care for HIV patients)*
- *Workload had increased quite rapid in past few years – especially in Ghana and Zimbabwe.*

Several effects of migration have been mentioned including it enhancing inequity of access to services and the loss of experience needed to build and sustain continuing capacity.

What interventions may be needed?
- *No data exists on health workers and information systems are crucial.*
- *Revision of salaries and incentives – including utilizing part-time employment especially of some specialists*
- *Policies and strategies are needed to enhance retention*
- *Training multi-purpose workers as alternative may need to be pursued.*
- *Using community health workers*

Countries together can;
- *Strengthening national and regional training institutions*
- *Agreements with recipient countries and rotational migrations?*
- *Compensation for workers recruited*
- *Adoption of code of recruitment by all countries.*

Impact of the crisis includes:
- *The Africa Union has declared 2004 as "The year of HR in Africa" and the summit meeting for that year will focus on the Human Resources Crisis and the brain drain.*
- *The WHO Executive Board was meeting at the same time as this conference in Accra, Ghana with the main theme on the Human Resource Crisis. There remains possibility of strong opposition from developed countries to decision that may arise.*

Presentation 2: Opportunities and Innovative Strategies for Improving HR Development in Africa - Dr. D. Dovlo

Dr. Dovlo's presentation emphasized the fact that there now exists a window of opportunity with prominent persons and organizations showing keen interest in addressing the longstanding problem of HRH. This wave of interest may not be long sustained, thus there is a need for immediate action, lest the world loses interest before HRH benefits.

A number of international forums are forthcoming on HRH. There is a need for member countries to get thoroughly prepared and to put up effective advocacy to elicit support for HRH. The advocacy should start at home by involving all the stakeholders, heads of state, other ministers, health workers, the public etc.

Countries should be well prepared and have strategic plans with costs and benefits properly laid out. The case for HRH must be supported by evidence and concrete data and must be convincing. We must show how much health systems we will gain economically by investing in HRH and delineate the roles of national and regional organizations in what needs to be done. Africa and the ECSA region should have a common stand to negotiate with the developed country receivers of African health workers and to tackle strategies effectively..

The Need to be Innovative

The causes of the HRH problems are now well known. There is a need for urgent action using innovative strategies and encouraging creativity, deploying new thinking and ways of doing things. Examples were given of innovations in training, education, recruitment practices, deployment, and distribution and Research priorities in HRH.

Training and Education

Development of new types of courses with innovative curricula, e.g problem-based learning is required. Others include training multi-purpose workers, creating mid-level medical specializations and skills delegation to enrolled nurses and clinical officers. Other innovative training methods include on-site training and mentoring.

Recruitment Practices

Innovative recruitment practices mentioned included -

- Rural and gender based recruitment
- Step-ladder recruitment and career progression
- Foreign recruitment with replacement planning
- Managed return of migrant nationals
- Special-to-person recruitment and remuneration
- Development of non-tradable cadres
- Using wage and non-wage incentives
- Job-enrichment schemes
- Welfare and benefits incentives
- Civil Service Reforms
- Taxing workers living abroad (Eritrea)

- Bonds and compulsory service

Deployment and Distribution
In order to influence equitable distribution of health workers and ensure availability of health personnel in rural areas, incentives suggested included:-

- hardship allowances
- faster promotion for staff in rural areas.
- Risk allowances
- Non-financial rewards and valuing the health worker are strong incentives.
- Managers must be empowered to develop local incentive schemes through decentralization.

HRH Research
Research should be strengthened to establish evidence on best HR practices. For example, some countries have been using clinical officers in place of doctors but this has not been properly researched and documented.

In conclusion, the rational four stage process was again suggested. This involves

1. Research, information and data collection
2. Inclusive Stakeholder consultations
3. Strategic HRH Planning
4. Formulation of implementation plans and actions with regular reviews.

Presentaton 3 : Recommendations of the DJCC 2003 - Mr. B. Nalishiwa
Mr. B.C. Nalishiwa, Chairman of the Directors' Joint Consultative Committee Meeting, presented the report of the Consultative workshop on HRH in East, Central and Southern Africa and the DJCC Meeting of 21-25 July 2003 held at Arusha and the recommendations.

The DJCC was preceded by a 2 day consultative meeting with HR experts, educators, senior health professionals which fed technical input into the main DJCC meeting. Factors were outlined that were influencing the HRH crisis in the region and its continued brain drain experience.

The DJCC determined 4 core issues affecting HRH. These were

- *Human resources management: Conditions of Service, Motivation and Remuneration of Health Workers.*
- *Human resources development: Training, Education, Quality and supply of Health Workers.*
- *Establishing Visionary leadership.*
- *Cross cutting Issues comprising HRH Policies, HIV/AIDS and the workforce and the new Aid Instruments.*

The DJCC's recommendations to member countries included actions on -:

- *Formulation, review and strengthening of policies on terms of service of health workers.*
- *Countries to hold national forums on HRH*
- *Need to carry out comparative regional studies on salary and non-salary incentives and share best practices.*
- *The need to establish Health Insurance and Medical Aid schemes for health workers.*

*The DJCC's final recommendation was to member countries to establish a **"Technical Advisory Committee on HRH"** working under the auspices of CRHCS to be called "**ECSA Human Resources for Health Technical Advisory Committee".***

The rationale of the committee was to serve as an HRH technical resource group which would monitor and advice on the implementation of the HRH recommendations of the DJCC and the Health Ministers Conference.

Mr. Nalishiwa formally presented the report of the DJCC and its recommendations to the Ministers Conference for approval. He stated that the recommendations were earlier presented to the advisory committee of the CRHCS in September 2003.

Main Discussion Points.

