

2009 AMR e-discussion on Global Public Health  
Part I: Strengthening health systems

**Responses in Full by Contributors: Part One**

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**Dated: January 29, 2009 – Vol. 1**

## **1. Training of medical personnel**

To strengthen health systems, we have to see where the bottlenecks are.

One of most important elements is the human resources. The lack of people working in the health care sector is a big constraint of strengthening the health care system.

We need well-trained people in all levels of health care - having a well working health care team is of utmost importance. In this contribution, I would like to focus on medical doctors and their training, because this is my field of work.

We have to start from the bottom. The past decades have shown that it does not help to send doctors from the North to the South. They do proper work but the moment they leave there is nothing to replace them and their work.

### ***Brain drain?***

It has also shown that training doctors from the South in the North is not effective either. For example in Botswana, for many years the government paid for young people to be trained in the UK, less than 5% returned back home to work. Many PhD doctors stay in the university in the North to continue their research instead of going back to their home country.

Training doctors in the countries of need is therefore what is needed. Though again, this is also not always leading to more local doctors. In Ethiopia, they train many excellent doctors, but "there are more Ethiopian doctors in Chicago than in the whole of Ethiopia itself". In Uganda it is said after 5 years of graduation more than 80% of the doctors work for international, well-paying, NGO's and don't see patients anymore.

### ***"Problem" focused learning***

We believe the way of teaching therefore is what needs to be focused on: the curriculum of undergraduates needs to focus more on health inequities and social determinants of health. And from the start of the study students need to see the areas of need and do appointments there to feel what it is like to work there and know the difficulties and learn to solve these. Problem based learning: starting from the problem and then studying and discussing that leads to solving this problem.

For postgraduates the family medicine training needs to be developed: training doctors to be specialists in primary health care; the first place where the majority of people will come with their wide range of health problems. Primary health care teams need doctors who are well-trained. Don't train these doctors in the big tertiary hospital in the capital where most equipment is available. But train them where they will do their work as a family physician, in the more rural district hospitals and community health centers. This makes them stay there after finalizing the training.

Of course this does not work when family medicine training is put in place by the ministries of health. In Kenya the ministry of health has made a policy: "the strategy of family medicine", making that family physicians are accepted and paid as other trained medical specialists and they are placed to work in district hospitals to work for the public health care system.

### ***Strong primary health care***

The horizontal care with strong primary health care as the basis to build on is what we need. And in this we need well-trained people to work in their home country and helping their own people where it is needed most.

We notice more and more people, universities, organisations and even governments are starting to think this way and we hope this will continue in the positive direction with good outcomes as strong health care systems all around with quality health care affordable, equitable, acceptable and available for all.

At Ghent University in Belgium, department of family medicine and PHC we have a 2-year project funded by Edulink ACP-EU, Primafamed, where we are working with 10 universities in Sub-Saharan Africa developing and improving the family medicine training. [www.primafamed.ugent.be](http://www.primafamed.ugent.be)

With several organisations we have started the 15by2015 campaign: over 1500 people from all around the world have signed the petition "We, the undersigned, call upon all donor organizations to allocate 15% of their budgets for vertical disease oriented programs towards strengthening locally horizontal primary health care systems by 2015". Please have a look on the website [www.15by2015.org](http://www.15by2015.org) and sign if you agree upon the above.

In November 2008 the new African Journal of Primary Health Care and Family Medicine was launched on the Primafamed conference on "Improving the Quality of Family Medicine Training in Sub Saharan Africa". This online journal serves as a repository for cutting-edge, peer-reviewed research in all fields of primary health care and family medicine in a uniquely African context. It is free for all to read and send in articles. [www.phcfm.org](http://www.phcfm.org)

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## **2. Water, hygiene and governance challenge**

Dear all,

Still after 2009 years of counted existence, and 6.8 billion of people in the world, the discussion is on how to provide public health globally.

There can be not much differences in global health requirement, except in the 9 developed countries.

Water is the main source of living, not a word is thought about, storage, treatment and supply to the children in schools at 10th class.

Not many are learning about Hygiene in the class rooms.

Asia, Africa, and Latin American countries need resources, training and economic backing for better public health.

Why some one should waste their monies in many of these countries, where the leadership is not, motivated and oriented.

Even the available systems are being thrown to at will and pleasure of the elected leaders, like in India, Andhra predesh, state government is a good example, where the existing systems are not maintained and new one are constructed at a hefty cost.

Shall we start basic lesions to the bureaucrats, legislators, and the public at par with the 10th standard students? I invite comments, suggestions and criticism before going further in to water and drainage systems as an engineer with 40 years experience and 58 years age.

Thanks

s.suryanarayana  
Hyderabad  
India, A.P.

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## **3. Certification of health education specialist**

I am one of the participants of Galway meeting (hosted by the International Union for Health Promotion and Education), which was a meeting discussed global health educators' roles, accreditation and certification system. The US has the Certified Health Education Specialist (CHES) system (see <http://www.nchec.org>) and several EU countries also have certification

system of health educators. We are thinking about universal roles of this profession and related to workforce development of health.

Many countries do not have certification systems or simply have no such professions. But we can think about trainings in developed countries (e.g., US) and improve the system. Galway meeting is just the first meeting that US and EU folks met and we continue this discussion at IUHPE Conference at Swiss in 2010. I just thought it may be better to include this topic as issues of global public health.

Thanks

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**Dated: January 30, 2009 – Vol. 2**

## **1. Training of medical personnel – practical challenges in community based training**

I enjoyed reading all the three responses and picked up the first one ‘training of medical personnel’ I fully agree with Dr. Maaiké Flinkenflögel that learning should be “problem focused.” Training should focus on the rural community and should be conducted at Community Health Center and in District Hospitals where we want our primary health care doctors or Family Physicians to work at.

Now I would like to share my experience of Bangladesh, where we reviewed our undergraduate medical curriculum in 2002 and tried to make it ‘Community Oriented’ (in the professional status of Assistant Professor Center for Medical Education).

We kept the provision of Community Based Training for students for 2 weeks under the supervision of Community Medicine Department in the 4<sup>th</sup> year of the course. It is designed that the students will be placed in “Upazila Health Complex’ which is 31 bedded hospital, providing primary health care (PHC) and also acting as a referral center for the community to provide indoor services. The students in addition to other activities, are supposed to conduct a community survey and submit the report after finishing the placement. We struggled to implement the program through the Ministry of Health and Family Welfare while the World Health Organization (WHO) provided financial support (while I was working as a Program Coordinator for the Program of WHO). Many constraints have made the program stagnated, hardly achieving desired results. Some examples are the following:

- 99.9% undergraduate medical education is conducted in tertiary hospitals in big cities and 90% students are coming from city dwelling families (The admission test is a competitive one and this group is lucky enough to have all the opportunities for



studies). Therefore these students are not motivated enough to go to rural health complex for studies even for 2 weeks. Because most of them know they will not be working there.

- Most of the teachers who accompany the students from different departments have other commitments in the city so they can't spend even 1 whole week with the students.

- The doctors working in rural health complex hardly have experience of teaching, have other commitments; lack of motivation is also negatively influencing their participation in the program.

- Poor rural infra structure to support residential field site training, ensuring safety and security.

- Lastly lack of financial and logistic support contributes to the retro productivity of the program. Most of the time the department faces difficulty in arranging vehicle, fuel, overtime of driver, arranging residential accommodation, food and safety.

- Not going to share other confounding variables like political unrest and environmental hazard (flood, cyclone) etc

We know what to do, how to do, but we don't know how to arrange financial support most importantly how to motivate the future doctors to be a primary health care doctor at least for first 2 years after graduation before s/he enrolls for post graduation.

Please share your experiences and suggestions with us.

Kind regards,

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## **2. Health inequalities – creating opportunities & incentives to work in developing countries**

Health inequities are not unique to developing countries. Although there is universal health care in Canada, there are rural areas especially in aboriginal communities where there are shortages in health care workers. There are incentives built in to sustain them without much success.

I agree with the previous responses. May be there should be a way to provide funding to train new graduates to work in developing countries for a minimum period (for example 2Years). I know there is a program at St. Joseph Hospital (primary care hospital) in Toronto, ON where they send medical residents to most countries around the world for short periods varying from one to three months. These doctors who have had this training are more open to working in developing countries.

Same goes for nurses and other health care workers. Young people are more open to work in developing countries if there are opportunities created and opened before they graduate.

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### **3. Health inequalities: Investment at local levels**

To overcome health inequalities, there need to be direct support and investment at local grassroots level. In developing countries, the number of primary healthcare doctors is very limited and the most majority of them are stationed in large cities. They do not well to provide services in rural area, mainly due to low level of income; living standards; and insecurity. Therefore, the best way to overcome the problem of health inequities and enhance access to quality healthcare, we need to invest at local levels. This means there need to be efforts to train and educate healthcare staff from the same region and encourage them to work in their own province for a period of time.

#### ***Lack of incentives?***

In addition, many of the healthcare professionals are not in their field where they are supposed to be. This is particularly true in developing countries where a professional with Medical Degree is working in non-medical field. This is due to low level of advantages to these professionals. Even if they want to stay in health system, they prefer to stay in large cities rather than going to rural areas where there is a great need for healthcare professionals. Again, effective strategy would be to invest at local level and train the people from the same community to deliver healthcare services. This will take time; however, once initiated, we will see the positive effects in the long run.

#### ***Capacity development and cost sharing***

Developed countries can play a major role in enhancing health system of the developing countries. They can provide trainers, lecturers and professional to go to developing countries and provide short and long term trainings to medical students and healthcare staff. This has to be regular and fixed term based on a specific strategic plan. Developing countries which need support in terms of training and professional workers has to be identified and categorized as first level, second level and so on. After categorizing the countries, one developed country (interested in providing support) would chose one developing country (or a mechanism for choosing country would be developed) to provide support only in terms of organizational development, capacity building and training. The budget for fulfilling this program needs to be provided by both the developing and developed countries with support from the major donors interested in healthcare. Currently many of the developed countries provide support to healthcare system of the developing countries in one way or another which is appreciable; however, if there be a systematic and harmonized step in addressing this problem, we will witness a better result particularly in the long run.

Best regards,

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#### **4. Private vs. public health care system**

It is clear that health and education has been made as private as possible to enhance the wealth of the countries that control funds for programmes in both areas. Developing countries are also systematically abdicating their roles to the private sector, relieving them of accountability to the voters. In India multinationals and the influx of economic globalization has destroyed the public health systems. Putting it back in order or train health workers who will agree to work for inadequate remuneration is going to be a serious challenge.

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#### **5. Untapped resources – veterinarians: Importance of cross-practice collaborations**

In response to your first and second questions regarding how to renew primary care that can benefit both developed and developing countries and overcome shortages of health care workers, I would like to highlight an untapped resource: veterinarians.

Veterinarians study disease processes across many species. With some additional training, they could provide health care to humans as well.

The articles that I am attaching highlight the critical inter-connectedness between animal and human health. Indeed, in some developing countries, nomadic pastoralists place great emphasis on the health of their livestock and are more willing to let them be vaccinated than their children. They are more likely to accept vaccination of their children if their livestock get vaccinated at the same time.

“One Health” is a concept that promotes increased communication and collaboration across specialties. (<http://www.onehealthinitiative.com>) This concept opens many avenues to increasing access to care.

Sincerely,

Laura H. Kahn, MD, MPH, MPP

Research Scholar

Program on Science and Global Security

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## 6. Health care worker shortage – on-line training resources

One response to this problem is the Health Sciences Online (HSO), which is the only health-sciences website ([www.hso.info](http://www.hso.info)) with comprehensive, authoritative, free, and ad-free courses, references, and other resources. HSO already includes more than 50,000 such resources, with searching and text resources automatically translated into 22 languages. It is a virtual learning center for health scientists in training and practice, including copious materials in medicine, public health, dentistry, pharmacy, nursing, and other basic and clinical health sciences. It provides searchable access to materials donated, hosted, and maintained by our distinguished content partners, and screened by our knowledgeable staff for objectivity, credibility, and good design. To encourage the local development of health care providers, we are beginning to partner with Universities and Ministries to offer courses, certificates, degrees, and residency programs, using HSO-identified materials. We would welcome correspondence from readers of this note who would like to partner with us in training.

Sincerely,  
Erica

Erica Frank, MD, MPH

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**Dated: 2 February, 2009 – Vol. 3**

### **1. Proper allocation within health sector: Investing in what's more profitable or what's needed?**

Defining what universal coverage in healthcare means is of utmost importance when one considers health inequities with particular reference to the social determinants of health. Consensus needs to be developed on what services will be part of the universal healthcare package for equitable distribution of health budgets. In Pakistan, there has been an on-going debate about the low budgetary allocations for the healthcare sector. However, it has been realized that proper allocation of the low budget within the healthcare sector would show better results. This is particularly true when primary healthcare is compared with tertiary healthcare. The former being the need of majority while the latter utilizing most of the funds. The question remains why 'the obvious disparities' have been ignored? Is it merely the lack of vision and political will in the country's leadership that allows such obvious inequities to prevail or is it the global phenomenon of 'investing in what is more profitable'?

From my work experience in Pakistan I understand that renewing primary healthcare requires a reorientation in approach to budgetary allocations not only by the government but also by the international donors. A shift is needed from the quick fix approach towards a more latent one

that focuses on addressing inequities in social determinants of health so that people are able to make better choices and opt for healthy behaviors. In the current economic order, funds also drive curricula and career choices.

### ***How to attract medical and paramedical graduates back in local setting?***

If more funds are allocated for addressing the social determinants of health, medical undergraduate curricula would steadily shift their focus from disease treatment to health promotion and disease prevention. Change in division of funds would also affect choice of career specializations in medical graduates who currently resort to working in tertiary care settings or migrate to developed countries. I would like to mention such experimentation in disciplines of basic sciences in Pakistan where the Higher Education Commission sent out graduates for PhD studies and attracted them back to work in local settings by offering them very high salaries. The success of this venture has not been 100% but better than many similar programs. Such programs have yet to be tested for training of medical and paramedical staff. What I intend to address here is the establishment or re-establishment of medical and paramedical graduates trained in technology supported environments in local settings where diagnosis and treatment rest more on clinical expertise.

Regards,

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## **2. Ways to achieve universal coverage and reduce health inequality**

Strengthening health systems based on the values of primary health care is the best way to achieve universal coverage/access and to reduce health inequity. Those values are articulated eloquently in the **Alma-Ata declaration**<sup>[1]</sup> and include concepts such as 'practicality, scientific soundness, social acceptability, universality, participation, self-reliance and self-determination' all words lifted directly from the declaration. The values of primary health care cannot be broken down neatly into components or building blocks and unfortunately one of the tendencies has been to focus on the mechanics of PHC, i.e. assuming that there are isolated programmatic and technological fixes, rather than looking at the entire system. It does not mean that there are not times when it is appropriate to work on one aspect of a system. But, that should only be done taking into account the entire system. If a project, a programme or even a country works on one aspect of a system, ignoring the rest of the system, there is a risk that the entire system will not get any stronger, and in some respects, the rest of the system can even be weakened.

There are countries that have done better than others when looking at health outcomes compared to the investment they have made in health. The graph below makes that point. Certain societies do better with the same amount of funds invested in health, of course, recognizing that there are a lot of determinants of health outside the health sector. It is perhaps important for countries of similar income levels, governance systems, and maybe epidemiological patterns to learn from each other. In many cases, it seems that those societies

that committed themselves to universal access to primary health services using a significant amount of public financing for their total health expenditure have done better.

### ***Shortage of healthcare workers: Lessons learnt***

I am going to discuss a subset of problems within health care workers that is particularly apropos to those countries that have a high level of inputs from international aid. I would like to address the decapacitation that occurs due to aid programmes when they distort the incentive and compensation system for health workers. Examples of this are:

- a. In many situations, staff make more money being away from work than being at work. When capacity building (training) is converted into income supplementation it often becomes the reverse of a capacity building programme.
- b. Salary supplements paid to programme managers for specific projects or activities supported by donors distorts the system, tends to move people towards managing aid rather than managing health services, and creates long term sustainability problems for when the donor programme ends. But, we frequently take the path of least resistance, which allows the short term goals to be met, and hope that the long term problems take care of themselves.

An old adage taught in medical school is 'the first do no harm'. When aid programmes distort the incentives in countries for work, we often violate that basic principle. What can we do?

1. Don't pay programme specific incentives.
2. Look at ways to rationalize training such as joint agreed courses and curricula supported by different donors.
3. Look at more cost effective ways of training, such as distance teaching. I am not arguing that donor money should not be used to increase the incomes of underpaid health workers, but just saying it should be done in ways that give an incentive for being at work, not away from work. Incentives should probably be part of a larger civil service reform and performance based incentives that work across the entire sector, not just one programme.

Regards,

Dean Shuey

[1] The Declaration of Alma-Ata was adopted at the International Conference on Primary Health Care, Almaty (*formerly known as Alma-Ata*), Kazakhstan on 6-12 September 1978. It expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world. It was the first international declaration underlining the importance of primary health care. The primary health care approach has since then been accepted by member countries of WHO as the key to achieving the goal of "Health for All".

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### **3. Investing in capacity: Haitian case**

It seems that the first thing to do is look at the "health needs" of the area or the country and then set out to find ways to help that area or country to meet them. In 2001, I was asked by my church to help Haiti set up a nursing school. I first looked for information on the health needs and the nursing resources of the country. I found that both the infant death rate and the Child-under-Five death rate were more than 12 times that of the U.S. I found that maternity death rate was 52 times that of the U.S. I found that Haiti reported 1 nurse per 10,000 people, while the U.S. reported 77 nurses per 10,000. I found that Haiti had 2.5 physicians per 10,000. This shortage of both nurses and physicians spoke to the needs of both, although the ratio was out of expected balance. The health needs of Haiti, as evident in the public health data, were the kind of needs that nurses are excellent in meeting by providing teaching and care. In reviewing the level of education and practice of nursing in Haiti, I found that they were several decades behind the level of care and knowledge elsewhere.

I was able to recruit volunteers to help develop the program and try to prepare the region for the school. The Presbyterian Medical Benevolence Foundation already had funding for the buildings from USAID plus the required matching funds to start. The Episcopal Bishop declared the school to be part of the Episcopal University as we requested as part of the development. I started my nursing career at Johns Hopkins, and I had just retired as a professor from the University of Michigan School of Nursing in Ann Arbor, Michigan. I worked full time as a volunteer on this. We did some things right from the beginning, other things needed to be modified as we learned more. The person we hired as the Doyenne (Dean) was a Haitian nurse who had spent almost 30 years in nursing positions in the U.S. and wanted to give back to her country. This was an answer to her prayers. I believe that we all feel that God guided our work.

The Faculté des Sciences Infirmières de l'Université Episcopale d'Haïti (FSIL) in Léogâne, Haïti, was opened in January, 2005, with Hilda Alcindor as Doyenne. The program is a 4-year program, designed to meet international standards, and focused on the health needs of the Haitian people. To enter the University, students were required to have completed 14 years of elementary and secondary schooling as well as to pass an entrance exam. The Governing Board, which was setup to guide and support the Dean, has worked well with volunteer Haitian and American members, chaired by a wise, experienced, doctorally-prepared nurse. The first class of 13 members (3 men and 10 women) graduated with Baccalaureate in Nursing Science degrees on January 10, 2009. The graduates will be taking their licensing exams in March. They must work in Haiti as a nurse for at least 2 years after graduation. There have been many challenges and hurdles, but the students have completed the program as excellent graduates. We were able to hire Haitians as faculty for the humanities and science courses. But there were no Haitian nursing faculty prepared to teach in the school. Many visiting medical teams, who have worked with these students, rave about their capabilities and ask to work with them. The Dean worked with these students to practice their leadership skills as well as their clinical and critical thinking skills. The graduates are the beginning of improving nursing education in Haiti. We have to develop our own nursing faculty.

We have ideas of continuing to develop systems to help provide public healthcare through employment of some graduates, but details have not been worked out. We also hope to start graduate programs as well as continuing education to serve as a conduit for keeping up and developing advanced practice in Haiti. In order to share the leadership of improving the health of its citizens, nursing in less developed countries needs to have bright and well-educated

students. Perhaps some of the educated people who have left these underdeveloped countries would be willing to return to help their own country.

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#### 4. Key components of Health Promotion (HP) strategies in fostering PHC

I have been reading with great interest, contributions from different regions of the world in relation to placing PHC high on the health agenda. The countries in the Caribbean region are developing with resource-constrained health sectors and the health promotion approach has been identified as the vehicle to drive PHC. Health promotion is being recognized as an essential element of development since it focuses on the determinants of health. The strategies of the Caribbean Charter for Health Promotion, (an adaptation of the WHO Charter for Health Promotion) have been operationalized in some health regions in Trinidad and Tobago since 1995. I would like to take this opportunity to share with you, some examples of the operationalization of the HP strategies in fostering PHC:

1. **Formulating healthy public policy** - while policies emanating from the public health sector such as the *National Breastfeeding Policy* and *National Sexual and Reproductive Health Policy* are commendable, policies from other sectors also have a PHC focus such as the *National Policy on Health and Family Life Education* and the *School Policy on Drugs and Prevention*, both formulated by the Education sector. The lesson here is that the determinants of health do not all fall within the ambit of the health sector. Therefore they cannot be addressed by the health sector alone. The key is to work closely with the other sectors that can contribute to achieving the goals of PHC.
2. **Empower communities to achieve wellbeing** - the *Healthy Communities* approach (PAHO/WHO) has been successfully used to improve the nutritional status of urban, depressed communities through container-gardening and rural communities through fish-farming. These communities were also able to improve their socio-economic status by transforming these activities into income-generation activities. This required close collaboration with the Agricultural and Community development sectors and started with community consultations where the communities identified their needs. The lesson here is that the PHC under-girding principles of inter-sectoral collaboration and community participation are still relevant today.
3. **Develop and increase personal health skills** - some of the programs that have been implemented are the *Healthy Lifestyle Empowerment Program for Teachers* so that they in turn can share the information with students and parents; Diabetes Peer Support Group where diabetics support each other in maintaining well-being; *Project Lifestyle* which is a school-based program focusing on eating right, weighing right and regular physical exercise. The lesson here is that individuals can assume some



responsibility for their health and well being when they have the required knowledge and skills and are thereby less dependent on the PHC services. In this way services can then be extended to other individuals and communities in need.

4. **Re-orient health services** - some of the PHC initiatives that have been developed in response to the changing diseases patterns and limited health service resources are the *Program to Improve the Non-Pharmacological Management of Chronic Diseases at Health Centers*, in which medical and nursing personnel are exposed to training in nutritional management of obesity, diabetes and hypertension; *Exercise-by-Prescription Program* in which Health Center chronic diseases clients are referred to a physical fitness center for supervised sessions in physical exercise. The physical fitness center is owned by a Regional Health Authority and managed by Nursing Assistants, some of whom have been specially trained as fitness instructors. The lesson here is maximizing the available human resources through multi-skilling and multi-tasking within the PHC Team.

These are just a few of the many examples of the operationalization of some of the strategies of the Health Promotion Charter in fostering the PHC approach in a developing country. In Trinidad and Tobago, Health Education Specialists have been the focal point for Health Promotion and give direction to the process.

#### ***“Team” approach***

The overall lesson is that PHC requires a team approach - doctors, various levels of nursing and dental health professionals, dietitians/nutritionists, environmental health officers, health education specialists, social workers, pharmacists and other support staff. In some Caribbean countries, nurse practitioners function at the PHC level, reducing the workload of the doctor. In other countries, lower level healthcare workers such as Community Health Aides or Patient Care Assistants relieve nurses of lower level functions.

Many of the contributions so far have focused on the role of the PHC doctor. However, we need to place more emphasis on the functioning of the PHC Team. Remuneration packages must also be attractive and workers should be placed as close as possible to areas where they reside. No effort should be spared in strengthening the PHC Team.

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## **5. Need to raise health awareness in the population**

Starting off, I would like to emphasize at the grass root level of problems faced in the healthcare field. Whether it is a question of Universal coverage or the shortage of health care workers, the

main aspect which I understand in the present day is that of HEALTH AWARENESS in the population. This awareness level is quite low particularly in the developing countries, like India. This unawareness is perhaps the first hurdle in implementation or improvement of any healthcare program.

A thirsty person would search for a well no matter how difficult it may be. Similarly applying the same logic, if the population is thoroughly aware, they would definitely search out a healthcare center or personnel in case of illness and health problems. These hidden cases are the biggest obstruction faced by the concerned authorities in any developing country.

Secondly, health awareness reduces the percentage of ailing and unhealthy persons in a particular community or region. Indirectly, this is the first step in tackling the problem of shortage of health care members. This aspect can be understood by the persistent cases of polio being detected in India, particularly in the cities of Uttar Pradesh. The cases are generally among the under developed areas and also in orthodox communities, who are still not aware of the campaign being put up by the Government for eradication of polio and moreover cases where the people are unaware to an extent that due to their own beliefs, do not want to avail the benefits of the campaign.

Coming to the solution part, I completely agree with the opinion of Dr. Maaïke Flinkenflogel that 'the curriculum of undergraduates needs to focus more on health inequities and social determinants of health'. Here I would like to add that the undergraduate students of Medical, Pharmacy and nursing courses should be made to understand the health scenario they may have to face in the future and thereafter this huge young force of the 'would be' healthcare members can be utilized in improving the first step of healthcare, that is, awareness in the population. Much can be discussed and implemented on what has been mentioned above, thereafter we can proceed towards tackling the healthcare issues at higher levels. Suggestions are welcome.

Good health to all.

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## **6. Cross-sector collaboration: expanding partnership**

It has been refreshing to read the contributions to this discussion. In reference to the last couple of batches of posts, I'd like to highlight and add to comments by Dr. Khaleda Islam, Dr. Abdul Alim Atarud, and finally Dr. Maaïke Flinkenflogel.

As Dr. Khaleda Islam mentioned, the issue of rapid urbanization in most of the countries we are discussing is a huge concern, since it leaves rural populations further disenfranchised, and a concentration of talent and resources in the cities. The broadening of what it means to be a

"health care worker" should be considered to address the many needs of the population – both urban and rural, particularly when the need is for low-cost, high impact health workers, such as physician assistants that are so widely used in the US. Non-urban placements do, therefore require an investment in local resources – ranging from adequate education for the children of healthcare workers, access to technology, and continuing professional development - acting as incentives for providers to work in rural or underserved areas, as Dr. Abdul Alim Atarud mentioned.

Some of the other practical challenges of community-based education for students can be managed through targeted recruitment and training of preceptors in local facilities. Preceptors must have a passion for students, medicine, and the ability to juggle many tasks, including some administrative responsibilities to be a part of the program. This is a special type of person, and I have worked with some of them in countries as diverse as Bolivia, India and South Africa. But they are hard to find, and take an investment to keep. But they are there, and are not all working in universities. I would encourage more cross-sector collaboration in order to manage the logistical details of transportation, safety, and emergency policy development and implementation. NGOs and other [global North] universities who send their students abroad have created these procedures and subcontracting procurement strategies over and over and should be encouraged (and in many cases expected to) assist institutions in other countries to build this capacity – both in bricks and mortar and administratively.

Finally, to go one step beyond university to university collaboration, and in the vein of the journal mentioned by Dr. Maaiké Flinkenflogel, I would encourage funders to identify educational institutions in target countries to work toward an integrated regional network of collaboration that allows students and practitioners to exchange teaching positions and clinical rotations for their students who face similar clinical, infrastructure, and demographic challenges. Students are amazing ambassadors, and can motivate each other to do the work that is needed in their own countries. Cross-cultural immersion brings about a better sense of one's own culture and appreciation of home. Students should be encouraged to learn about each other's health system, successful programs, and associated challenges, while simultaneously analyzing key similarities and differences between home and host countries. The added opportunity for practitioners and students to work within the context of "partnering" health systems will bring greater innovation in programming and system reform.

Thanks, I look forward to reading more.  
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## **7. Health systems impact assessments**

Greetings, and thank you for this forum and opportunity for discussion. I have enjoyed the varied comments of previous contributors. There seems to be wide spread and increasing global agreement that a strong, equitable, robust health system is necessary for health for all.

There is also increasing recognition of the impact, both positive and negative, that externally funded, focused interventions (disease-specific, or so-called "vertical" programs) can have on existing health systems, and concern that some programs can be leading to fragmented systems.

We hope you'll join us as we consider the impact that health programs have had on health systems, and call for health systems impact assessments to be done on all global health programs prior to program implementation. Details on the review of evidence and call to action can be found at this "blog": <http://ghsia.wordpress.com/>.

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MPH Student, Johns Hopkins School of Public Health  
Emergency Physician, Utah Valley Regional Medical Center

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## **8. Training on primary health care**

The only possibility to overcome the health inequalities is to eliminate or at least to diminish the physical and the social distance to health system.

In many European countries, community/family nurses are already during the undergraduate education prepared for the work in primary health care system equally as for the second level-institutional care. According to their description of tasks, they are taking care for the population of all ages in their homes by planned visits or in case of an existing health problem, advised by family doctor.

This is true for urban as also for rural areas. The second very important approach is the so called dispensary method-active approach, open door system, systematic screening of risk or specific age groups. In this process all members of primary health care team are involved.

How can countries learn?

We should not forget that all the WHO documents since Alma Ata declaration are based on facts and on scientifically based vision of the future processes what is already proved and confirmed by the nearest history of health problems in the world.

There is a lot of WHO literature on PHC services, many workshops have been organized and quite some Collaborating Centres have been designated to establish the networks between the countries. We do not need to reinvent the wheel; we should only bring to life what was proposed and even agreed by countries in the past.

Majda Šlajmer Japelj  
RN, grad in Sociology

## **9. Capacity building: leadership, management, infrastructure and partnership**

There is a great need, not yet fully realized, to strengthen global public health capacity-building (leadership, management, infrastructure, and collaborating opportunities for all sectors), government, business, nonprofit, and academic. Linking progress and needs in the global public health infrastructure of all sectors is the myriad of people, organizations, and systems that have been crafted to improve the public's health. These efforts have also been characterized by fidelity to a handful of health organization models and driven by a belief that with more authority, staff, and resources, these models will cost-effectively lead to improved health status.

This is not a new disclosure. The history of health systems is a history of efforts to increase resources and then employ them more effectively. From the perspective of global health development, these efforts have been incremental and have in large part consisted of attempts to transfer relatively successful experiences among very different cultures with uneven results.

From my experience, these models of organization, derived in conditions that are changing rapidly, now become more confining than empowering. It is well known that most systems are not performing perfectly. The largest global public health gap of all is the inability to apply existing knowledge. Perhaps the situation is best described by William Foege, MD, MPH, Senior Advisor to the Bill and Melinda Gates Foundation and Principal Editor of Global Health Leadership and Management, who wrote:

"As the tools and resources improve in global health, the real barriers now are deficiencies in our leadership abilities, management, logistics, the ethics of business practices, and an infrastructure needed for the practical application of our science and technology."

Identifying the global public health issues is a formidable task even for those professionals and scientists who have made global health a career. In addition to the importance of capacity-building, topping the lists are many of the long-term problems that have affected the morbidity and mortality of the world's population for decades and some to generations. As statistical and demographic data has become more refined and official agencies at the country level have found them to be useful, more concrete information has been made public. Among the world's health issues, my top list of critical issues includes: pure water supply, chronic diseases (Alzheimer's, diabetes, cancers, and respiratory and cardiovascular diseases), emerging and reemerging infections, air pollution, and poverty and health. These critical global public health issues affect the morbidity and mortality of most of the world's population. While the leadership and management skills needed to eliminate or lessen the impact of these critical issues are complex, we have the knowledge to do so. Effective transformational leadership with emphasis on capacity building and the required resources can change the world health statistics positively.

Perhaps the one of the most complex and greatest of global health challenges is corruption. Transparency International is the leading global NGO engaged in gathering data and fighting against corruption. Their CEO, Peter Eigen, likens corruption as an institutional disease: it spreads through the body politic with amazing rapidity and has proved remarkably resistant to cure. Some leading professionals in countries where corruption is running rampant, say that the ethics issues education needs to start with early childhood education and run through adulthood—and may take decades or a generations to change the ethical environment in any one country.

In facing up to these critical issues over the long haul requires strong transformational leadership skills—capacity-building skills that permeates all sectors. As Kofi Annan, Former Secretary General of the United States, summarized the United Nations Development Goals, in the book *Global Health Leadership and Management*, this is applicable to global health transformational leadership: Achieving this requires leadership and responsibility between donor and recipient governments alike, it requires us to work in partnership—between the developed and developing world, among governments, international organizations, civil society, and the private sector. Transformational leadership with emphasis on capacity-building is one of many solutions needing more attention.