The developed countries are reluctant to see the viewpoint of African countries on the issue of health worker emigration. It is unlikely such countries will give assistance to resolve HRH problems being faced. Is there a hidden agenda in the assistance and aid provided? It is critical that Africa quickly and comprehensively defines its own agenda whether an external agenda exists or not.

Member countries do need to undertake radical and unconventional reforms of HRH following the Chinese and Cuba experiences with health care.

The way forward – the regional body (CRHCS) is well placed to coordinate countries coming together to speak with one voice against the taking away of health workers. Countries need to come out strongly on issues like compensation and request support for training extra health workers.

The conference needs to focus on making plans on issues such as re-establishing the enrolled nurse cadre and other so called "substitutes".

The conference should identify roles that the CRHCS could play in HRH support and ministers could give guidance on this issue.

What exactly is "visionary leadership" in concrete terms? Leadership is expected to encompass establishing personal knowledge and advocacy for the HRH problem. Leadership also involves having "personal responsibility" for achieving the goals and must include ministers drawing up personal action plans.

It was suggested that a regional team should be set up to lobby the partner countries on the personnel and other health systems issues. It was also suggested that countries could utilise their professionals in the diaspora as a pressure group. There is need to use a compendium of innovative actions in tackling HRH and avoiding piecemeal actions. Whilst a lot of information has been shared, each country needs to focus and identify what exactly it needs.

Are there any experiences with professionals who have returned? Are people really happy out there?

We must not regards "non traditional Staff" such as clinical officers as "substitutes" but as part of a clear cost effectiveness decision and as staff who play a well targeted role in health services.

How are we going to approach this HRH challenge? A "mission" (comprising a group of experts) have to be put together to assist develop a set of actions for the region than each individual country attempting to take fractured actions.

The conference facilitators should provide a one-two page personal brief for the Ministers to assist them develop personal action plans on the issues raised.

There is a need for persistent advocacy, that demonstrates to the developed countries how the poaching of health workers effectively kills hope for poor people fighting AIDS, TB and Malaria in Africa. The ECSA requires a tenacity of leadership with personal interventions with heads of state to prepare for year 2004. Health Ministers will need to take a personal interest in holding the national HRH forums proposed.

Respecting and valuing the health worker remains a critical and urgent step of motivation and encouragement.

SESSION 6: LEADERSHIP IN THE HEALTH SECTOR

Chair: Hon. Dr. M. Phooko, Minister of Health and Social Welfare, Lesotho

Presentation 1: The Role of Leadership in Effective Health Services Delivery:
Dr. Alex Opio. (on behalf of Hon. Brig. Muhwezi)

This presentation covered the need for leadership in different sections of the health sector and at all levels by various stakeholders and partners. Uganda was given as an example of good leadership in combating HIV/AIDS.

Leadership is required at all levels of the health system. A study in Uganda showed that the marginalization of nurses and midwives from mainstream decision making negated their involvement in policy development and reduced their commitment to making the health system work.

The Uganda national response to HIV/AIDS involved the following::

- *Support by the President – chairing meetings himself.*
- *Openness by leaders on the epidemic*
- *Decentralization of the response to local government levels*
- *Involving various partners and stakeholders in programmes*
- *Multi-sectoral leadership was involved in managing programmes*

Presentation 2: Resource Mobilization for HIV/AIDS & Other Interventions: Report of Inter-Ministerial Task Force. Hon. Patrick G. Pillay

Hon. Minister of Seychelles presented a summary on the result of a meeting in Nairobi this year, held at the request of Regional Health Ministers on mobilizing resources for a comprehensive response to HIV-AIDS etc.,. Clearly gains in Gross Domestic and National Product of countries in the region are likely to fade away with the rapidly increasing disease burden. Further country needs were summarised as involving -

- *Developing Implementation strategies;*
- *Studies and research on key issues*
- *Participations and collaboration of partners in mobilisation of additional resources.*

In his report, the Minister presented revised TORs of the inter-ministerial Task Force and the Proposed Implementation Strategy. The report, particularly the TORs were presented to the 38th RHMC for approval.

Presentation 3: Scaling up: Improving Access to ITN through Advocacy and Leadership: Challenges and Opportunities Dr. HA Mwenesi

"Netmark" helps to define how far the market can help with health interventions through support for research, monitoring and evaluation. The presentation

reiterated the challenge of malaria as a preventable tragedy with several tested and ready interventions. Factors affecting malaria include the fact that countries still exacted high tariffs on imported treated nets. There must be an all inclusiveness of partners and strategies in responding to malaria including utilizing the private sector as a major partner (and not seen as an enemy).

Tanzania and Uganda have gradually started scaling up towards meeting the Abuja targets. .

Key Concepts of Insecticide Treated Nets (ITN) response include:

- *Reaching targeted vulnerable groups with resources*
- *Strategies aimed at developing a commercial market for nets*
- *Emphasis on creating an enabling environment for all partners – private sector, CBOs and NGOs,*
- *Demand creation.*
- *Continued commitment to Abuja declaration remains important.*

DDT use should not be pitted against ITN strategies. Both interventions have roles to play depending on the epidemiological, financial and human resources situation of each country.

Discussions

Within new funding frameworks do we need to develop separate funding to support human resources? Examples of such systems support by programmes existed with some reproductive health research programmes.

Main themes are emerging
- The HRH "Window of Opportunity" is rapidly closing and we need to recognize this and take necessary action.
- Leadership: Effective leaders
  - *a. scan environment looking for challenges,*
  - *b. Focus on the challenges identified,*
  - *c. mobilise resources, inspire people and*
  - *d. implement actions.*

We need to avoid prolonging the "scanning" phase.

Significant success and experiences have been chalked in getting resources for HIV/AIDS and malaria but efforts must be doubled to take advantage of the said window of opportunity.

SESSION 7 : PROGRESS IN IMPLEMENTING RESOLUTIONS OF 36TH RHMC

Presentation1: Progress Report by CRHCS – Dr. Mark Bura

Progress report on the completion of actions on resolutions of the 36th health Ministers conference held in Entebbe, Uganda was presented. The Conference Theme was: "Improving Equity, Efficiency, and quality of health services in ECSA".

Resolutions were passed concerning -:

1. *CHRCS strategic plan and institutional reforms.*
2. *HIVAIDS*
3. *FP and RH*
4. *Malaria*
5. *Nutrition*
6. *Non Communicable Diseases*
7. *Appreciation of Uganda Government for hosting the conference.*

Progress Report by Member States: Discussions.

Problems were mentioned concerning late submission of country reports and of vagueness in some report areas. There may be a need to improve communication between member countries and CRHCS to ensure quicker and more accurate feedback on the implementation of resolutions and recommendations.

SESSION 8: RESOLUTIONS AND RECOMMENDATIONS

Presentation and Discussion of Draft Report of the 38th Regional Health Ministers' Conference - Dr. D. Dovlo.

Dr. Dovlo briefly presented an outline of the report and defined each of the chapters and the summaries condensed from the presentations. Summaries of the discussion points made in plenary were also included. He indicated the information that would go into the appendices.

The conference noted the format presented but as the draft report had just been distributed, Hon. Ministers decided that they would be unable to make meaningful comment and discussion on the content.

Resolutions and Recommendations of the 38th Regional Health Ministers' Conference - Dr. S. Shongwe, Regional Secretary

Dr. Shongwe presented the core aspects of each resolution which was then followed by a discussion. Corrections and opinions were expressed as to content and coverage of the resolutions. Some issues of wording and clarifications were also discussed and consensus reached.

In all 6 resolutions were presented and reviewed by the conference. The final resolution expressed gratitude to the Government and People of Republic of Zambia, for hosting the conference..

The resolutions covered

- *Scaling up health interventions*
- *Health workers and quality of care*
- *Strategies for improving retention of health workers in ECSA*
- *Visionary Leadership*
- *Amendment of the Convention*
- *Expression of Gratitude to the Government and People of the Republic of Zambia.*

The Regional Secretary also presented the Personal Briefing paper for Ministers that the secretariat was requested to prepare. A two-page summary was developed that covered in succinct style the key issues and actions discussed during the conference and made suggestions of next steps and actions that Honourable Ministers may wish undertake.

Adoption of Resolutions and Closure of 38th Regional Health Ministers' Conference.
The Draft Report and the Resolutions of the 38th Regional Health Ministers' Conference as amended in the foregoing session were approved and adopted by the Conference.

CLOSING REMARKS

Dr. Steven Shongwe, CRHCS Regional Secretary
On behalf of the CRHCS thanked the Ministers for their participation. The conference was a success in terms of organization and its focus on the key issues affecting countries. The success is also a tribute to the government and people of Zambia for good organization and reception. Appreciation was expressed to cooperating partners, delegates, the CRHC Secretariat Staff, Facilitators and other Presenters for their contributions to the conference.

Hon. Patrick G. Pillay, Minister of Health, Seychelles
Speaking on behalf of all Ministers and Delegates, Hon. Pillay felt that the inspirational opening of the conference had set the tone for the active flavour it took and the Ministers have given themselves quite clear tasks to take home.

The Cultural dimension of the week was very useful in further confirming the links between health and the culture of peoples and Hon. Pillay thanked the host government for the rich cultural context that we went through especially the meeting with His Royal Highness Chief Mukuni which was much appreciated by all. This is considered to be one of the best conferences with a good atmosphere that made for good discussions.

Hon. Dr. David Parirenyatwa, Minister of Health & Child Welfare, Zimbabwe
The Hon Minister of Zimbabwe appreciated the organization of the conference by the Zambian Government and also by the Secretariat including the presentations and good facilitation. The organization has come of age and finances have now been streamlined. There is a need to strengthen the profile of the region even further. Health under the SADC platform exists only as part of the social sector which dilutes it somewhat. He urged the Secretariat to follow through the resolutions adopted to ensure that the succeeding conference will have good reports delivered. Hon. Parirenyatwa welcomed participants to next year's conference in Zimbabwe.

CLOSING ADDRESS

Hon. Mrs. Mutale Nalumango, Acting Health Minister of Zambia

Hon. Nalumango, the acting Conference Chairperson, closed the meeting with a speech outlining the Importance of the implementation of the resolutions passed at the conference most especially the one on mitigating the impact of HIV & AIDS on the health workforce. ECSA needs to combat HIV & AIDS using the strategies outlined during this meeting.

Other key issues that countries must follow up include improving quality of care and enabling health as a cross-cutting issue important for overall development. The ECSA region can no longer continue to lose its health workers to migration and the resolutions in this area must be vigorously pursued.

Member countries need to proceed in unity and with persistence. The Hon Nalumango expressed her congratulations to the CRHC Secretariat for making the conference successful and also to the Zambian health technocrats, the cooperating partners and others who assisted in making the meeting very successful. She hoped that the visit to Zambia had given delegates a view of the centre of Africa.

The 38th Commonwealth Regional Health Ministers Conference at Livingstone Zambia, 2003 was officially declared closed.

CONCLUDING SUMMARY

A health crisis is engulfing the ECSA region as well as the entire African continent. This crisis, caused by increased morbidity from HIV/AIDS as well as other re-emerging diseases, is further worsened by a paucity of human resources for health in the region and serious continuing shortfalls in numbers from losses from migration to developed countries and from HIV/AIDS. Poor motivation and low productivity compounds the problems.

It is clear that any attempt to tackle the increasing health burden of the region must necessarily find means of having adequate numbers of appropriately skilled and motivated health professionals to meet the challenges ahead.