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## **10. Need to promote the role of pharmacists**

In India the scenario of health care of modern medicine is quite complex. Hence I would like to describe before I talk about overcoming health inequities. The health care is mainly dominated by doctors and pharmaceutical Industry. Hence in the absence of poor documentation (non existent) of clinical services no body will ever know what the trend of practice is. The absence of pharmacists and nurses is felt very much in the community.

The modern health care identifies four stake holders of clinical services (Doctor, Nurse, Pharmacist and patient). As pharmacists in India has remained out of clinical scenario, there is a need to promote the role of pharmacist in clinical pharmacy, community pharmacy and hospital pharmacy need to be promoted and sponsored so that the burden on physician lessens and primary health care becomes more cost effective.

There are nearly 20,000 graduates in pharmacy are coming out of 800 pharmacy education institutions every year. It is becoming increasingly difficult to get placement for all these pharmacists into the industry. The pharmacists in India are serving as community pharmacists in developed countries. The reorientation of graduate pharmacists in India and taking them as in

charge of primary health care provider would lessen the burden on numbers of doctors. The doctors may be utilized for serious illness in higher level of care.

### ***Migration of healthcare workers***

There should be an international agency for migration of health care worker. Although it is not possible to ban a migrations however the countries benefited by migration should compensate for taking away the trained manpower from a developing country. It can be monetary or scholarships for the student to pursue education etc. The benefits of draining a trained health care professional should be shared by the country which provides jobs to the health care worker from a developed country.

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**Dated: February 3, 2009 – Vol. 4**

## **1. Health service providers vs. households and communities: Tensions and consequences**

Health service providers are increasingly aware that households not only take the majority of preventative health actions, but also provide clinical care of the critically and chronically ill. In sub-Saharan Africa, most child death occurs at home (without any contact with the health system) and is usually caused by preventable or easily curable diseases such as malaria, measles, acute respiratory infections, pneumonia, diarrhea and malnutrition.

The culture of dominance among service providers against silence among households and communities makes it difficult for the ideas of the communities to be heard. Service providers never really get to know what their clients understand. Thus they often assume that what they have said, advised or given has been accepted and will be done, only to be surprised later that no change has taken place in terms of behavior and practice and therefore health outcomes.

It is to be realized that households and communities have the deepest interest of their own health at heart and they are always trying their best even when what they do appear unreasonable. Yet the service providers do not listen enough to hear what the consumers are expressing in their own terms and context, because providers tend to be uprooted from their socio-cultural contexts. This leads to loss of trust as local efforts and initiatives are ignored or displaced by temporary actions that fizzle away. The consequence is that households and communities continue to ignore formal facility-based health care system as people's confidence in the formal health sector has eroded.

Emily Muga  
Kenya

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## 2. Need to improve remuneration for health workers

I wish to commend Dr. Dean Shouey for his contribution on health workers and allowances from projects. I am happy to hear from you Dean after some time!

What Dean has said is very logical and it has for a long time a correct answer to a question on the "integration vs. vertical services" in the examinations of Master of Public Health and Health Management students. So, we need to keep the health workers on their desk and not on the road or in training and we also need to avoid distorting the payment structure within health fraternity. That, by the way, is also a darling statement of the Ministries of Public Service (especially in developing countries).

My only problem now (as at the time when Dean and I worked together at the Uganda Ministry of Health in the 90's) is that this good prescription then gives these net results:

- 1) Vertical projects with very highly paid staff and the health system with workers on scanty pay. Most project staff are increasingly non medical and (lately) non-health because you do not want to deplete HRH from their mainstream duties.
- 2) Many expatriate or "exogenous" staff earning this forbidden money in the health sector, creating a "starvation in the month of plenty" among the workers in the health services.

I will remain on line until one discussant can help me with advice ***on how to keep our health workers at a level of remuneration commensurate with their vital input*** and to be at (or near) par with their peers in other sectors like finance, management and (a recent development) politics.

Dr. Edward Kanyesigye  
Senior Lecturer, International Health Sciences University  
Formerly Head  
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## 3. Health inequality and shortage of health workers: Practical suggestions

Solving the problem of **health inequities and the overcoming of the shortage of health workers** are one and the same. This is so because if Health Workers are properly taken care of, they will do their jobs well and also encourage growing youths to develop themselves in their field of study.

To reduce the above problems, individuals, governmental and non-governmental organizations ought to work towards the same goal by:

- Giving adequate remuneration to Health Workers
- Ensuring that they are not over worked by implementing strict shift schedules



- Providing efficient and effective working tools that will help improve the turn around time of their work
- Encouraging them in their search for ways to improve health.
- Reducing stigmatization among health workers who are infected as a result of their rendering service to mankind.

Thanks.

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Dated: February 5, 2009 – Vol. 5

## 1. Gender: Women's access to and use of health services in rural areas

As a Pacific journalist from the Oceania region with a longtime interest in health budgets, health care, and transparency of data and information on health issues, I have followed the discussion so far with much interest, especially the issues of governance raised by a colleague from India last week, and the recent post on households and their interests.

I was waiting to see when in all this the issues of GENDER, in particular the gendered role of women as caregivers especially in households, and in terms of their access to and use of health services especially in rural areas where transportation to health centers is a security and economic nightmare for women caregivers/patients. If strategies are to be inclusive, I think incorporating some questions on how this policy or that intervention, this fee scale or that medical subsidy, affects women and girls and actively seeks answers at all levels, would help provide some way-forward actions.

There need to be strong, supported communications networks between health practitioners and media practitioners as ways of helping useful, life saving information travel to the public served by both sectors. There is a divide of information and transparency, helped along by mutual distrust; myths, and fear and needing to be broken down by lots of dialogue and bridge-building.

Tackle the gender issues around health and taboos around reproductive health, build those communications bridge with the public using relationships with the mass media; involves ways to engage with young people to ensure innovation and sustainability of approaches, and you will be well on your way to achieving that magical formula of the MDGs Goals 1 +2+3=6

Lisa,

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## 2. Community's role in health education

The reach of health information can be expanded by enlisting community and religious leaders as health educators and role models. Especially for preventive health behaviours such as smoking, nutrition, and exercise, advice does not need to come from highly educated and overworked professionals, but can be disseminated through community channels.

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### **3. Strengthening national budgetary system**

I do also agree with Dr. Shuey, with whom I have worked in Lao PDR (good to hear from you indeed), on the payment of salaries through project modalities. While it is extremely important to have adequate salaries for all health workers we have to aim at doing this through the strengthening of the national (financial) system, in which case one would also avoid that health workers will seek alternative incomes. This means however also that the overall budgetary system is strengthened and that the competent ministries (health, social security) get appropriate budget allocation.

In terms of financing the health system it seems to me, that it is indeed important to strengthen the social protection systems, adopted in a way that responds to the means and needs of each country. The tax base plays an important part. There is certainly not "one size fits all". While micro-insurance systems could be valuable, they were after all precursors of social protection systems in Europe, one must not lose out of sight the overarching national systems that can bridge gaps among different social classes and inequities in general.

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### **4. Free services for pregnant women and children**

A sensible first step to achieving universal coverage of health care and the health related MDGs would be for all agencies to promote the provision of a basic package of health care, free at the point of delivery, for all pregnant women and children.

WHO should be commended on their initiative to ensure universal coverage of health care in order to achieve the health MDGs and reduce health inequities. Clearly financial barriers are one of the main reasons that poor and vulnerable people are not accessing effective health care but many governments and stakeholders are reluctant to introduce universal free health care.

However by prioritizing easily identifiable MDG client groups, might we be able to reach a consensus which recommends that "countries should provide a package of basic health care, free at the point of delivery, for all pregnant women and children". The advantages of this position would be as follows:

- Extensive evidence has shown that the removal of user fees would lead to a significant increase in the use of health services by these priority groups.

- Higher health care outputs consumed by these groups would improve efficiency and equity in developing country health sectors.

Countries would be able to define their own package of free health care. Virtually all countries are already providing some free services for these groups e.g. ANC consultations and immunizations for children.

Many developing countries have launched free public health services in recent years; unlike the imposition of fees this would not be a donor led process.

Ensuring that free services are available would not mean that all services would have to be free. Private sector providers can continue serving people with a greater ability to pay.

Public funding (including aid) would be better targeted at the poor and vulnerable.

Launching free health services for pregnant women and children would not inhibit the development of other financing mechanisms such as community or social health insurance.

Such a policy would be very popular and would be likely to be attractive to political leaders worldwide.

After decades of unproductive argument and poor policy advice could the international community reach a consensus along these lines and promote this as a sensible milestone en route to universal coverage?

Rob Yates

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## **5. Inequalities: care delivery and pension systems in aging society.**

This contribution is related to addressing health social inequities, care delivery and pensions systems from the demand side.

The world is aging; some regions are ageing at a faster pace than others. In the North, older adults are ageing healthier than in the South. The demographic shift caused by declining fertility is in favor of older persons. This shift is expected to increase the cost and duration of health care. Many countries are telling us that a few will be able to finance pension systems while at the same time maintain high health expenditures. They have to give something up.

The matter is most and foremost of national budgets. Several health publications argue that countries in the North and South should begin to abandon the largess of expensive procedures and treatments rather than court further waste. Money is better spent on infrastructure, which leads to more efficient labor and better pensions and higher savings. As a result, some governments and civil society groups are rethinking their approach to the delivery of care over the life span in an effort to cut long-term care costs.

Would it be politically correct for ageing countries facing pension systems bankruptcy to draw a line, hold it, and hold people to it to the extent possible? And only when the line is widely acknowledged, offer both. The line is a "health line" that puts a person within the limits of say - 2000 calories and 30 minutes of exercise a day. For extra pension credit, a person must observe a restricted dietary intake of 1500 calories and one hour of physical exercise a day.

Research shows that this is the line that can offer a person tremendous freedom from physical dependency, infirmity and psychosocial disorders, which in turn will reduce dependency on costly drugs for treating the constellation of chronic diseases an average urban person is likely to acquire after the age of 50. A health line can also help society address obesity, ineffective treatments and poor physical conditions.

Recommendation: Establish a "health line" and hold people to it.

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## **6. Nursing: enhancing image as a professional career**

Shortage of nursing is an issue with multiple intrusions. Nursing shortage is a global matter. All countries are competing for sources of nurses to meet their own needs. When we talk about nursing as a profession we mean health awareness and promotion, faster patient heal, less medical treatment complications, and fast bed turnover. Nurse's role ranges from tender loving care to contribution to community development. Retaining nurses in developing countries had become a major concern. A nurse at the end of the day is a member of a family who strives to make good living. If the nurse is unable to attain good living she/he will always look for a better place. Nursing profession has become, especially in developing countries, a money making profession, and as a nurse, hospitals (within or outside the country) will compete to hire you, so the nurse has several choices, and of course, she/he will pick the best choice.

Will local poor hospitals be among those best choices? Of course not!

So, poor communities will not benefit the role of the nurse mentioned above, hence, they are sicker. There should be an ethical commitment among countries to balance the gap among them. But who will commit. Hospitals- in general- are after profit, this profit has requirements, one of them is certain standards of nurse FTE's, skill mix and patient nurse ratios; if unable to meet that, it is less patient "customer" satisfaction, and less financial return.

One of the major issues which countries leaders must work on is to enhance nursing image. Nurse is still looked at as "help" in certain communities; it is sometimes linked with house maids. There must be a collaborative approach from all governmental sectors to encourage nursing as a future career. These efforts must be supported by financial plans. Nursing deals with people's lives, nurse must feel at comfort when practicing this profession, providing a friendly non-threatening and healthy atmosphere at health care facilities, removing all stressors, empowering the nurse are among some of the managerial aspects which must be looked at to retain nurses in the profession. Many nurses are refraining from bedside to managerial posts so that clinical stresses and burnout are lesser. There are many other factors

to deal with in order to encourage enrolments in nursing schools and retain experienced nurses. Unless we work out a global plan, we will reach to an unhealthy situation which we can feel it now.

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## **7. Inequalities: The role of mid-level health workers**

I would like to bring into this discussion the role of the 'mid-level' health worker in addressing inequities in coverage and gaps in primary health care and suggest some new and innovative means of rapidly up-skilling this level of health worker.

While it has been well documented that there is a great need to train new cadres of doctors and nurses, it is also clear that to date this higher level worker has achieved inadequate penetration into rural health services, and in some cases low usage rates (due to costs and other factors) even when health posts have been established. Furthermore, the costs and time involved in training at this level of worker means that tangible 'on the ground' improvements are still years off – even if we were to solve the training methodology, infrastructure requirements, and migration issues overnight. Certainly not it is time to meet the MDGs.

I believe we need to have a parallel and complementary strategy that targets the mid-level health worker with innovative training strategies. By mid-level health worker I'm talking about workers with a diverse range of basic skills focused on the biggest epidemiological concerns in each geographic region. Such workers have localized skills – skills that are not transferable to developed countries, and even not directly without further training to urban areas in their same country. Skills recognized within their own health system, but not beyond, yet with a solid educational grounding that will enable them to expand their training towards formal (transferable) skills in the future. Their competencies might include: detection of key clinical signs, appropriate management strategies following defined clinical guidelines, appropriate referral pathways, and a full range of local public health strategies of relevance to the disease burden of the local region.

Training for this mid-level health worker needs to be delivered locally, rapidly, and at low cost. I suggest integration with the national TVET framework – and I encourage rapid adoption of the African Union Strategy to Revitalize Technical and Vocational Education and Training in Africa for countries in this region. Standardization of qualifications at the national level can aid in ensuring quality and consistency. These qualifications and the competencies within them (including the localization of competencies in line with local epidemiology) should be managed by a national health skills authority. This skills authority could (with donor support) commission the development of training materials and work with national and multilateral stakeholders to target and manage funding towards agreed national health training goals.

Each national authority may chose a delivery strategy that suits their environment, but one I think worth some pilot work is the incorporation of flexible learning strategies. Recently mobile computing technologies have become quite robust and affordable. The One-Laptop-Per-Child program has demonstrated the potential of affordable technologies. A range of mainstream manufacturers now produce low cost mobile computers that are worthy of more research

regarding their application in resource poor settings. The bottom line is that computers designed for education in resource poor environments can now be purchased by national authorities for between \$100-\$200/unit. Pre-installing a training program, cycling the computer to new trainees over a period of 3-5 years, and backing the program up with a mix of distance learning, workplace learning, and preceptor type supervision could significantly reduce the costs of traditional training programs. With an added advantage that the trainee is working in and actively contributing to a rural health post for the entire time that they are undertaking their training.

There is no doubt that the problems highlighted by these discussion questions are massive, but our response must equal the enormity of the problem in both breadth of our creativity, and depth of our commitment towards the goal. My call is for more new and creative thinking – the old models will take more time than the world has given us. In the spirit of this new era the world is entering, let this discussion continue to bring us some truly new ways of thinking and doing.

Looking forward to reading more ideas and experiences!

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## **8. Community Health Workers: Selection, training and suggestions for remuneration**

Dear all, greetings from Afghanistan. I am enjoying reading the responses. Special thanks to Betsy Fuller Matambanadzo for his suggestions related to my concern of Community Based Medical Education. I am learning a lot but sometimes finding difficulties to go beyond existing structure and system. I would like to share my experiences and concerns related to the Community Health Workers.

The community Health workers (CHWs) are playing a very vital role in providing PHC in Afghanistan, where the structural and functional system of the government is severely damaged. The Ministry of Public Health (MoPH) has contracted out a national NGO (Coordination of Humanitarian Assistance CHA) to deliver Basic Package of Health Services (BPHS) in 10 provinces out of 34 and Ghor is one of them (where I am working). The CHWs are working here as the front line workers at the community level from Health Post which is the first static center.

Motivation and willingness are mostly the prerequisite criteria for selection of CHWs. The Surah (committee of community leaders) proposes the names and selection is made from them by interview on a competitive basis. Usually one male and one female CHW are selected for one Health Post and one of them must have few years of schooling. Considering the socio cultural context of Afghanistan the selection criteria for female CHW is that she must be related to the male CHW (wife, daughter, sister). The female CHW is taking care of the female specific issues (safe motherhood, family planning etc) while the male CHW is taking care of other components

and is in charge of the Health Post. The CHW voluntarily designates one room of his house as the Health Post. Both of them are taking care of 150 families. Community Surah plays a vital role in management of health post.