Interventions in developing Human Resources in health take time to become effective due to the lengthy periods of training required and all the other resources that are required to produce good quality staff in enough numbers to make an impact. This is why the current global interest in the development, retention and motivation of health's human resources provides for an opportunity that countries faced with this crisis cannot afford to miss.

The 38th Commonwealth Regional Health Ministers' Conference reinforced the need for research and evidence to support interventions that are to be implemented. Advocacy and inclusive stakeholder debates are necessary to develop strategic and innovative HRH plans of action. Perhaps even more critical is the implementation of such plans with the due political commitment and regular reviews to assess progress and modify plans where necessary.

Tackling the human resources crisis requires strong leadership initiatives in each country, as well as in the region, mobilizing Health Ministers and other leaders towards achieving health objectives.

Africa's year of Human Resources in 2004 represents another unique opportunity to develop early and sustained advocacy with Heads of States and governments as well as communities and among other stakeholders.

Strengthening the Human Resource base of the ECSA region is critical to expanding the response to the health crisis and it is incumbent on all stakeholders to appreciate the value of health workers and to invest in *the people who work for our health*.

Commonwealth Regional Health Community Secretariat
for East, Central and Southern Africa

38th Regional Health Ministers' Conference
17 –21 November 2003, Livingstone, Zambia

Resolutions of the 38th Regional Health Ministers' Conference

Preamble

The 38th Regional Health Ministers' Conference (38th RHMC) took place between 17 – 21 November 2003 at the Zambezi Sun Hotel, in the southern city of Livingstone, Republic of Zambia. The Conference was formally inaugurated by His Honour, the Vice President of the Republic of Zambia, Honourable Dr Nevers Mumba, MP and attended by Health Ministers and their delegations comprising senior officials from East, Central and Southern Africa (ECSA), representatives of regional and international organizations as well as development agencies.

During the Conference, Hon. Dr. Brian Chituwo, Minister of Health, Republic of Zambia was elected the Conference Chairperson while Hon. Dr. David Parirenyatwa, Minister for Health and Child Welfare, Zimbabwe was elected the Conference Vice Chairperson.

The central theme of the 38th RHMC was "**Strengthening and Scaling up Health Interventions in ECSA: The Central Role of Human Resources for Health".**

The Conference approved and adopted the following six resolutions:

Resolution 1: Scaling up health interventions

Resolution 2: Health workers and Quality of health care

Resolution 3: Strategies for improving retention of health workers in ECSA

Resolution 4: Visionary leadership

Resolution 5: Amendment of the convention

Resolution 6: Expression of gratitude to the Government and People of the Republic of Zambia

Resolution 1: Scaling up health interventions

The 38th RHMC,

Deeply concerned about the growing burden of disease posed by HIV and AIDS, TB, Malaria and other conditions such as reproduction ill health and Non Communicable Diseases (NCDs) on the region;

Recognizing the adverse socio-economic costs of this heavy burden of avoidable ill health and premature death, especially among the poorest and marginalized people;

Concerned that the majority of patients do not have access to appropriate treatment and care for HIV and AIDS, TB, Malaria, Reproductive health ill health and NCDs;

Noting that resources for HIV and AIDS, TB and Malaria are inadequate and further noting that the ECSA region is not on target to reach the health expenditure commitments made in the Abuja Declaration;

Underscoring the crucial role of human resources for health in scaling up health interventions including HIV and AIDS prevention, treatment, care and support;

Urges Member States to:

a) Develop/strengthen plans for scaling up health interventions including Anti Retroviral Therapy (ART), Malaria, TB prevention and control and reproductive health and child survival;

b) Increase the percentage of public spending on health towards the 15% of national budgets as pledged by Heads of State in the Abuja declaration of April 2001;

c) Strengthen health systems, services and infrastructure in order to scale up communicable and non-communicable disease control and treatment programmes so that they can provide affordable, effective and equitable quality health care;

d) Explore options for utilizing expertise of traditional medicine in improving access to health care;

e) Invest in national and regional pre-service training to increase Human Resource (HR) supply of core service providers essential for scaling up;

f) Introduce flexible scopes of professional practice to enable health workers to take on additional functions, increase productivity, improve service delivery and minimize costs;

g) Conduct a national stakeholders forum on the Human Resources for Health (HRH) crisis to strengthen the evidence base on the magnitude and consequences of the crisis and make a strong case for investing in human capacity development as an essential prerequisite for scaling up and improving health outcomes.

Urges CRHCS to:

a) Provide technical and strategic support to member states to develop their plans and strategies scaling up health interventions;

b) Assist member states to develop human resources for health situational analyses;

c) Document and disseminate better/promising practices and tools in scaling up health interventions and HRH supply and retention strategies.

Resolution 2: Health Workers and Quality of Health Care

The 38th RHMC,

Aware of the poor quality of health care provided in most countries in the region;

Deeply concerned about the insufficient numbers of health workers and the inadequate skill mix in many health facilities in member states;

Concerned about the fact that many health workers are ill-motivated because they are overworked, underpaid, insufficiently valued, poorly supervised and managed and working under inadequately equipped health settings;

Further concerned that health workers have limited career growth and personal development opportunities within the public service;

Acknowledging the direct relationship between poor quality of care in facilities and adverse conditions of service of the health workers;

Acutely aware of the need to improve and strengthen collaboration amongst regional bodies such as AMCOSA, ECSACON that deal with issues of quality, standards of health services and safe practice.

Urges member states to:

a) Adopt a comprehensive and systematic long term approach to dealing with the HRH crisis in tandem with strategies to improve quality of care;

b) Review training programs with a view to harmonize them and enhance quality of care and infection prevention and control;

c) Provide adequate clinical/field supervision during training to improve the quality of health care;

d) Ensure that regulatory bodies collaborate with relevant institutions to put in place high quality continuing medical education programmes and mechanisms that are linked to annual registration and renewal of licenses to practice.

Urges CRHCS to:

a) Facilitate the harmonization of relevant training courses in the region to improve management and utilization of human resources for health across the region;

b) Facilitate the cooperation of medical councils, nursing councils and other regulatory bodies in harmonizing accreditation and registration of health workers across the region;

c) Develop and disseminate a directory of training institutions in the region.

Resolution 3: Improving retention of health workers

The 38th RHMC,

Deeply concerned about the growing evidence of attrition of health workers reaching unprecedented levels due to the combined effects of the search for greener pastures locally, regionally and overseas, civil service retrenchment, voluntary retirement, and the absenteeism, illness and death primarily due to AIDS;

Recognizing the impact of the adverse terms and conditions of service for health workers and other "push" factors that fuel attrition and out migration of experienced health professionals;

Aware of the current window of opportunity in terms of regional and international organizations interest to address the HRH crisis;

Cognizant of the fact that the Commonwealth Code on ethical recruitment of health workers is not legally binding;

But aware of the value and importance of sharing human resources and expertise within the ECSA region

Urges Member States to:

a) Use data and information to develop an evidence-based strategy to advocate for fair salaries and compensation benefits for health workers;

b) Collate and compile evidence on the benefits of de-linking health workers from the civil service and the establishment of Health service commissions or Boards to plan and manage human resources for health;

c) Develop and sign legally binding agreements with other governments in the region and overseas regarding migration of human resources from the region, especially relating to aspects of ethical recruitment and compensatory arrangements;

d) Put in place strategies and mechanisms to improve the value placed on health workers, and improve motivation and retention as a matter of priority;

e) Encourage donors and cooperating partners to support human resource needs of member states;

f) Incorporate human capacity development needs in future proposals for funding from sources such as the Global Funds and related aid instruments

g) Develop and implement HIV and AIDS work place prevention programmes for health workers.

Urges CRHCS to:

a) Document and disseminate current best practices and guidelines on legally binding agreements among member states and developed nations on the ethical recruitment of human resources;

b) Produce and disseminate information on the various strategies and options including monetary and non-monetary incentives on staff motivation and retention;

c) Collaborate with WHO and other international agencies involved in human resources for health development in the region to ensure complementary actions towards addressing the HRH crisis.

Resolution 4: Visionary Leadership

The 38th RHMC,

Deeply aware of the need for inspirational leadership and stewardship from government actors and other players at all levels of the health system to give priority and visibility to health;

Aware of the opportunities provided by the current interest in HR for Health including the recent declaration of the Year 2004 as year of HR by the AU Heads of States and Governments;

Recognizing the direct co-relation between good leadership and management practices and effective health care delivery and the examples of positive results associated with sustained and effective leadership and commitment in fighting diseases such as HIV and AIDS in the region;

Urges member states to:

a) Provide effective political and technical leadership in the health sector;

b) Utilize existing training facilities to provide ongoing team building and leadership development programmes for policy makers, planners, programme managers and health facility management teams;

c) Critically analyze the role of human resource planning and management and improve Human Resource and Management Systems (HMR) and practices;

d) Uphold the principles of transparency, merit, experience and competence in appointments to positions of leadership and management in the health sector;

e) Invest in leadership development and advance preparedness for key policy making positions in the health sector.

Urges CRHCS to:

a) Identify and disseminate information pertaining to regional leadership development courses and programmes for health professionals;

b) Coordinate a regional retreat for Ministers in team building and leadership development;

c) Expand the mandate and terms of reference of the inter-ministerial task force on resource mobilization to include provision of effective leadership in addressing common health priorities.

Resolution 5: Amendment of the CRHC Convention

The 38th RHMC,

Recognizing that the Conference adopted the amendments to the existing Convention as proposed by the Working Group of Legal Experts but subject to each member state's mode and procedure for signifying approval for such amendments;

Further recognizing that the Conference also adopted the proposed draft amendments to the Standing Orders for both the Conference and the Advisory Committee;

Urges Member States to:

- Signify their approval to all the amendments to the Convention at the May 2004 Conference of Health Ministers after the necessary consultations with their respective Governments.

Resolution 6: Gratitude to the Government of the Republic of Zambia

The 38th RHMC,

Noting with profound appreciation of the acceptance by the Ministry of Health of the Republic of Zambia to graciously host the 38th Regional Health Ministers Conference;

Deeply aware of the extensive and elaborate planning, coordination and preparations that went into all Conference activities;

Remaining forever grateful for the very warm hospitality extended to all Ministers and their delegations;

Appreciating the excellent arrangements that were put in place during the entire Conference period by the Government and People of the Republic of Zambia;

- **Wishes to express its gratitude to the Government and People of the Republic of Zambia**
- **Humbly requests the Minister of Health of the Republic of Zambia to convey the individual and collective gratitude of the Ministers and delegates to His Excellency Levy Patrick Mwanawasa, SC, President of the Republic of Zambia.**

ii. Facilitators Recommendations for Next Steps

The DJCC in July 2003 expressed a number of actions recommended for countries to undertake. There is a need to review and critically analyse these recommendations for implementation.

- A critical recommendation concerns the formation of a Technical Advisory Committee on Human Resources for Health. This would gather evidence; provide information, and technical support to countries wishing to launch HRH development programmes.

- Within countries, strenuous efforts are necessary to collate data and conduct research to establish baseline data and the situation analysis on health workers. These efforts should be followed by the critical step of getting the consensus of various stakeholders and partners on the problems and how to resolve them,

- Persistent and sustained implementation of HRH interventions is important and personal oversight provided by health ministers would raise the profile of HRH,

- It may be useful for the member countries of CRHC/ECSA to seek common grounds on the issue of health worker migration, to look for inter-country agreements and arrangements. The CRHCS and the proposed advisory committee may help by developing a position paper to be agreed to by member countries as the basis of their discussions in international fora on the international migration issue.