The CHW attend the basic training course following MOPH curriculum which is organized as 2 weeks theoretical followed by 5 weeks practical and the cycle repeats twice. At the end of the training the CHW is provided with one kit containing the basic instruments for dressing MUAC tape etc. They also receive a medical kit with essential drugs, the supply of which is repeated every two monthly. After first 2 months of working with the community, the CHW attend a 2 days refreshers training. They receive few more trainings from time to time depending on availability of funding. The Community Health Supervisor (CHS) supervises the activity of the CHWs and also provide them on job training.

Ghor province having worst infrastructure and road communication, is suffering from acute shortage of health professionals and health centers. Donkey is the main means of transportation. In the background of such a scenario, the role played by the CHW is crucial for the people of Ghor province. They are voluntary health worker and the main incentive they receive is the increased social status, occasionally gift in kind. The training they are receiving, the incentive they are getting is negligible in comparison to the bulk of responsibilities they are bearing and the amount of services they are providing. They need to be supported to improve their overall performance. The mechanism should be strengthened to function well. Going beyond existing structure and system is not possible and suggestion for remuneration is not practical. Here are few suggestions other suggestions:

- Close monitoring and routine supportive supervision of CHW

- Introducing structured on job training following logbook

- Supporting CHW with a mobile /cordless phone for consultation with supervisor or health center incase of complicated or referred patients (at the moment no network for mobile phone in most of the districts)

- Active involvement of CHW in referral mechanism like providing feedback to him for further follow up of the patient in the community after release.

- Training of technical competencies and creating some opportunity for earnings like measuring blood pressure, doing dressing of infection.

- Creating opportunities for further professional development for young CHWs like after certain years of service as CHW getting opportunity to be enrolled in Paramedic, Nursing or Medical Assistants' school.

- Certain years of schooling would be a prerequisite criteria for selection of CHW which may encourage young generation to be involved in the profession.

Please share your experience which will be applicable in this regard.

Best regards,

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## **9. Setting up or strengthening social insurance schemes for all**

The challenge of good health services affects both the developing and developed worlds though the magnitude of the problem is more intensive in developing countries. I will delve more into discussing on the developing countries.

In countries where huge populations live below the poverty line, it is important to consider adopting health systems that exempt the poor from payment of levies as a requirement to receive medical attention. In Africa, for example, where many national health systems charge some levies, the poor tend to shun such services in favor of traditional medicine. In fact, today herbal medicine is fast becoming an alternative to the majority poor who cannot afford services at conventional health institutions.

It would be therefore important to consider setting up or strengthening existing social health insurance schemes to ensure entire population has access to quality health services. A process headed this direction will of course face the challenge of tilting the equilibrium where health services are a major commercial activity. It calls for wide consultation among key players in the health sector including private medical practitioners, health insurers, policy makers, scholars, etc. Even then, governments need to move with purpose and clear focus to guide the process to arrive at a viable and sustainable social health insurance scheme for all its citizens.

I know it is easy to dismiss the case of Cuba success as based on communist ideology but in as far as health service delivery is concerned, it may be important to learn the excellent examples on health service delivery from the country that are replicable. There is nothing more precious for a government to protect than the lives of its citizens. It is therefore worthy exploring the success of Cuba with regard to health since it has probably one of the best health schemes in the world.

### ***Working conditions***

Even though the question on this topic is framed to suggest that developed countries also face shortage of health workers, I think it is an understatement if compared to the countries in developing world. We know that despite the fact that developing countries train health personnel, they face a serious shortage of the same in their national health institutions. I even think one of the biggest causes of deaths in third world countries, especially in Africa, is lack of qualified and adequate health staff.

While the developed world also faces shortage of qualified health staff, it has been attracting such staff from developing world in its effort to address the shortage. It is important therefore to explore ways of ensuring that each country trains its own health staff and refrain from poaching such staff from countries already facing severe shortage of health staff.

On their part, developing countries need to address the working conditions of their health staff to ensure their retention. They should invest in better pays and better health facilities to allow the medics utilize their acquired skills in full. Also, they should provide them with befitting social environments that commensurate their statuses. I am imagining a doctor posted to a health facility in a remote African village with no electricity, no running water, no road, no school to

take his/her children, etc. It is to our self delusion if we expect such an officer to continue staying there when someone makes the slightest offer for them to relocate.

Please explore setting in motion a process to establish what it takes to set up effective national health social schemes in each country. Just explore what it might take.

Kind regards

Kavengo

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**Dated: February 6, 2009 – Vol. 6**

## **1. The role of hospitals in strengthening health systems**

Hospitals have a role to play to strengthen health systems, as they are central providers of healthcare -from PHC to specialized care. They are also key player to improve capacities (i.e. university hospitals) and to lead the thinking on better national public health policies, allocation and use of resources. Hospitals are the first health employers in the world and have a central role in coordinating healthcare provision. They must then be considered as a full-fledged entity and a privileged links between population and health professionals.

In the 70's, hospital's role to provide effective PHC has been neglected, when attention has been put on the grass roots level. A consequence of that is that in a lot of developing countries, hospitals did not play the role they should and have evolved in a misappropriate way, for example by providing high specialized cares in places where there was low demand.

Health system strengthening goes through harmonizing and improving reference system through the different levels of the sanitary pyramid. In addition, funding of hospitals involving comprehensive public health support would ensure delivery and financing of services in the appropriate areas and in cost effective ways. That's why hospitals have a critical role to play to reinforce the health care continuum that could revitalize PHC strategies. The issues which have been considered in this discussion, i.e. human resources challenges, training, capacity building, partnerships, etc. are part of hospitals issues.

However, few international discussions about public health policies deal with hospital role in national health systems. Hospitals are often considered as resources-consumers, whose care delivering is not adequate with population's needs. But limited solutions are discussed to enhance their performance.

However, hospitals are more and more a hub for health service provision. In fact, dimension like communities support, or first level supervision are rarely fully taken into account. The consequence is that hospitals do not receive adequate resources to fulfill their missions.

Another example is emergency management. One of the missions of hospitals consists in being able to face crisis situation and making the population feel secure. But if hospitals don't have appropriate financing to ensure this task, they will not be able to respond adequately.

Hospitals have been blamed for not doing enough in supporting PHC. This may be attributable to financing systems favoring payment of curative care. As a result, this has limited hospitals support to PHC. It is urgent now to have international discussion on hospitals' role in health system, in order to build adequate resource allocation policies.

The International Hospital Federation, therefore, looks forward to the revitalization of PHC as a refreshing approach in developing sustainable health system and providing quality health services for those who need them through a better articulation of care across the level of service provision and through an effective combination of prevention, treatment and rehabilitation.

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## **2. Rethinking Primary Care: Training of health outreach workers and improving access to health knowledge in rural areas**

There is a need to rethink the way primary care is provided to rural communities, based on a realistic understanding of current practice and achievable resources. In many cases, this means improving access to health knowledge in rural areas, where 70% of African people live, by rethinking the training of health outreach workers, nurses and medical assistants/officers. This can be achieved by using the capability of information and communications technology (ICT), particularly mobile phones.

Doctors in such areas, who may be serving 50- 80,000 people, need to be trained to work through the primary care team with limited direct patient contact, using ICT. Basic medicines need to be available through nurses, medical assistants and local pharmacy assistants with an agreed list of the further medicines available at controlled prices through licensed pharmacy stores. Such approaches to primary care provision need to be the basis for training and developing a healthcare workforce that would not be suitable for work in other types of healthcare system without further training. At present inappropriate professional education of doctors, nurses and pharmacists often produces health workers more suitable for export than for local needs.

For best practice see rural healthcare programmes in Eritrea and Tanzania and consider the current programme for Improving Nurse Education and Practice in East Africa led by the Aga Khan Foundation. Specific initiatives of ECOSOC should include support for the WHO partnership programmes to identify, accredit and link higher and further education and research institutions

and south led research and training partnership programmes focused on new and emerging models of primary care.

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### **3. Role of community members: Tapping on tacit knowledge**

I wish to express my agreement with the discussed issues about the key role of the community.

The strength of community members themselves in identifying problems and finding solutions in their search for health is 'acknowledged' in science and public health, but often not a priority when it comes to finding budget for supportive (rather than intervention) programs. Problems are identified behind desks, as well as solutions, however often overlook the social-cultural nature of problems and existing social networks. This may be due to the difficult match of those problems with 'evidence based' solutions.

I would like to make a call for the wider use of approaches that better match with the community members' everyday-life issues, e.g. a participatory or an autogenic approach. It just may be that within the process, the positive impact easily out-rates conventional methods.

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**Dated: February 7, 2009 – Vol. 7**

### **1. Principles for renewed primary health care: Rights-based approach and roles of community- and faith-based organizations.**

We need to see PHC as integrated within a context's overall health strategy - not as a solution on its own. PHC must ensure that those in greatest need have accessible healthcare. PHC can and should engage communities to tackle their own health issues so they have genuine ownership of the processes. With local people at the helm, actions undertaken can support the total wellbeing of communities.

Community-based organizations, including faith-based organizations can take key roles in implementing PHC. Perhaps, in the place of primary health care - we need to think 'community health development', 'primary wholeness strategy' or 'community activities for health and wholeness'. But, since PHC is the established term - we'd best retain it but give it further clarity.

PHC needs to use a rights-based approach, leading to empowerment, advocacy and a move away from the perception of "helping the deserving or undeserving poor". As we seek to revitalize PHC we must keep intact the links between levels of health provision - the family level, the community level, referral centers and tertiary treatment facilities.

PHC should promote subsidiarity - the most peripheral and least technical health facility that can provide a service well should provide it. Much care should be home-based. Good examples of PHC that could be emulated include examples in India - Delhi's Asha project, Pune's Jamkhed integrated development project, and Kenya - Tenwek community health project, in Bonet.

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## **2. Overcoming shortage of health workers: Enhancing the role of pharmacists in health care**

The education wing of the International Pharmaceutical Federation (IPF) is involved in an experiment to address this realizing that the potential of pharmacy as part of the solution to the problem of health professional shortage great. I like to share the information and the efforts of the West African Health Organization to address the problem of health personnel shortage in relation to pharmacy.

What steps can both developed and developing country governments take to overcome the shortage of health care workers?

The steps must ultimately result in increased numbers without compromising quality. The FIP is developing a model for cooperation between developed and developing countries. The guiding principle is "First do no harm" so developed countries should interact with developing countries in a true spirit of cooperation for the mutual benefit of both. The federation therefore encourages a pull system from developing countries for assistance. The FIP thus facilitates acquisition of resources requested from more endowed partners in developed countries. The FIP has developed a list of competencies that pharmacists should acquire during their training. Countries are encouraged to use the guide and develop their own programs according to their needs but bear in mind that pharmacy education should be competency based.

What can be done to limit the damage and create opportunities through increased migration of health professionals?

Here it is tempting to focus on only numbers which may be dangerous if quality is not considered simultaneously.

- Pharmacists are an underutilized resource in health care. They can be useful and effective as both resource managers and care givers. They can also be used more widely in many disease prevention and health promotion programs.
- The attempt to address shortages should include elements of quality. Again the FIP is developing global guidelines for quality assurance for training of pharmacists. Ghana and Zambia (Universities and regulatory bodies) are reviewing the tools for suitability in African settings. We find the tools to be very useful. With scarce human resource capacity in many countries and underdeveloped systems, institutions will save resources (human, time and material) by simply adapting these tools.

The West African Health Organization (WAHO) is promoting/facilitating harmonization of curricula in the sub-region. This will allow for mobility of both health professionals and trainers in the region. We hope this will make it easier for countries in the region to share health human resources to mitigate the effects of migration.

What specific initiatives can the Economic and Social Council launch in July 2009?

Do not re-invent the wheel as useful initiatives exist. Examine the programs of organizations like the FIP and WAHO and support them to increase their interactions with professional bodies at country level leading to harmonized regional standards in training and practice.

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### **3. Healthcare privatization and healthcare workforce**

I appreciate all of the insightful comments already offered on this thread, and would add to the public/private sector and brain drain issues.

Public versus private sector

I agree with the comment from Ms. Matthew about the trend toward privatization of health care, and the threat this poses to universal access to health care. I recommend a report that Oxfam will be releasing in the next week or so, entitled “Blind optimism” which addresses the myths of privatization (that it is more cost-effective, higher quality, etc.)—in fact evidence to date shows that it is often not the case. The public sector in many countries has been severely underfunded (due in part to terms of international loans, on top of having limited revenues), providing the rationale for the need to have private providers fill the gap. In reality, the public sector is the only entity that has a mandate to provide care for all citizens—urban and rural alike, including the poor—and that can scale up across an entire country, given the right resources and knowledge. Especially in the U.S., the private sector is revered and it will take educating policy makers to change how and where aid is distributed.

## Health workforce: Address external and internal brain drain

Health workers from poorer countries leave the public sector health system in their countries due to both external and internal brain drain. To deal with external brain drain (the flow of health workers to other countries), we need to both reduce the “push” factors that make workers want to leave (low pay, poor working conditions, insecurity, etc) as well as the “pull” factors that developed countries exert: active recruitment of foreign health workers, and under-producing their own health workforce. Reducing push factors requires investment in the health system in developing countries as well as the educational system to train sufficient numbers of workers. This would mean removing wage caps and other conditions of loans that the IMF and World Bank often impose, and also coordinating among bilateral donors to fund the public sector rather than fund NGOs to set up alternative systems.

Reducing pull factors requires effort at international and national levels – many codes and resolutions have been developed by the World Health Assembly, Commonwealth countries, WHO, etc. to encourage voluntary adoption of better practices particularly in recruiting health workers. It’s unclear what effect those have had. The UK has adopted a Code of Practice for the international recruitment of healthcare professionals, and they have also entered into bilateral agreements with South Africa and the Philippines among others to reduce the numbers of health workers leaving those countries (or at least provide for time-limited placements, training exchanges, etc) rather than outright departures. The bilateral agreements seem to have been most effective, although recent budget cuts that mean fewer UK training positions are available, therefore in several years NHS may end up with either unfilled job vacancies, or have to recruit and hire more internationally.

The U.S. needs to address its own workforce shortage, in part looking at the number of spots in medical and nursing schools, how medical residencies are funded (through Medicare), and the increase in specialists as opposed to family practice and primary care providers who are in short supply especially in rural areas, as others have mentioned.

As for internal brain drain (workers staying in their countries but leaving the public sector and/or clinical practice), NGOs hire workers out of the public sector as staff, and as others have mentioned, this often means into program positions so they aren’t even doing clinical work anymore.

To address this and other burdens that NGOs place on the health system, more than 40 organizations have signed onto the NGO Code of Conduct for Health Systems Strengthening (<http://ngocodeofconduct.org/>). This Code deals with issues of recruitment, compensation, coordination with the Ministry of Health, advocacy, and other factors to help NGOs build the health system in countries where they work. It certainly won’t solve the whole problem but it is a start in building awareness and responsibility on the part of NGOs and funding agencies to be part of the solution. We welcome other NGOs to review the Code and sign on.

### Additional needs?

One comment often made is that “health systems strengthening” is a vague term and it’s unclear how to measure it, especially in low-resource countries where data is not available. Responding to the question about possible ECOSOC initiatives in 2009, bringing stakeholders

together to discuss this and coming to some kind of consensus about measures, indicators, etc that could be used by the global community would be valuable. Similarly, highlighting the need for funding for the public health sector (whether horizontal or “diagonal” funding, with the example of the 15 by 2015 campaign that Dr. Flinkenflogel mentioned) would also be a useful contribution. The International Health Partnership and Related Initiatives (please refer to the following website: <http://www.internationalhealthpartnership.net/>) may be doing work related to both of these issues, but perhaps ECOSOC can contribute as well.

Best regards,  
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#### **4. Sharing the best practices among African researchers and practitioners**

There have been a number of recent initiatives across Africa to create discourse between primary health care researchers and practitioners across the continent. The facilitation of dialogue between PHC practitioners is fundamental to the development of PHC as a clearly defined discipline. One of those initiatives is Primafamed, a Belgian initiative run by Dr Maaïke Flinkenflogel at the University of Ghent ([www.primafamed.ugent.be](http://www.primafamed.ugent.be)). At the end of 2008, Open Journals Publishing, an open access publisher based in Cape Town, South Africa, launched the African Journal of Primary Health Care & Family Medicine ([www.phcfm.org](http://www.phcfm.org)), an online journal whose full text articles are available online free of charge to anyone who has an Internet connection. The first of its kind in Africa, the journal was launched in connection with Primafamed and received considerable funding from the Flemish Inter-University Council (VLIR). The main reasons for the launch of the journal included:

- To facilitate discourse among African researchers and practitioners in order to share best practice;
- To open up dialogue between practitioners from Africa and those in the rest of the world, in order to explore the idiosyncrasies of the provision of PHC in a given location;
- To explore the difference between, and challenges of, the provision of PHC and family medicine in the developing and developed worlds;
- To help cement PHC and family medicine as distinct disciplines in Africa;
- To explore the unique characteristics of PHC and family medicine in an African context;
- To contribute to world literature on PHC and family medicine from an African perspective.