- A similar position paper/advocacy paper should also be prepared to assist countries negotiate how best new aid instruments can be utilized to foster well trained and motivated health workers.

iii. Conference Programme

THEME: "STRENGTHENING AND SCALING UP HEALTH INTERVENTIONS IN EAST, CENTRAL AND SOUTHERN AFRICA: THE ROLE OF HUMAN RESOURCES FOR HEALTH (HRH)"

Time	Activity	Presenters/Chairpersons / Rapporteurs
Sunday, 16 November 2003		
	Arrival of Ministers and delegates.	
Day 1: Monday, 17 November 2003		
	Day 1 :OFFICIAL OPENING	Master of Ceremonies: Dr. Simon Miti, Permanent Secretary, MOH, Zambia
0800-0930 hrs	Registration of Ministers and delegates	CRHCS
0930-1000 hrs	Ministers, Delegates and invited Guests take seats	
1000-1005 hrs	Arrival of Guest of Honour, His Excellency Levy Patrick Mwanawasa SC, President of the Republic of Zambia.	
1005-1015 hrs	Welcoming Remarks by Hon. Chilufya Kazanene, Deputy Minister, Southern Province, Zambia	
1015-1025 hrs	Remarks by Dr. Steven V. Shongwe, Regional Secretary, CRHCS-ECSA	
1025-1035 hrs	Remarks by Dr. Andy Sisson, Regional Director, USAID/REDSO	
1035-1045 hrs	Remarks by Dr. Rufaro Chatora – Director, Division of Health Systems and Services	

Time	Activity	Presenters/Chairpersons / Rapporteurs
	Development; WHO Regional Office for Africa	
1045-1100 hrs	Remarks by Hon. Brig. Jim. K. Muhwezi MP Conference Chairperson and Minister of Health, Uganda.	
1100-1115 hrs	Remarks by Hon. Brig.Gen. Dr Brian Chituwo MP Minister of Health, Zambia.	
1115-1145 hrs	Inaugural Speech by the Guest of Honour, His Honour Nevers Mumba Vice-President of the Republic of Zambia.	
1145-1200 hrs	**GROUP PHOTOGRAPH**	
1200-1230 hrs	**REFRESHMENTS**	
1230-1400 hrs	***LUNCH BREAK***	
1400-1530 hrs	**SESSION 1: BACKGROUND ON HRH CRISIS IN ECSA**	**Chairperson: Hon. Brig. Jim Muhwezi, Uganda Rapporteurs: Kenya**
1400-1410 hrs	Conference Theme, Sub-themes and Objectives	Dr. Steven V. Shongwe, Regional Secretary, CRHCS
1410-1440 hrs	Keynote Address: Strengthening and scaling up Health Interventions in ECSA: The Central Role of HRH.	Dr. Delanyo Dovlo HRH Consultant
1440-1500 hrs	Scaling up Health Interventions: The Zambian Experience.	Hon. Brig. Gen. Dr. Brian Chituwo, Minister of Health, Zambia:
1500-1530 hrs	Discussion	
1530-1600 hrs	**TEA BREAK**	
1600-1800 hrs	Regional Health Ministers` Conference (Closed Session)	
1900-2000hrs	**COCKTAIL**	
	END OF DAY ONE	

Time	Activity	Presenters/Chairpersons / Rapporteurs
Day 2, Tuesday, 18 November 2003		
0800-1000 hrs	**CLOSED SESSION**	
1000-1030 hrs	**TEA BREAK**	
1030-1300 hrs	**SESSION 2: THE IMPACT OF HIV/AIDS ON THE HEALTH WORKFORCE**	**CHAIRPERSON: Hon. Brig. Gen. Dr. Brian Chituwo RAPPORTEURS: UGANDA**
1030-1050 hrs	The Impact of HIV/AIDS on the Health Workforce: An Overview	Prof. Stephen N. Kinoti, Senior HIV/AIDS Adviser AED/SARA
1050-1110 hrs	An Assessment of the Impact of HIV/AIDS on the Health Workforce in Malawi	Dr. Andrew Gonani District Health Officer, Machinga District Hospital
1110-1130 hrs	An Assessment of the Impact of HIV/AIDS on the Health Work Force in Kenya	Mr. Boaz K. Cheluget Statistician, Kenya National AIDS Control Programme
1130-1200 hrs	Discussion	
	SESSION 2 CONTINUED	**Chairperson: Hon. Dr. M.W. Phooko, Minister of Health and Social Welfare, Lesotho**
1200-1220 hrs	Human Capacity Development (HCD) for An Effective Response to HIV/AIDS	Mr. Ummuro Adano HR Consultant & Facilitator
1220-1240 hrs	Leadership in the Health Sector: A NEPAD Perspective	Prof. Eric Buch, NEPAD Health Advisor
1240-1300 hrs	Discussion	

Time	Activity	Presenters/Chairpersons / Rapporteurs
1300-1400 hrs	**LUNCH BREAK**	
1400-1600hrs	**SESSION 3: SCALING UP HEALTH INTERVENTIONS: HUMAN RESOURCE IMPLICATIONS**	**Chairperson: Hon. Ashok Jugnauth, Minister of Health and Quality of Life, Mauritius** **Rapporteurs: Swaziland**
1400-1420 hrs	The HIV/AIDS Treatment Emergency: Achieving the 3 Million by 2005 Global Target	Dr. W. Mpanju-Shumbusho WHO/HQ
1420-1440 hrs	Expanding PMTCT services	Nomajoni Ntombela, LINKAGES
1440-1500 hrs	Discussion	
1500-1520 hrs	Access to Reproductive Health Services with a special focus on Family Planning.	Hon.Dr David Parirenyatwa, Minister of Health and Childwelfare, Zimbabwe
1520-1540hrs	Improving Access for Family Planning/Reproductive Health in the Era of HIV/AIDS: Challenges and opportunities	Dr. Ndugga Maggwa, FHI
1540-1600 hrs	Discussion	
1600-1630 hrs	**TEA BREAK**	
1630-1830 hrs	**SESSION 3 CONTINUED**	**Chairperson: Hon. G.S. Konchellah, Assistant Minister of Public Health, Kenya** **Rapporteurs: Swaziland**
1630-1650 hrs	Scaling up TB prevention and Control	Hon. Dr Motloheloa W. Phooko,Minister of Health and Social Welfare, Lesotho
1650-1710 hrs	Scaling up Malaria Prevention and Control	Hon. Anna M.Abdallah, Minister of Health, Tanzania
1710-1730 hrs	Review of Policies and Programmes on Malaria in Pregnancy in ECSA	:Dr. Q.Q. Dlamini CRHCS
1730-1800 hrs	Discussion	
	END OF DAY TWO	

Time	Activity	Presenters/Chairpersons / Rapporteurs
Day 3: Wednesday 19 November, 2003		
0800-1030 hrs	**SESSION 4: IMPROVING QUALITY OF HEALTH CARE: Human Resource Implications**	**Chairperson: Hon. Elizabeth Lamba, Deputy Minister of Health and Population, Malawi Rapporteurs: Seychelles**
0800-0815 hrs	Improving quality of Pharmaceuticals & other commodities in East, Central and Southern Africa (ECSA)	Dr. Mark Bura (CRHCS) and Dr. Michael Thuo
0815-0830 hrs	Discussion	
0830-0845 hrs	Improving Quality of Health Care Through Legislation and Regulation: An Overview	Mrs.Eleanor Msidi, General Nursing Council, Zambia
0845-0900 hrs	Improving Quality of Health Care Through Legislation and Regulation	Ms Elizabeth Oywer – Nursing Council of Kenya
0900-0915 hrs	Quality of Health Through Regulation of Allied Health Professions in ECSA: A Study Report	Mrs. Olive Munjanja, CRHCS
0915-0930 hrs	Discussion	
0930-0950 hrs	Improving Quality of Life through NCDs prevention and Care: The Mauritius Experience	Hon. Ashok Jugnauth, Mauritius
0950-1010 hrs	Addressing the HRH Crisis: The importance of Infection Prevention and Control	CRHCS/WHO-AFRO/JHPIEGO
1010-1030 hrs	Discussion	

Time	Activity	Presenters/Chairpersons / Rapporteurs
1030- 1100 hrs	**TEA BREAK**	
1100-1230 hrs	**SESSION 5: STRATEGIES FOR IMPROVING RECRUITMENT, RETENTION AND DEPLOYMENT OF HEALTH WORKERS**	**Chairperson: Hon. Patrick Georges Pillay,Minister of Health Seychelles Rapporteur: Tanzania**
1100-1120 hrs	Migration of the Health Workforce in Africa	Dr. Rufaro Chatora, WHO/AFRO
1120-1140 hrs	Opportunities and Innovative Strategies for Improving Human Resources Development in Africa	Dr. D. Dovlo
1140-1200 hrs	Presentation of recommendations of the Directors Joint Consultative Committee (DJCC)	Mr. B.C. Nalishiwa DJCC 2003, Chairperson.
1200-1230 hrs	Discussion	
1230-1330 hrs	**LUNCH BREAK**	
1330-1540 hrs	**SESSION 6: LEADERSHIP IN THE HEALTH SECTOR**	**Chairperson: Hon. Dr. David Parirenyatwa, Zimbabwe Rapporteurs: Malawi**
1330-1350 hrs	The Role of Leadership in Effective Health Services Delivery.	Presenter: Hon. Brig. Jim Muhwezi, Uganda
1350-1400 hrs	Resource Mobilisation for an Expanded and Comprehensive Response to HIV/AIDS and other Health Interventions in ECSA: A Summary Report of the Inter-Ministerial Task Force on Resource Mobilisation for HIV/AIDS and other Health Interventions.	Hon. Patrick Georges Pillay, Seychelles
1400-1430	Discussion	
1430-1450 hrs	New Funding Opportunities for the Fight Against HIV/AIDS	Dr. Greg Pappas POLICY PROJECT

Time	Activity	Presenters/Chairpersons / Rapporteurs
1450-1510 hrs	Improving Access to ITN through Advocacy and Leadership: Challenges and Opportunities	Dr. Halima A. Mwenesi AED/NetMark
1510-1540 hrs	Discussion	
1540-1600 hrs	**TEA BREAK**	
1600-1730 hrs	**SESSION 7: PROGRESS IN IMPLEMENTING RESOLUTIONS OF THE CONFERENCE OF HEALTH MINISTERS**	**Chairperson: Hon. Chief Sipho Shongwe, Minister of Health and Social Welfare, Swaziland Rapporteurs: Lesotho**
1600-1630 hrs	Progress report on implementation of the resolutions of the 36th Regional health Ministers Conference.	CRHCS and Member States
	END OF DAY THREE	
Day 4 Thursday, 20 November 2003		
	ZAMBIA THE REAL AFRICA: FIELD VISIT	
0900- 1200 hrs	Visit to Chief Mukuni's Village: Cultural dances and a glimpse of Zambia's Village Life.	
1300 - 1400 hrs	**LUNCH BREAK**	
1400 -1530 hrs	Visit to the Victoria Falls	
1630-1900 hrs	African Queen Boat Cruise	
1930-2100 hrs	Dinner at the Bomas	