The journal also offers an author assistance feature, which aims to help less experienced authors improve the quality of their manuscripts for submission. Through this initiative, the journal seeks not only to report on African developments in PHC and family medicine, but also to actively contribute to the development of the discipline and the corpus of African and Africa-related academic literature on these topics.



The journal is published in South Africa, but its Editorial Board contains members from numerous African countries and has a large number of non-African representatives. It is double-blind peer-reviewed by carefully chosen PHC and FM experts, and is published on a rolling basis (i.e. as soon as the article is ready for publication). The idea behind rolling publication is to ensure that the journal is a repository for the very latest research on PHC and FM.

For more information, please visit [www.phcfm.org](http://www.phcfm.org) or contact me at [helen@openjournals.net](mailto:helen@openjournals.net).

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## **5. Overcoming health inequality and shortage of health workers: Some suggestions**

How to overcome health inequities, achieve universal coverage and renew health care in Africa, needs new approaches and improving on what has been successful. Some of the things which need to be worked on are:

- a. Change the way health institutions are run by introducing health managers with skills to run hospitals as enterprises, unlike the way things are now using professional medical staff to run hospitals. The health professionals are not good managers as the criteria used is their skills in their field of operations i.e. surgery for appointing them to run health institutions.
- b. Ministry of Health Budgets should include funds for training some people from the community to help out in carrying out some medical duties which be delegated like weighing patients, measuring blood pressure. This is being done with success in management of HIV clients in health centers, but the training currently is sponsored by donor driven projects, this implies sites not under these projects are not benefiting from improved access to universal primary health care resulting from this initiative.
- c. Training of health care staff should be stepped up in both numbers and capacity to handle emerging public health issues, by opening more training centers for health workers, this approach is being undertaken by the Zambian government and in five years and beyond the results will be seen.
- d. Transfer of skills from the western specialized health professionals in managing some of the public health problems like cervical cancer is the way to go for Africa where training specialized professional is difficult due to limited resources

Both developed and developing governments must come up with regulations to address migration of health professions to the West which will be beneficial to both like:

- a. Developed countries to help train more health professionals than they take out of the developing countries.
- b. The health workers working in the developed countries to be contributing through a minimal taxation (3%) of their income back to their countries of origin.
- c. A guideline is put in place which only allows professionals to be recruited from the developing countries through their governments.
- d. The developed countries to identify the type of health professionals they want, numbers they want and only recruit from these cadres as this will be tied to their sponsored training programs in the developing world.

Best regards  
Billy

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## **6. Vertical projects in Uganda: Concerns over country's ownership and sustainability**

I wish to thank Rob Yates for his contribution on free health services for mothers and children. I remember Rob as a team player while working with us on the Uganda Health Plan implementation.

Now, I wanted to bring to the forum an interesting development. Most vertical projects have been minimized in Ministries of Health because of the great campaign not to create inequities in remuneration among public servants.

Alas, these projects have re-incarnated elsewhere in the sector as standalone donor or NGOs projects. In Uganda, the commonest are the HIV/AIDS research projects which are not attached to any Ministry and may be loosely affiliated to a public university for purposes of securing their funding. I recently counted 20 such projects in Uganda and most of them employing a minimum of 10 doctors some of them specialists!! These are directly "extracted" from the Public of PNFP jobs, thus further worsening the HRH crisis. If current trends continue, this situation will worsen.

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## **7. Providing quality primary health care: The role of nurses and midwives**

Developing the role of the nurse and the midwife is one of the most important requirements for providing high quality primary health care. Nurses have in many countries been neglected as a key resource for providing high quality PHC services. They need to be provided with the opportunity to develop their skills and expertise through improved education and service conditions. In many countries it is the nurses who are the back bone of the rural health services

and it is nurses and midwives who have direct contact with families and who provide a holistic approach to care giving.

The development of the Family Health Nurse role in Europe, particularly in the CIS countries of Central Asia has the potential to make a real impact on the health of communities. It has required a radical change in the education of the nurses, recognition of their value and a change in the overall approach to primary health care away from a purely medically led service to an integrated team approach.

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## **8. Resolving health system problems: Innovative engagement of other players**

The efforts on strengthening health system and myriads of problems in Phase 1 questions may require attention or support from beyond the health sectors per se. A common root problem that may be peculiar to these issues is management. Although there are gaps in the management approaches employed by developed nations compared to the developing counterparts for several reasons, the facilities to domesticate the best management principles to strengthen health system is quite available in the developing nations. If well tapped into, the identified issues in question could be resolved earlier than imagine.

Developing countries need to commence the approach to solving health inequities, poor primary health care delivery services, shortage and migration of health workers by involving other sectors in a strategic, collaborative and innovative manner. Drawing on basic principles for deploying the concept of Science, Technology and Innovation into national development strategies, primary sectors that may be crucial to partner with the Health ministries on the identified problems include Education, Science and Technology, and Economy, with mandate for collective engagement from the National governments.

The Universities and their multi-disciplines beyond colleges of Health sciences, and the communities in the disease endemic countries need to be fully engaged to pivot the changes required to develop an all involving health care system.

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## **9. Integrated approach to health systems (as opposed to vertical systems)**

Health systems cannot be built vertically, disease by disease. By working together with cardiovascular and other chronic diseases, health professionals can add strength to weak systems. This is the contention of the World Heart Federation, which represents 195 cardiology societies and heart foundations from more than 100 countries and with a mission that focuses on low and middle income countries. We believe that vertical programs do provide the vital work of delivering interventions which may save lives or prevent illness.

However, for the health system to deliver these interventions over a prolonged period of time requires that issues of financing, human resources and the information base of a health system be addressed. Given that the long term management requirements of HIV/AIDS shares common elements with that of hypertension, it is more efficient to develop an integrated platform rather than for each program to reinvent its own financing, human resources and information system; which is the approach usually applied today.

To date there has been little or no effort to conduct primary prevention programs in resource constrained settings, and evaluate the leverage to be gained from such a collaborative approach. In the face of a critical shortage of health resources – human, financial and knowledge – it is imperative that those involved with the prevention and treatment of infectious and chronic diseases combine forces to strengthen health systems and that donor agencies respond to such a collaborative effort.

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## **10. Migration of health workers: Better working environment and career prospects**

Shortage of healthcare professionals remains a palpable challenge to achieving the goals of universal healthcare coverage and primary healthcare. This problem is compounded by the 'Brain Drain' syndrome in developing countries. Any meaningful initiative to achieve global success in healthcare delivery should of necessity address this issue. The low capacity of healthcare professionals in Africa and other developing countries is drained further by migration of existing ones to developed countries in search of so-called 'greener pasture' - improved

working conditions particularly higher wages, better work environment and better career prospects. This phenomenon has created great imbalance in healthcare human resources between developed and developing countries such that many healthcare professionals chase too few jobs in advanced countries while too few professionals are burdened with so much healthcare jobs - a situation only worsen the resource-restricted and near frustrating environment they often have to work in.

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## **11. Shortage of healthcare workers and migration: Out-of-the-Box solutions – beyond enhancing remunerations**

Inequities in health care in developing countries are due to some fairly well known reasons. In India 80% of the trained and certified health workforce is in urban areas serving 20% of the population. The health infrastructure is similarly concentrated in urban areas.

Working conditions and remuneration are often cited as the reason for this disparity. The problem of health worker shortage in remote rural regions where most of the country's population lives cannot be solved by simply enhancing remuneration. Out-of-the-Box solutions are needed. Creating a work force which is oriented for the rural health care requirements is being considered. The economic disparities and living conditions between urban and rural India are so wide that a candidate with an urban education and lifestyle will serve in a rural area only if he is compelled.

Hence the training of a rural health care provider should start with the selection of appropriate candidates. The training should be in locations which are similar to their ultimate workplace- which is rural health care settings. A task force established by the Government of India for medical education reforms to address the rural health care needs recommended drastic reforms in medical education.

([http://www.mohfw.nic.in/NRHM/Documents/Task\\_Group\\_Medical\\_Education.pdf](http://www.mohfw.nic.in/NRHM/Documents/Task_Group_Medical_Education.pdf))

The recommendations included the creation of a new cadre of rural health care providers through a shorter course than the present 5 year medical degree. The Government of India has adopted these recommendations, but several powerful forces, which include the Indian Medical Association (the largest professional Medical association of India) and the Medical Council of India- the country's medical education regulating body. The undercurrents which drive such opposition to Government policies in public health interest are purely commercial and a form of 'professional turf protection'.

The problem of health workers migration should be seen from a historical perspective. Most serious health worker shortages are in countries with a colonial past. Health workers in these counties are trained in the language of their colonial rulers (English or French) in models of education which were developed for- in most cases- UK or France. These models – I will refer to these in the future as Euro-Western models- produced health workers for needs of the former colonial rulers and more recently the US. It is well known that these rich countries have desisted investments in infrastructure to produce the health workforce that is required in their countries as they are assured, through migration, of the cream of health workforce from poor countries

where the language of instruction is English. These countries are bound to discourage any reforms in much needed medical education systems of poorer countries.

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## **12. Team work concept, free education for girls and involvement of local authority in Sri Lanka**

Having served as a Medical officer of Health for more than 5 years I would like to share some of the experiences and the problems I faced in this primary care setup during my career as public health personnel in Sri Lanka.

### ***Success story lies with the “team work” concept in the primary care setting in Sri Lanka***

Currently all primary health care services are delivered through units-known as the MOH (Medical Officer of Health unit).At present we have 288 MOH officers in Sri Lanka. Every household belongs to a MOH area and this is the administrative and service delivery unit of the area. The recommended population of a MOH area is approximately 60,000. With the MOH as the head of the institution all services are provided through Public Health Midwife (PHM) and Public Health Inspector (PHI) who are the two grass root level workers in the primary health care setting. A MOH area is divided into several PHM and PHI areas. The recommended population of a PHM area is approximately 3,000 while for PHI area this is 10,000.Public health midwives provide antenatal, post natal care, immunization, family planning services and they provide these services by both domiciliary (Home visits) and field care (Field clinic).Their field services are offered at antenatal clinics, well baby clinics and family planning clinics. During domiciliary care the midwife visits households to recruit, examines pregnant mothers, conduct basic investigations provide health education and motivate to utilize primary health care services.

The role of PHI is to conduct epidemiological surveillance in relation to notifiable infectious diseases, water and food sanitation. Field visits are made to supervise the maintenance of water supplies, ensure proper disinfection, send water samples for bacteriological and chemical analysis, inspect private and public wells and ensure that improvements are carried out. This solid framework of PHC staff with their activities have paved the way, to improve health indices-reduction in high rates of maternal child mortality and birth-related diseases and a very good coverage of EPI in Sri Lanka, which has resulted in a sharp decline of vaccine preventable diseases. Health care workers have a due respect from the society and this has improved in accepting and delivering their services very efficiently. PHC worker in each and every MOH unit acts as a family on every occasion, in a disaster, epidemic or in any health related problem, national or at local level and they act promptly as a team to halt the current problem in spite of their routine activities. Apart from this “team work” concept the motto in each MOH unit is ‘to know your people, know your area ’which is very essential in delivering primary health care successively everywhere and I suppose it should be the same universally.

### ***Investment in free education for girl child has played a big role***

Soundly health of family mainly lies on the literacy rate of their mother; which is very true for the Asian countries who take much of the burden in rearing children and looking after their family; and Sri Lanka is not an exceptional to the rule. Apart from this solid approach of Primary Health care other non health related factors especially high literacy rate of the females and free health services to all have contributed immensely to the success story in Sri Lanka. With Free education and equal educational opportunities to both boys and girls, every child- rich or poor if eligible gets the opportunity to climb the horizon –up to the Post Graduate Education. We as citizens are indebted for this free education system, which otherwise would not have been what we are today. Besides it has paved the way in accepting and practicing the basic health messages given at primary care setting correctly.

### ***Local Authorities should get involved actively in delivering primary health care efficiently***

All local authorities are elected bodies, and their chief executives are Mayors in the respective Municipal councils and Chairman's in the local councils. They have a broad function on environmental sanitation and Public health in their respective areas in implementing health related issues, which is not active in most instances. For instance in construction of Housing and Buildings in Sri Lanka, the Local authority should contact the relevant health authority and forward the relevant applications with the plans; before granting permission to construction purposes. Here the relevant Public health personnel, specially the area PHI have to visit the place, environment and inspect for the suitability of that place as a location for the required purpose, according to relevant ordinances; and go through the building plan to see whether it is fit for human dwelling/for construction.

But now we see that is not followed as taking ransoms bribes for granting permissions haphazardly, by passing the health authorities resulting in many unhygienic and illegal dwelling places have cropped up. Further in other public health problems like dengue which is occurring in epidemic proportions even now the respective local authorities are not bothered - haphazard solid waste collections, has resulted in difficult to controlled many communicable diseases. Solid waste management is a responsibility of the Local governments in Sri Lanka. There is no proper garbage-discharge system in many local authority settings, though collection method varies from place to place; so the sanitary conditions are poor due to animals like goats, dogs, cows, cats, foraging for food. Many drains are full and blocked with garbage, resulting many preventable health problems .So there should be more motivated leadership which can cater to the local health needs more efficiently.

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### **13. Overcoming health inequalities: Health financing and health insurance based “community” approaches**

I have agreed that inequities in health services have occurred in everywhere in the world. To overcome health inequities, a lot of stakeholders and different domains should be considered for renew PHC, especially Health Financing and Health Insurance Based Community Approaches.

To achieve MDG in health, different stakeholders should take their owners responsibility for overcome inequities health care services. The government should consider to investment for health system in mountainous and remote area of the countries (they have understand on that, but they have a lot of things need to be focused at the same time also). However, inhabitants, especially people in remote and rural areas of developing countries, should aware of their rights and their responsibilities to overcome health inequities. Most of them are passive in receiving all services but they not much aware about quality of services (qualification standard, quantity of services, accessibility, attitude of caregivers, costs of services etc) while they consider that health care services need to be subsidized all from government, or they cannot pay the cost for health services (including prevention and intervention in care and treatment).

Health Insurance and Health Financing was considered to start in developing countries that experiences from developed country will be applies in this term. E.g. lesson learn from some countries like Philippine, Indonesia, Vietnam and Cambodia to be replicated in Laos or Africa countries. In this term, villagers at grassroots level will be capacity building (bookkeeping, account, fund management etc) on micro credit and saving for as saving fund for group members who are sick. Some experiences have been gained by apply that term e.g. Vietnam and Indonesia.

But HIF is one aspect only. Caregivers play a big role for Strengthening Health System. Health workers normally want to work in convenient places. Health worker want to work in the city or town, where inhabitant can pay the cost easily than in sub urban or report/mountainous area. It means, give health services in these place, their salary or income may be better. That is why number health workers in cities or towns is much higher and higher. In a lot of developing counties, percentage of health worker per inhabitant is not the same. It means, shortage of health care workers is occurring in remote, poor and mountainous areas. To overcome it (health inequities and shortage of health care workers), several steps may consider as follows:

- Increasing benefits of health care givers in difficult areas (income and abilities for upgrade professional trainings)
- Improving health facilities at difficulties areas
- Renewing medical equipments (and capacity building for workers who use these tools)
- Learning and sharing opportunity for all stakeholder, not government office at higher level (focusing in private sector and communal level)

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#### **14. Achieving universal coverage through financial risk protection: Nigeria's case (MDG 4 and 5)**

Poverty is the main reason why many people are not able to have access to basic health services in many parts of the world. In Nigeria, the lack of financial access is a major driver behind people's decision whether to access ante-natal and emergency obstetric care, immunization, malaria treatment or other health services. Apart from the direct cost for treatment and drugs, indirect costs such as loss of productive man-hours, and even travel to a health facility often act as a significant barrier of access to the poor for services such as TB treatment, family planning or ante-natal care. It has been observed in Nigeria that the biggest source of finance for the health sector is out of pocket expenditure and that the poor spend a disproportionately higher percentage of disposable household income on healthcare. Most of this expenditure occurs in the private sector or through unofficial user fees in the public sector. These out-of-pocket payments in the form of user fees create considerable negative impact on equity and access in addition to healthcare utilization. It has been noted that people do not attend health facilities unless they are seriously ill. When referred to a hospital, people often turn up only after several days because they needed time to organize the money from relatives or out of other sources. Delays in seeking care and the diminished healthcare utilization especially by vulnerable groups such as pregnant women and children have been linked with the high morbidity and mortality figures experienced by these groups.