Time	Activity	Presenters/Chairpersons / Rapporteurs
	END OF DAY FOUR	

Day 5, Friday, 21 November 2003		
0900-0930 hrs	Presentation and Discussion of Draft Report of the 38th Regional Health Ministers' Conference	CRHCS and Facilitators
0930-1030 hrs	Resolutions and Recommendations of the 38th Regional Health Ministers' Conference	CRHCS and Facilitators
1030-1100 hrs	***T E A B R E A K***	
1100-1130 hrs	Adoption of Resolutions and Closure of the 38th Regional Health Ministers' Conference (see separate Programme)	
1130hrs	***END OF PROGRAMME***	
1230-1400 hrs	***L U N C H***	

iv. Briefing Paper for Ministers

HRH Crisis in ECSA: A Time to Act!

Exit Briefing Note for Honourable Ministers

Background

WHO defines human resources for health (HRH) as the stock of all individuals engaged in promoting, protecting or improving the health of populations.

The HRH problem in the ECSA region has reached crisis proportions in many countries. The complexity and seriousness of the problem varies across the region, but the situation in some member states is so grave that urgent and concerted action is needed.

Dimensions of the crisis

In summary, the unsatisfactory situation can be characterized by the following:

- Inadequate supply of trained health workers; and scarcities in almost all cadres
- Severe levels of attrition due to the combined effects of retrenchment, retirement, local and out migration (brain drain), absenteeism, illness and death primarily due to AIDS
- Ill-motivated health workers who are overworked, poorly paid and insufficiently equipped to provide acceptable quality of health care
- Worsening imbalance in the distribution of health workers
- Weak and highly centralized HR policy planning and management systems
- Introduction of new labour and technology intensive practices and treatments such as VCT and ARV on an already fragile HR system and resource base

Theme

The 38th Regional Health Ministers Conference took place in Livingstone, Zambia between 17 – 22 November 2003. The central theme of the Conference was "strengthening and scale up health interventions in ECSA: the role of human resources for health".

Four priority areas for action

Although HRH issues are now slowly receiving the attention of most member states, there are also many other issues that are competing for attention at national and regional levels.

Therefore, maintaining the current prominence of HRH will require strong advocacy by all stakeholders, especially by health ministers of member states.

The Conference resolved that the health ministers, shall continue to provide personal leadership and play a visible role in addressing the following four priority areas for action:

- Improved incentives and motivation for health workers

- Tackle health workforce geographical and skills-mix imbalances to improve coverage and introduce effective changes in deployment of essential cadres

- Collect evidence on migration – more knowledge required on flows and destinations of migrant health workers, what they do in those countries; monitor recruitment methods and promote ethical recruitment practices

- HIV and AIDS: document the numbers of health workers infected; develop work place prevention programmes to protect and ensure the safety of the uninfected and develop practical strategies for treating those infected.

Immediate follow up actions

- Arrange detailed briefing for MoH senior management on the dimensions of the HRH crisis and the resolutions of the 38th Conference of Health Ministers

- Prepare and submit Cabinet memo on the HRH crisis outlining priority areas for action

- Improve HR information base, conduct HR situational analysis including HIV/AIDS impact assessment on the health workforce and organize national stakeholders workshop to develop consensus on taking the HRH agenda as a national priority

v. LIST OF PARTICIPANTS

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For East, Central and Southern Africa

38TH REGIONAL HEALTH MINISTER'S CONFERENCE
17 – 21 NOVEMBER 2003
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vi. Evaluations

A SUMMARY OF EVALUATION FOR 38th RHMC HELD IN LIVINGSTONE, ZAMBIA: 17-21 NOVEMBER 2003

		Grading and number/percentage of scores				
	Objectives	**Excellent**	**Very Good**	**Satisfactory**	**Total**	**General Assessment**
1)	How well did the meeting accomplish it's objectives and meet your expectations?	11 (38%)	18 62.1%)	-	29	Very Good
	Content					
2)	How would you rate the content of technical presentation?	12 (41.4%)	17 (58.6%)	-	29	Very Good
	Style					
3)	How did you find the quality and style of presentation?	10 34.48	18 (62.1%)	1 (3.4%)	29	Very Good
	Organization					
4)	How would you rate the quality and effectiveness of conference planning and organization?	18 (62.1%)	10 (34.5%)	1 (3.4%)	29	Excellent
	Facilitation					
5)	How would you rate the quality and style of facilitation?	6 (20.7%)	20 (69%)	3 (10.3%)	29	Very Good

	General Comments	
6)	What did you like BEST about this year's Conference?	• Organization (11) • The Theme (7) • Very productive and well organized • Frank discussion of issues by Ministers • Very high level of commitment by the Health Ministers
7)	What did you like LEAST about this year's Conference?	• The hotel was too expensive (3) • Mixture of entertainment and business • Adequate solutions/strategies to really resolve Brain Drain • Transport by road from Lusaka (2) • Too much technical details on Powerpoint • Absence of some Health Ministers (2) • Movement from one Hotel to the other
8)	Please write down any other general comments about your experience at the Conference that you may wish to share with us	• Include more nurses in these Conferences as frontline workforce • Very enriching experience • Consider Hotel charges and time given for shopping • Thank the Organization for job well done • Need for specific practical solutions of the problems of staff attrition • Share the concern to raise the profiles of the Conference in the region • Well organized – Keep it up (9) • Please include more country presentations • Do not rely on reports you receive during the Conference. Follow-up implementation of resolution. • All participants to be in one Hotel • Give less time for presentations and more time for discussion • Accredit More Press to highlight the Conference • There are many resource person in the region with valuable contributions. The Secretariat should seek them.