Under different donor supported programmes but in particular Partnership for Transforming Health Systems (PATHS), funded by the UK Department of International Development (DFID), several strategies to help reduce financial barriers to health care services have been tested in Nigeria. These include: promoting community loan schemes, community transport schemes, and promoting birth preparedness plans with advice to save money in case of emergencies. Others are deferral for payments for clinical services, exemption from payment for certain health commodities such as insecticide treated bed nets, and free maternal and child health services. A national health insurance scheme that adopts a modified managed care model using a phased approach towards the national goal of achieving universal coverage has also been in operation for the past five years or so. Only recently part of funds available through the debt relief granted to the country has been channeled through this mechanism to specifically provide financial access for children under five of age and pregnant women – targeting the Millennium Development Goals (MDGs) 4 and 5. Community Health Funds (heavily subsidized by donors or government) that allow rural people to access the same level of health services available to workers of Multinational Corporations are also in operation.

Many of these programmes could be judged to be successful as demonstrated by the widespread adoption by many State governments<sup>[1]</sup>. However, after several years of implementation, many of them still operate on a scale that is still far from making significant progress towards universal access for basic health services. For example, the national health

insurance scheme only covers 2% of a population of 140 million compared to 30% in neighboring Ghana, although with only a seventh of the total population of Nigeria. Similarly, the financial access component for achieving MDGs 4 and 5 only operates in 6 out of the 36 States and in only 3 three districts in each of the States where the programme is currently being implemented. Apart from the small scale of operation, there is still lack of understanding of the equal importance on working on the demand side of the health system that can match on-going actions of working on the traditional supply side. Many of the reforms in re-vitalizing the health system has been targeted at the supply side – building and infrastructure, drug and equipment availability, human resources for health; without considering how people are going to pay for the care they will receive.

However, we have gained some useful insights on how to achieve universal coverage from running these pilots. First, we have become aware that mechanisms other than social health insurance and general taxation, which provide access to health services ‘free at the point of delivery’, have huge potential to reduce inequity, increase health service utilization and consequently improve the health status of the population. We have also come to understand that in order to achieve the desired impact – financial risk protection schemes have to be undertaken on a large scale. Apart from the potential of achieving greater impact, the same level of managerial sophistication is required to manage even the smallest of such a scheme – large scale programmes therefore could take advantage of economies of scale and reduce transaction cost. Lastly, we have come to appreciate that systems for financial risk protection have to be deliberately undertaken as critical components of the health system and indeed can serve as the main ‘control knob’ for transforming national health systems that are failing to deliver even the very basic of health services for its citizens.

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[1] Many of the States in Nigeria have populations well above many countries in sub-Saharan Africa. And Nigeria being a federal country, the States also have considerable autonomy and resources to plan and implement their specific health programmes.

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## 15. Grassroots mobilization of public opinion for two key UN resolutions

We represent a catalytic grassroots global movement of more than 19,000 nurses and concerned citizens (from 87 UN Member States) participating in the first steps of a global advocacy initiative called the “*Nightingale Declaration Campaign*.” Of these individuals, 1000 represent organizations and associations that total millions of constituents worldwide. This Campaign is creating public awareness about health as a global priority for everyone.

Particularly, the *Nightingale Declaration* encourages nurses to speak up for a healthy world everywhere (See [www.NightingaleDeclaration.net](http://www.NightingaleDeclaration.net)).

From this vantage, we fully understand and appreciate that one of the key priorities for global health is the global strengthening of health care delivery systems. We have reviewed the excellent responses from stakeholders concerning health inequities and we appreciate the expertise being focused on this multi-faceted global challenge by this first e-Group project of the UN ECOSOC planners seeking to strengthen health systems delivery worldwide.

Almost everywhere there is sickness and suffering, nurses are present, at least 15 million worldwide. They are universal caregivers providing 80 percent of the world's hospital and primary health care delivery. Nurses are revered and respected the world over. They are end-deliverers of health care in every nation and community catalysts of health development. They are the 'arms and legs' of health care, steadily advancing — including through health promotion and education — toward the goal of health for all humanity.

Our recent research, however, reflects that awareness of the critical roles, played by nurses in society, is very poor. Although each nurse is committed to promoting the health of people, wherever they can, very few have used their voices to impact health on global scale. As individual nurses come together worldwide — in teamwork with citizens who are also concerned about health — this Campaign will indeed become a powerful force for the health of humanity. To achieve this goal, we have identified several innovative approaches which we encourage the UN ECOSOC planners to review and incorporate into their discussions and recommendations for consideration of the 2009 UN General Assembly.

A public awareness campaign using 2010 as the *International Year of the Nurse* is being planned (by nursing groups around the world) as a united, catalytic call for "*Creating a Healthy World.*" The *2010 IYNurse* will actively involve the world's nurses (as many of the estimated 15 million as possible) in celebrating their profession and renewing their commitment to bring health to their communities, locally, nationally and worldwide. The *International Year of the Nurse, 2010*, is a collaborative grassroots global initiative to honor nursing's voices, values and wisdom and to launch the proposed *United Nations Decade for a Healthy World, 2011-2020*.

*The 2010 IYNurse is, thereby, a global platform for millions of nurses to call for renewed commitment worldwide (nationally, regionally, locally and individually) to establish and implement the mandate of this UN Decade for a Healthy World, 2011-2020.* In the next round of discussions within this e-Group, we will be sharing more about these proposals. Based upon two years of pro-active planning (throughout 2007 and 2008) a worldwide network of nursing representatives will continue to develop, throughout 2009, an interactive *2010 IYNurse* website (under construction at [www.2010IYNurse.net](http://www.2010IYNurse.net)) and related international, regional and community events and projects (both large and small) to span the entire *2010 Year*.

All *these* events and projects for the *2010 IYNurse* (as well as the global call for the *United Nations Decade for a Healthy World, 2011-2020*) will be highlighted for coverage, on a global scale, by media-re-disseminators, journalists, broadcasters, publishers, filmmakers and Internet content developers. These plans for mobilizing public opinion are also fully in keeping with World Health Assembly Resolutions 59.23 to "rapidly scale-up health workforce production" and 59.27 to "strengthen nursing and midwifery." They also support current related international

and national efforts to establish a plan and 'Framework of Action' to follow through on Resolutions of the World Health Assembly.

The *International Year of the Nurse, 2010*, also marks the Centennial of Florence Nightingale's death [1820-1910] and the concluding year 2020 of the *Decade for a Healthy World* marks the Bi-Centennial of her birth. Both years (2010 and 2020) will become significant milestones highlighting the worldwide contribution of nurses in achieving a healthy world. The *International Year of the Nurse, 2010 (as the launching year for the United Nations Decade for a Healthy World, 2011-2020)* will provide 15 million nurses with a global opportunity to strengthen the multi-disciplinary and multi-sectoral ranks of pro-active civil society to broaden the scope of their health promotion practices, and to be heard as trusted *global* voices expressing their concerns and establishing a significant, effective global platform for their advocacy.

We believe that all aspects of the *Nightingale Declaration Campaign* fully support the 2009 UN ECOSOC theme of "implementing the internationally agreed goals and commitments in regard to global public health." And, in particular, we are certain that our catalytic proposals to mobilize public opinion are profoundly relevant to the 2009 UN ECOSOC mandate.

With all of these global developments in mind, we strongly encourage that 2009 UN ECOSOC discussions and plans include a specific initiative recommending these proposals requesting the 2009 UN General Assembly to adopt two United Nations Resolutions for the:

*United Nations International Year of the Nurse, 2010* as a catalytic launch to strongly establish the *United Nations Decade for a Healthy World, 2011-2020*.

A Preliminary Draft of these two UN Resolutions is available on request.

In addition, we strongly encourage that all developed and developing country governments request each of their 2009 UN General Assembly Representatives to adopt these two UN Resolutions. Such a global commitment (within the UN's high-profile international arena) would establish a clear collaborative public stand, addressing the shortage of health care workers and the social and environmental conditions that contribute to this critical, chronic condition, a social wound that daily affects the health of all humanity.

Respectfully written (on behalf of 19,752 nurses and concerned citizens from 87 UN Member States) and submitted to all interested parties on February 6th, 2009 by:

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## **16. Challenges of overcoming health inequalities and shortage of workers in Sierra Leone**

I have been reading your interesting contributions on overcoming health inequalities. My country is a least developed country and facing many issues of health inequalities and access to treatment. Utilization rate of health facilities was estimated at 0.5 contact per capita per annum (health sector review 2004), meaning half the population attend a health facility once a year, which is relatively low by international standards.

According to service delivery perception survey 2006, the southern region of Sierra Leone, has the highest proportion of people feeling sick. The first option for many are community health centers, health post and maternal and child health post (MCHP), with government hospital the second option-Traditional birth attendants (TBA's) are an important stake holder in our health setting. According to recent survey by UNFPA-Sierra Leone, majority of rural pregnant women felt comfortable and open with these TBA's and rely on them greatly, rather than the formal health workers. These rural women are now the main target as maternal death is high among them (Sierra Leone has the highest maternal mortality worldwide).Some of the factors responsible for these increases are: -Reluctant of TBA's to refer when complications arises.

The cost of treatment in the formal settings

Unpreparedness of rural community hospitals to adequately respond to obst/Gyne emergencies

Distance to health facilities.

The government of Sierra Leone has now establish measures to offer free obst/Gyne care for all pregnant women who attend clinic or hospital and also free under fives treatment to children. In addition, the Bamako Initiative on cost recovery for essential drugs is been implemented, making drugs available at affordable cost to the poor and vulnerable. This is to address the issue of cost alone, but other important measures must be taken into consideration to address some of the other barriers, i.e. Reluctance to refer, Unpreparedness of formal health facilities and Distance.

I think proper sensitization of TBA's on importance of early identification of complication with immediate referrals. Again, incentives to TBA for any such referrals are essential

Allocation of formally trained personnel to oversee these birth attendants but again, were do they get these trained personnel, as most skilled nurses and doctors are not willing to work in rural district hospitals not to mention remote villages were these target women are.

This brings me to the second part, overcoming shortages of health care workers.

Retaining our health workforce is a significant step in improving health in poor nations but this has been almost impossible as a result of factors such as low salary level for health professional, particularly doctors and nurses. One method Sierra Leone has implemented is decentralization of training institutions in community health nursing, this might help in retaining these nurses to work in communities were they have trained. But what about specialist nursing training and medical training, these are still centralized in the capital city, resulting in reluctance to work in rural areas upon completion of training.

Generally, rural areas of developing nations must be developed and made attractive so as to reduce rural-urban migration among the population. In this way, health workers originating from these areas would be motivated to go back and help in their communities

Training of more personnel is also an option, though not effective. For the past five years, government has been losing doctors and professional nurses faster than anticipated.

I think involvement of nationals (Doctors & Nurses) living and working in developed nations should be encouraged to 'Give-Back' to their various countries, either in the form of remittances or knowledge sharing and transfer. Meanwhile for those still working, they should be encouraged through health professional salary restructuring is mandatory for all governments.

Professional Development for staff

Other staff welfare consideration

Introduction of 'Rural Workers Package' to attract more health workers in the rural areas

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Ministry of Health & Sanitation, Sierra Leone

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**Dated: February 9, 2009 – Vol. 8**

## **1. Use of data for cross-sector influences**

One of the things that are missing in the discussion is worthwhile data. Without useful data, all we are doing is sharing opinions, which may be interesting, but is a bad basis for decision making and policy formulation. I am struck by the rather limited attention to cross-sector influences (e.g. lack of roads, transportation, electricity, equipment, trained staff, medicines and money, etc). I am also struck by the health experts' lack of attention to the role of malnutrition and what might best be done to prevent disease.

My work in development planning goes back some 30 years ago, and I find it appalling how little information there is about what things cost and how effective things are. There is little feedback about how hard a few health professionals work, how little useful support they get, and how much need there is for basic (very basic) medical services. I am sure there are many with good experience around the world that good give guidance about how modest amounts of incremental money and knowledge could improve the health outcomes significantly. The conversations I have had suggest that modest improvements in the rural health infrastructure might be a good starting point, with infrastructure here being the broader meaning that includes both physical infrastructure as well as the human capacity.

Peter Burgess

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## **2. Reaching rural communities in Namibia**

Strengthening Primary health care plays a critical role in achieving universal access. In Namibia, Prevention of Mother to Child Transmission programme is managed under the primary health care division which has deeper networks into rural communities. Since more than half the population of Namibia resides in the rural areas, access to PMTCT programme for pregnant women is made easier and affordable. The first dose of Nevepapine that is given to a pregnant woman when she goes into labor is available in the rural health care centers and administered by trained health care workers. Measures are currently being put in place to include treatment of both parents. Therefore, strengthening this system through strong policy backing and consistent deployment of trained health workers can yield profound results in achieving universal coverage especially to communities in the rural areas.

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## **3. Investing in community participation and empowerment**

Thank you for consolidating all the contributions. As for the hypothetical situation that you have posed, this is the actual scenario in many areas of the world. However, designing incentive schemes to encourage health professionals to work in such areas will seem similar to providing ready made solutions borrowed from outside to address very complex indigenous problems.

The whole point in empowering people (“People should be better informed of basic health information and care availability to able to tackle their challenges. More investment should be made at community levels both in terms of human resources and empowerment of local populations”) is to promote people’s participation in understanding and solving their problems. Empowering people is not just about improving health indicators but about investing resources, both financial and human to support autonomy in communities. From our work on empowering women in Pakistan we have learnt that empowerment is a process of liberating the self accompanied with giving autonomy to others. The mere process of empowerment contributes to the overall well being of individuals and communities while other objectives may also be fulfilled.

So my suggestion would be to invest in programs that promote community participation and empowerment not just situation analysis or problem resolution. I am not suggesting that situation analysis or intervention projects are useless but their approach is more paternalistic (as opposed to being participatory) hence their success limited by community acceptability. From what I know, health projects and programs are usually designed to achieve institutional goals that may be relevant to the communities but are not their priorities. Despite such

unshared vision we expect community people to abandon their fears and accept everything from the outside (why should they?), knowing that projects and programs will leave them in the lurch once their goals are achieved? We forget that considering human relationships is important when we talk about addressing health problems as individuals do not exist in a vacuum but in an ocean of varying relationships. Health programs that endeavor to understand and build on the existent human relationships would prove to be more successful in empowering people while resolving problems that may include those of health, education and economy.

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Karachi-Pakistan

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#### **4. Extending healthcare in the poorest parts of Africa: Health scheme voluntarily financed by the predominant informal economic sector**

A few years ago, after completing my PhD studies in Development Communications & Public Administration in Canada and a few stints as a World Bank Consultant in Africa and Albania, geared toward the improvements of health, nutrition and populations or social Security policies, with my former partner who is more specialized in telemedicine and PHC issues in the continent, I developed some thoughts about how to extend healthcare in the poorest parts of the continent, through a health scheme that could be voluntarily financed by workers in the predominant informal economic sector of the continent.

Since many in Africa work in that sector to make ends meet or as a temporary employment while waiting for a job in the formal sector and in the meantime, honing their business skills, I wondered to what extent a system set up by people in the sector, managed by themselves with their own long term interests in mind through a small "tax" or deduction from their sales, could not grow up to a national level, therefore providing them with an adequate healthcare system and coverage, capable of supplementing public funding of the sector; this will also help to avoid corruption that may hinder the system if it were to be managed by appointed civil servants not part of the scheme.

The idea stemmed from my own mother who occasionally sells some sugar canes, banana plantain bunches, pigs, chickens, pineapples and various products from her field, in front of her house on the road from Yaounde to M'balmayo, Cameroon. She uses the products of these sales to supplement her income (or for various social events such as births, deaths, sickness of family members) but not in a systematic/national scheme for her own health.

I do not know if any scheme like that works in any part the world? Villagers who make up more than half of the population of a large number of African countries, but do not belong to any official labor force are among those not benefitting from any systematic healthcare system, apart from those offered by States, with all the inadequacies already outlined by participants in this discussion group.



Best regards,

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## **5. Health inequities and renewed primary health care: Non-communicable diseases**

Non-communicable diseases are not currently part of the Millennium “Development” Goals (MDGs), yet non-communicable diseases (NCDs), such as diabetes, are most definitely strongly related to forces of development (e.g. mechanization, and globalization). The burden of non-communicable diseases is increasing in low- and middle-income countries and by the year 2030 80% of people with diabetes will be living in what is now called a developing country.

It is often not realized that there are inequalities in health in non-communicable diseases, even in poorer countries. Initially NCDs are more common in people who have higher incomes in lower income countries, but this pattern changes rapidly to become more similar to that seen in higher-income countries where those with lower socio-economic position are more likely to get diabetes and have worse health outcomes (more complications, higher mortality).

Care for diabetes in countries in Africa, for example, also tends to be delivered through hospitals rather than through primary health care, meaning that attending a clinic costs money for transport (in addition to any users fees that may be in place) and, sometimes more importantly, time. If we wish to “overcome health inequities, achieve universal coverage and renew primary health care” part of the renewal needs to include rethinking what primary care needs to be addressing. This means acknowledging that burden of disease patterns are changing in low- and middle-income countries and that primary care and the MDGs need to incorporate major non-communicable diseases.

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## 6. How to retain healthcare workers in rural areas: Zambia's case

Allow me to contribute to the following questions: What are incentives schemes for health care workers and doctors to work in rural areas? Have there been any innovative ways tested in specific contexts that demonstrated promising results?

### *The Health Worker Retention Scheme in Zambia*

Zambia has an acute shortage of health workers, in quantity as well as quality, especially in rural areas. The lack of trained health staff is the key factor that is being addressed by the government and its cooperating partners to improve health outcomes and in the potential scaling up of services. The retention scheme introduced in 2003 for Medical Doctors was successful in attracting and retaining this cadre in rural and remote facilities; 88 doctors were retained for the 3 year contract period and 65% renewed for a second 3 year term. The scheme has now been expanded to include tutors, lecturers, Zambia Enrolled Nurses (ZEN), Zambia Enrolled Midwife (ZEM), Environmental Health Technologist (EHT) and Clinical Officers. The Retention Scheme package includes Monetary and non-monetary monthly salary top-up, improving basic infrastructure, provision of equipment, staff accommodation, electricity/solar power, water, etc

### *The incentives differ in terms of distance and remoteness, but the objectives are the same:*

1. To encourage health professionals to move to and work in the rural and remote areas
2. To reward qualified employees for providing clinical and healthcare services to patients

The scheme is **NOT** about higher qualifications or job rank and levels - it is about provision of care to patients in hard to reach areas that are more than 65km away from the nearest District Health Office / District Hospital.

It is essential that these retention schemes are in line with one government led plan and pay reform. Governments must provide adequate high level leadership in the scheme. Government should also ensure that clear job descriptions, set targets for their own work and have their performance regularly monitored under the scheme. Strengthening leadership skills at all levels of the health system, together with stronger line management will assist with improving performance.

Emmanuel Mali  
Economist

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## 7. Overcoming health inequalities: Policy examples at community, national and international levels

Greetings from Afghanistan. I enjoy reading the responses and learning a lot. Based on my experience of working in Asian countries (Bangladesh, Sri Lanka, Pakistan and Afghanistan), I tried to respond to the questions of the moderators which are as follows:

a) What policies would universally be effective to address such a situation in order to reduce inequities and achieve universal coverage and renew PHC, regardless of other socio-economic parameters?

1<sup>st</sup> step (at community level) - Developing trained cadre of CHW

- Will be working at Health Posts – first static center
- Working with minimum remuneration but different motivational factors should be there considering the country context
- Will be the main focal point of community health
- Supported by Community Health Management Committee
- All the health activities at community level should be coordinated with CHW like immunization, health education and awareness campaign
- Supported with regular supply of basic medicines and other logistics for first aid
- Will be actively involved in referral mechanism
- They will be responsible for preventive as well as curative treatment

2<sup>nd</sup> Step (for few communities) - Trained technical cadre of Public Health Midwives (PHM)

- Who will be taking care of Maternal and Child Health referred by CHWs
- Will run Well Baby Clinic, Well Women Clinic, ANC & PNC clinic
- Will refer the cases to Basic Health Center (BHC) where Medical Officer of Health (MOH) will take care of the cases. The centers will have outpatient as well as inpatient facilities

b) What can and should the international community do to support national efforts?

***International Community should support the following:***

CHW system with ensuring

- Training of CHW -strengthening training centers with infrastructures, resources materials, trainers
- Supporting them with drugs and logistics, basic equipment
- Motivational factors like arranging exchange visit
- Helping further professional development with stipend, fellowship for potential CHWs
- Arranging annual award system for most dedicated, motivated CHWs

## PHM system

- o Strengthening further training and refreshers training of PHM
- o Construction / Renovation of PHM clinics
- o Supporting the clinics with, logistics, furniture, running water
- o Supporting the PHM with basic equipment and drugs
- o Arranging transport for the PHMs to attend clinics (once we supported the PHM with motorcycle but most of the time either husband or other family members were riding that)
- o Arranging residence for the PHM near clinics
- o Motivational factors like arranging exchange visit
- o Helping further professional development with stipend, fellowship for potential PHMs
- o Arranging annual award system for most dedicated, motivated PHMs

## Supporting overall Health System Strengthening, specially:

- o HMIS system with logistics (computer, software, internet) and training of personnel starting from data collection to data utilization.
- o Establishing Disease Early Warning System (DEWS) with collection and utilization of data on a regular basis.
- o Establishing referral system helping with ambulance, driver overtime, fuel and emergency doctor and paramedic
- o Supporting the health personnel specially the CHW, PHM with communication device like mobile phone, wireless phone to communicate with supervisor in case of complicated patients
- o Monitoring Evaluation system with expertise, financial support for vehicle, fuel to conduct regular monitoring of ongoing activities
- o Structured on the job training with logbook
- o Supporting training center for CHW, PHM, other Health Paramedics
- o Introducing motivational factors like exchange visit, fellowship for further professional development
- o Supporting preparation of report at least monthly basis from MOH /district level and utilization of the report

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## **8. Rural vs. Urban: Fair allocation of financial resources**

Though there are exceptions, governments and any other institution offering medical services should strive to remunerate workers equally irrespective of the regions where they are working i.e. urban or rural. Government and any funding should follow suit too with respect to allocation of funds, equipments donation, etc.

Training institution should ensure that admitted students are enrolled from all regions. Portion should be allocated to the regions and performance indicators analyzed periodically. In fact funding should be channeled to the local regions to gather for their specific needs.

The international community should visit and identify local needs to support. Such support should gather for all the relevant divisions involved and governments asked for their input.

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Kenyatta National Hospital, Kenya

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## **9. High Level of Brain Drain: Causal analyses**

### ***Why do healthcare workers migrate?***

The overall economic and social contexts in which healthcare workers make the decisions to migrate are: wars, deprivation, and social unrest may all provoke waves of migration. The migration of health workers is primarily demand led, with workforce shortages in some destination countries, such as USA and UK. The availability of employment, particularly in the developed world, has a significant impact on the decision to migrate. The factors affecting health professionals' decision to migrate are:

- Want better or more realistic remuneration
- Want a more conducive working environment
- Want to continue education or training
- Want to work in better managed health system

In general, migration is influenced by social networks, which offer support to new migrants and often connections to employment. Nurses have links with nursing organizations and networks that may foster further migration. These networks then assist new migrants with social and cultural assimilation. A similar picture emerges for countries with colonial and political ties, where there are already established cohorts of migrants.

### ***Strategies to address brain drain***

The issues surrounding brain drain are complex. For developing countries, scientific trainees who fail to return are a drain on the economy and on capacity building. While abroad, they can contribute to scientific advances of importance to their home country and serve as mentors for other trainees. Continuing Medical Education (CME) initiatives are one example of such efforts, which can be of benefit to donor, and recipient countries both. Some factors cited by researchers from developing countries as reasons for not returning after training include: lack of research funding, poor facilities, limited career structures, poor intellectual stimulation, threats of violence and lack of good education for children in their home country.

However, not all the factors involved in brain drain is due to scientific and research funding; some such as violence and civil war are major factors for not returning back to the home countries. Strategies to manage migration of health professionals to protect national health systems will be successful only if all stakeholders are involved in the process. Although the brain drain undeniably has serious negative effects, these may be turned around to benefit migrants' home countries if managed well. Some training and skills gained abroad may really be more appropriate and better applied in developed countries than at home.

Given the borderless nature of disease and the international and interdisciplinary nature of current scientific research, international collaborations are the key to addressing global health issues. Trained scientists are needed in every part of the world. The issues surrounding brain drain are complex. Providing equipment, access to journals and the Internet, and small re-entry grants appear to be practical strategies that could facilitate continuing research in lower-income countries. Low-cost measures such as networking support with writing grant applications and mentoring strategies also are useful.

How can research interest and funding in developing countries be sustained in order to attract the brain drains? Governance of local research institutions, perceptions of fairness of academic and career progression opportunities, general optimism regarding progress in the country as a whole and the outlook for ones family and children's future are significant factors in determining whether professionals stay at home.

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## **10. Overcoming shortage of health workers: Incentives must be realistic**

It is important to recognize that a qualified doctor has valuable professional skills and will have expectations and needs that simply cannot be satisfied in poor, rural areas. Thus apart from those obliged by training contracts to serve in rural areas and those motivated by faith, most medical practitioners in such areas will not be qualified doctors for the foreseeable future. Many doctors working in rural areas of China are the modern equivalent of "barefoot doctors"

selling traditional medicine and with some basic modern medicines, this work without much contact with the qualified doctors operating from clinics and hospitals in towns.

In Cambodia local doctors are part qualified medical assistants operating from hospitals and clinics in local towns. In Africa, “Daktaris” in District medical centers are mostly trained medical assistants able to diagnose common diseases and dispense a limited range of available medicines. In Ethiopia rural medical practitioners are likely to be health workers in villages building on tacit local knowledge working local community leaders as well as with qualified staff in district centers. These models work much better if nurses, medical assistants, health outreach workers and traditional medicine providers are not seen as simply “doctors’ assistants” but as the core of the health system with ICT providing improved access to medical knowledge from reliable sources.

The provision of better medical knowledge can be self-financing. Rural people know about modern medicine and pay a high price in transport and at shops, dispensaries or informal sources. They want better information and will pay what they can to obtain it, often using mobile phone based resources when available. Thus a local health worker supported by solar powered ICT could sell information services along the lines of NHS Direct and medicines dispensed according to ICT supported protocols.

An integrated approach to the provision of knowledge, including health, education, entertainment, contact and communications could also work. In Zanzibar for example District Information centers provide health and education knowledge. This does not require continuous online access, which is expensive. Schemes like eGranary and the Global Health Campus developed with the University of Iowa and used in Nigeria and several other African countries can provide access to up to a terabyte of knowledge held on portable hard discs ( now available for \$100 or less) and internet conferencing suitable for low bandwidth connection. Such services could be funded by fees or by local contribution as a form of mutual or cooperative funding. The main obstacle to such developments is lack of appropriate education and training and unrealistic models of health systems.

Current low pay rates in most poor country systems mean that informal payments produce incentives that are corrosive to the system. A recognition that people need to be able to earn an income commensurate to their capability could provide the basis for regulated local mutual insurance or fees for service which would be less costly to the system and to local people than current approaches which result in both low wages for health workers and high informal costs but without positive incentives to provide better health services.

The international community can support investment in the information and communications technology to make this work and could support higher and further education and research institutions in these new disciplines, it would even be possible to provide online backup to local knowledge services as a resource to local communities of practice. But most importantly the international community should stop pushing models of primary healthcare based on unrealistic assumptions about professional roles and structures.

Dr. Graham Lister

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## 11. Aboriginal health workers (AHW) Australia

**Dear Dr. Islam:** I found your description of health worker training and work in Afghanistan very moving and wonder if you have access to internet if you may be interested to Google Aboriginal Health Workers Australia. AHW in the Northern Territory/Old and Western Australia have for many years successfully engaged their communities and undertaken some clinical duties (please see [www.aihwj.com.au/issues.html](http://www.aihwj.com.au/issues.html))

Warm Regards,

Liz Orr

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## 12. Health inequalities: Roles of frontline health workers in policy formulation

How can we overcome health inequities, achieve universal coverage and renew primary health care (PHC)? What are examples of successes toward universal coverage that could be replicated or scaled up? How can countries learn from each others' experience in this?

### *Involvement of frontline health care workers as partners in policy formulation*

In most cases frontline health care workers are rarely involved in policy development and change. Their views are almost never solicited when policy reviews and change is done. Rather the people involved in the health policy development are often detached from the contextual realities on the ground. For this reason Health inequities from the perspective of the frontline health care provider is often left out. This leads to impossible to implement health policies, which tend to be developed to be implemented as vertical programs yet there are no human resources to cope with the numbers of these vertical programs.

Again the frontline health care workers may not know exactly what is contained in the policy documents for the simple reason that the documents rarely find their way into the health facilities. This also denies the frontline health care worker an opportunity to interact with these policies adequately to be able to raise issues around them that may be pertinent to addressing health inequities.

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### **13. Overcoming shortage of health workers: Improving remuneration, benefit structures and agricultural income**

Thank you very much for facilitating a fruitful dialogue. The moderators raise an important point in their conclusion drawn from the previous dialogue. To address the issue of inadequate human resources for health, we need to move away from the primary health care school of thought for some time.

While it is true that the primary responsibility of health care provision rests with the state (i.e. the governments, at any level), most of the time the factors that affect primary health care are beyond the reach of the health department. Primary health care is not a stand-alone issue.

Human resources for health - may it be doctors, nurses or health care worker at any level of training - cannot function in isolation. They would have a family to care for as much as the people living in the service area. To address the issue of brain drain or disproportionate access to health care services, we have to address the human aspect of the health care workers' lives.

Access to better schools for children, easy and affordable access to communication and transportation infrastructure, development of financial institutions, access to entertainment and amenities and overall uplifting of living standards are some of the most important factors for retaining the health care workers in a particular area.

Improving the salary and benefit structure of the health care staff is a must. Good results have been achieved in northern areas in Canada (e.g. Yukon Territory, Nunavut etc) by substantially elevating the pay scale of health care staff and providing the amenities for raising family and children. It is a good model that can be replicated in other countries as well.

Industrial expansion and/or boost in agricultural income have shown to work wonders in many under-developed areas and have dramatically improved their access to health care. The hands-off approach by the government (through instituting a robust public-private partnership to maintain health care facilities and run the services on daily basis) is another important issue.

Finally, with all the resources that a government can allocate for development and maintenance of primary health care services, they cannot survive without the local support. The people in the service area should be responsible for their own health care, including for the maintenance of facilities, ensuring supplies and retaining staff. Empowering the local government institutions and making them answerable for the health services and statistics in their area would be an important step in ensuring proper care delivery.

Please feel free to contact me at [maulik.baxi@gmail.com](mailto:maulik.baxi@gmail.com) for comments and questions. I look forward to an active dialogue.

Thank you and best wishes,

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## 14. Telemedicine: Serving for rural areas

***What are incentives schemes for health care workers and doctors to work in rural areas? Have there been any innovative ways tested in specific contexts that demonstrated promising results?***

We have found the only incentives which make anyone who has spent his life in skills development to work in a particular rural area is if he has his roots (in the form of parental or present family/spouse etc) there. So if any person from a rural area rises to be a good doctor, he will certainly contribute there. Thus the problem *is* compounded by the lack of basic education and related career advancement opportunities. So, healthcare provision should not be tackled in isolation from other facilities (such as good education and sanitation, etc) since they are also very important. However we have worked out successfully how Telemedicine can provide a solution (see [www.sathi.org/healingtouch.pdf](http://www.sathi.org/healingtouch.pdf)) where the doctor need not go but such projects require much ground work wherein some basic capacity building and change management for any new technology is required, Based on the success of this project which was following the tsunami disaster, we have been trying to provide similar solutions for many other pressing acute as well as chronic health needs. So far we have been unable to get funding and finally a trying it out on our own in Orissa. Hopefully some results will be obtained within the next three months as the project has just been launched

***What policies would universally be effective to address such a situation in order to reduce inequities and achieve universal coverage and renew PHC, regardless of other socio-economic parameters?***

Let us not try to get the doctor there physically. Your reasons are apt, but ask any person working in the city would like to bring up his family without good education for their children and an appropriate social life for themselves? Instead, use the trained and experienced in the tier I and II cities to provide some consultation and capacity building of those in working in rural areas. In our current project, Doctors attached with Rotary have promised to provide us 1 -2 hours of their time per week to take calls from rural areas (Software for telemedicine as well as Video phones have been provided to the NGOs in rural areas - albeit only those which have good broadband connectivity). We have set up our own expert units in the city equipped with similar software and video phones where these philanthropic doctors will provide some of their spare time. However it is too early to give results as installations and the exact time table is yet to be finalized (the reason why I was unable to participate in the discussion was that I was in the field - installing the very first 4 systems in the rural areas. The exact mechanism has to be very slow, deliberate and laborious as outlined in our previous project.

***What can and should the international community do to support national efforts?***

We are looking for suggestions as well as funding support for our project. We have been trying to get the same in the past. On the other hand if anyone from any country requires help in setting up Telemedicine services - in which tele-consultation is only the more famous but a relatively small part of a complete process of reaching healthcare for rural and inaccessible areas, we from SATHI (please refer to Society for Administration of Telemedicine and Healthcare Informatics, at [www.sathi.org](http://www.sathi.org)) and IAMI (Indian Association for Medical Informatics, at [www.iami.org.in](http://www.iami.org.in)) would be willing.

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## **15. Global media campaigns: Life style and family's role**

I have much appreciated reading the various comments. I essentially agree that it is important to put more attention on educating people on the essentials of how to keep healthy, rather than on treating disease. People should be encouraged and empowered from the grass roots family level to enjoy health and healthy positive attitudes. Make health a priority in their lives. A change needs to be made away from «do what you like and the health system will be there to «fix you». Personal responsibility needs to be encouraged based on continuing education. Therefore parents will be the «key» to educating and showing by example how to live healthy lives. Parents and parents-to-be would be assisted by health educators, nurses and midwives. More skilled physicians used only for more serious health problems. More emphasis should be given to «living healthily» rather than «fighting disease».

In light of our current understanding of the highly sensitive prenatal developmental period; all children youth, parents, health care providers, educators and society at large should be informed of the impact of the mother (and father's) life and lifestyle on the forming prenatal child.

Science confirms that the mother's diet, emotions, thoughts, beliefs, and lifestyle (particularly the impact of unhappiness/stress vs. happiness/creativity) affects the healthy physical, emotional, mental and spiritual (human values) development of the human being in utero. The prenatal period and the birth process have long lasting consequences on the over-all well being of the individual. A child that is wanted, loved, and correctly nourished in a loving peaceful and protected environment has a far greater chance to develop strong healthy organs and systems including immune system. This makes the child far less vulnerable to disease, more emotionally able to receive and give love, more intelligent and more creative.

The specific initiatives that the Economic and Social Council could launch in July 2009 and that the international community could offer are as follows:

Global media campaigns on healthy lifestyle (rather than on fighting disease).

Global media campaigns on the importance of bringing into the world a healthy and responsible human being through a healthy lifestyle during pregnancy.

***The following points should be taken into consideration to support families:***

Disseminating the latest research on nutrition, exercise, mind-body connections! More regulations on food production, limiting or eliminating processed food that is unhealthy (excess sugar, salt, chemical additives and trans-fat are known to be a cause of heart disease and diabetes, etc.)

Food should be encouraged to be grown locally and naturally. Pregnant mothers and couples wishing to conceive should be given help and support. No tax, perhaps even subsidies, on healthy organic food for families. Mothers should be encouraged to breastfeed whenever possible. This is known to offer important anti-bodies to the baby preparing the baby's adaptation to its environment and therefore to its healthy development.

A no-tolerance level for companies who produce or promote food stuffs which are known to be unhealthy. Pharmaceutical products that list severe or life threatening «side effects» should be banned. An immediate ban should be in place for all known carcinogenic substances. Stress management programs offered «free of charge» to parents to be, or during pregnancy. Studies show direct links to health deficiencies (and behavioral disorders) later on in the child born to stressed parents.

There should be an integrative health approach in the mind-body connection. Incorporate and valorized cultural approaches to community health. Studies show that watching violence on television or playing violent video games greatly lowers the immune system making people more vulnerable to infection. Whereas watching beautiful health promoting images/stories boosts the immune system and improves health. Grassroots and inter-generational community involvement in healthy living practices should include support for childcare and family.

Thank you for taking these proposals into consideration. I look forward to continuing to contribute actively in making the MDGs a reality for everyone.

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**16. Roles of community/volunteer health workers: Nepal, Bangladesh, Ethiopia, the Philippines and key elements of success**

I would like to join Dr. Islam from Afghanistan (network contribution, 05 / 02) in noting the role of community/volunteer health workers. Programmes designed to enhance primary health care network and to address inequalities through community participation and expanded outreach by local volunteers abound. Below are just a few examples, followed by some general observations:

**Nepal:** Female Community Health Volunteer (FCHV) programme was established in 1988 under the Public Health Division of the Ministry of Health. Nearly 50,000 FCHVs, present in all 75 districts, play an important role in contributing a variety of key public health programmes, including family planning, HIV/AIDS education, maternal care, sick childcare, vitamin A supplementation, deworming, diarrhea care and immunization coverage. For example, 85 percent of women who see an FCHV during pregnancy go for antenatal care. 62 percent of all FCHVs are literate, and to address the low literacy level of some FCHVs, effort was given to developing pictorial training manuals, educational materials and reporting booklets. FCHVs are present in over 97 percent of rural wards extending coverage beyond local health posts/facilities. Local mother's groups and FCHVs provide mutual support for each other. There is some evidence that FCHVs treat marginalized group (i.e. Dalits) more than their proportion in the population. FCHVs may therefore be a good way to increase service coverage for underserved groups, although it needs to be designed that way and cannot be simply assumed. (Source: *National Female Community Health Volunteer Revised Strategy, 2007; FCHV Survey, 2006.*)

**Bangladesh:** A pilot initiative *Community Support System* since 2005 helps bridge the gap between health facilities and communities in improving maternal and newborn health. According to UNICEF (which supported the pilot), there have been no reported maternal deaths in the 30 pilot communities in six upazilas and one factor in this success was the referral system that reaches from the community to the health facilities: trained volunteer workers make household visits, communicate regularly with health workers, refer cases as soon as complications arise and accompany pregnant women to health facilities in emergency cases. (Source: UNICEF, 2009).

**Ethiopia:** Tigray regional government introduced community-based malaria care. More than a half million people receive free treatments for malaria each year through a network of trained volunteer health workers, who mobilize communities and train neighborhood mothers on community / home-based care. This led to a 40 percent reduction in under-five mortality rate. It is being implemented nationwide. (Source: *Teaching mothers to provide home treatment of malaria in Tigray, Ethiopia*, Kidane and Morrow, 2000).

**Philippines:** Trained volunteer Barangay Health Workers (BHWs) provide to communities information, motivation and education for primary health care, maternal and child health, family planning, child rights and nutrition. BHWs administer immunization, growth monitoring and community-based monitoring and information system, which combines information gathering with basic service delivery and through which underserved populations were identified for community outreach and targeted interventions. The volunteers play a substantial role in motivating underserved clients to seek out the needed services. Incentives to motivate and retain the volunteers provided by the local authorities include: the volunteers were allowed to sell iodized salt during their house-to-house visits (San Jose del Monte, Bulakan); commission for health micro insurance was paid to the volunteers for premium collection among their catchment areas (Bukidnon). (Source: USAID; *Policy and Program Implications of the Matching Grants Programme of the Philippines*, Ogena N. and others, 2003; *Health Micro Insurance Compendium – A Working Paper*, ILO, Social Security Department, 2000).

***Success factors for effective and sustainable health volunteer programmes may include:***

- a) Recurrent operational expenditures (e.g. basic and refresher training costs, recognition award event costs, etc.) are reflected in a multi-year planning framework to go to national scale.
- b) Community contributions and resources are mobilized for village-level activities (e.g. village funds, generation of support including that of NGOs and the private sector, mobilization of blood donors and transport for bringing emergency cares to health facilities).
- c) Recognition and strong support from all levels: local, district/provincial and central. Opportunities for recognition exist during village/district level meetings, national volunteer day, through the visible commitment of local leaders and the influential.
- d) Clearly defined roles and responsibilities of volunteer workers, as necessary supported by policies and regulations (e.g. for the use of drugs by minimally trained volunteers).
- e) Intensive basic training and ongoing refresher training by district health department.
- f) Adequate oversight by health posts, including technical support, regular communications and meetings supported by logistical means and standard supervision process.
- g) Well-defined referral procedures and system.
- h) Logistical support and tools for volunteers' activities (e.g. transport, ID cards, bags, basic medical kit, reporting and referral forms, health education materials, etc).
- i) Various in-kind incentives for volunteer motivation, including skills training and recognition.
- j) Succession strategy to deal with drop-outs and retirement.
- k) Volunteers and community support group members are trusted by both women, men and marginalized families (e.g. minority groups). To promote inclusion and ownership, selection of volunteers must take into considerations dynamics existent within the community.
- l) Illiterate members of the community can perform the functions equally well as literate volunteers, and pictorial materials are used to train non-literate volunteers. Yet, its success may be highly contextual depending on whether illiteracy is prevalent in the society or not.
- m) Workload-regular engagement without making it too labor-intensive. Otherwise it risks becoming too expensive for the poor to continue to volunteer. FCHVs in Nepal, for example, work an average of 5.1 hours per week, and 77 percent of them would like to spend more time working as FCHVs (Source: FCHV Survey 2006).
- n) Locally appropriate and cost-effective delivery means (e.g. community meetings, home visits, radio and SMS, stationed or mobile services, etc.) depending on the population density, topography, media reach and lifestyle, etc. of the communities.
- o) Database to manage a profile of every volunteer for strategic planning and implementation.
- p) Periodic assessment of the programme, including survey among the volunteers, health posts and communities, for learning and adjustments.

In sum, properly designed and supported, community health workers / volunteer approach can make primary health care service delivery more cost-effective, efficient and rights-based, since volunteers:

Play a supportive role in linking the community with available primary health care services.

Promote the utilization of available health services and the adoption of preventive health practices among community members.

Act voluntarily as health educators and promoters, community mobilizers, referral agents and community-based service providers in each of the health areas they are trained and closely supervised by health / line workers.

Improve access to diagnostic skills, which is the main determinant of the speed of care-seeking – itself a crucial determinant of survival for the child, for example, with severe pneumonia or malaria (Source: *Evidence base for the community management of pneumonia*, WHO, 2007).

May improve inclusion of disadvantaged and marginalized groups in service outreach.

May empower the volunteers themselves through the knowledge and skills they gain, the trust and respect they establish in communities, and the networks and relations they develop in the communities and with local authorities and health professionals.

Best regards,

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## **17. Sustaining the health system: Financing, monitoring and evaluation**

The success or failure of any health system is fundamental to the people involved. I believe that until everybody decides to take responsibility there remains an underlying fundamental error. We must then tackle the problems associated with health systems with practical and attempt to solve them, first making sure there is a system in place that puts everyone in charge directly or indirectly accountable for their decisions and actions.

### ***Primary health care- solving the problem with all it takes***

First, I'd like everyone to realize that most of the problems encountered in delivering the best of services, especially in the communities can be solved by first tackling the cause and then the effects. Government should take care of community dwellers and provide basic amenities for them, this will go a long way to prevent many disease encountered in different communities. Health workers should be adequately provided for financially and in all wise (governments should strive to remove the inferiority complex associated with health workers working in rural

communities by increasing their remuneration). Hospitals built in rural communities should be adequately equipped by the government and funding bodies.

Health workers need not travel for training when it is not of utmost importance. Funding bodies and government of all countries should work together in order to bring world class training personnel and equipment to developing countries.

Primary health care is an integral part of a country's health maintenance system, of which it forms the largest and most important part (encyclopedia Britannica, 2006). As described in the declaration of Alma-Ata, primary health care should be "based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development." Health workers should be given internet facilities round the world, in order to achieve information exchange and learn from the experience of experts.

### ***Effective monitoring and evaluation***

Funding bodies should not depend only on theoretical report from the organizations or countries they are funding. Sophisticated mechanisms should be in place to monitor and evaluate funded projects in order to discover agencies, organizations and countries that are corrupt. In some countries where performance is not up to the expected outcome, the funding of such projects should be withdrawn. I would like everybody to realize that the issue at hand, I mean the health system, is what concerns everyone, and the pursuit of achieving the best of it should be a task that everyone will be involved in truth and honest dedication.

In conclusion, I want everyone to think about this "Health is a precious thing, and the only one, in truth, which deserves that we employ in its pursuit not only time, sweat, trouble, and worldly goods, but even life... As far as I am concerned, no road that will lead us to health is either arduous or expensive." Michel de Montaigne (1533 - 1592).

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## **18. Food intake in African countries**

One of the main up to date questions about health is its correlation with food intake. Food choice is connected with culinary habits. The lack of natural and economic resources in poor countries inhibits a nutrition variety, which is one of the first necessities for humans, but variety is also arrested by ignorance and superstition.



A big setback is the fact that poor food, especially cereals, is cooked for long time, causing several constraints: waste of time (women disregarding other things such as hygiene, children, house repair), and if women are working outside home they need one servant or more, continuing a long social situation of slavery; waste of wood for fire which also needs a quantity of time to be collected; danger consisting in constant fire at home; women bended over the fire for hours; loss of vitamins killed by the heat.

To solve those situations, population need more culture in order to know more foodstuff and to avoid false judgments about unknown aliments. For example in Mali, the people living in the southern part of the country don't drink camel milk because they don't use these animals for transport. Experts say that this kind of milk is very healthy, especially for children, helping to develop their brains, as it is the case for the children living in the northern regions. At the opposite, in the Southern Mali, population breeds goats, but these are generally so thin that they cannot produce milk (which is also very rich in mineral salt) or if they can, it is hardly sufficient for their offspring.

The maternal milk is also useless because after a child birth, very often mothers fall again in carrying a new baby, in fact in this condition a woman cannot produce milk; plus, women prefer to use dried imported milk - someone says because they like to emulate western habits or because they succumb to the advertisements - but the reason is because there aren't structures of refrigeration or of conservation through UHT system which is largely unknown. Plus, the Muslim women avoid to feed new born children with their first milk or *colostrum*, thinking it is dirty, instead it is the richest one and the best for new born children, in fact it is largely suggested by nurses and doctors in western countries.

In conclusion, it is unacceptable that children live without knowing the basis of nutrition as the milk is. To avoid this loss could be a very cheap step; to permit it would be very expensive in the adult life of that population.

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## **19. Pilot project on public-private partnership to address the shortage of health care workers in India**

I think members might like to know of a very successful public-private partnership that has been underway in the state of Andhra Pradesh in India. This pilot project currently covers over 76 million people (73% of who are rural) spread over 275,000 square kilometers (nearly 106,200 square miles), and is focused on surmounting health inequality, refurbishing primary health care, and attaining health coverage for all while addressing the shortage of doctors and health care professionals.

The initiative was conceived because Rural India that is home to over 72% of the country's 1.13 billion people lacks adequate earning opportunities, basic amenities, and infrastructure, which

has resulted in an on-going, one-way migration to urban centers. Despite the obvious demand for healthcare and other professionals in villages and small towns, even those going out for higher education and training prefer to stay on in cities because of better job and growth prospects.

To deal with the health-force crisis, most states in India have taken recourse to training locals for delivering healthcare services. In Andhra Pradesh, for example, the service providers are often daughter-in-laws in a village (the assumption being that they will continue staying in the area unlike daughters who marry and usually move out). Known as “ASHA Workers”, they are intended to be supported by district hospitals and community health centers (where they also receive training). However, in reality, most facilities are woefully understaffed and their services leave a lot to be desired.

Considering India’s geographical spread, its growing population, and the number of people below the ‘poverty-line’, the challenge has been to find innovative, low-cost, and rapidly scalable approaches that could reduce physical distances and provide health awareness and high-quality medical advice. The answer seemed to lie in using state-of-the-art information and communication technology to enhance healthcare delivery, and the Health Management and Research Institute (<http://www.hmri.in/>) went into operation in February 2007 with the sole objective of proving this to be true.

HMRI is a registered society with eminent healthcare and management professionals on its Governing Board. Its aim is to provide outcome-oriented management to enhance access and utilization of health services through IT-enabled support to policy makers, government and private healthcare providers, and teaching and training institutions. It has formed a US\$ 50 million public-private partnership with the Government of Andhra Pradesh, and has a recurring expenditure of US\$ 2.5 million a year. It offers a round-the-clock, state-of-the-art virtual medical advice hotline, a mobile health service, and a public health awareness and education service.

The hotline, ‘104 Advice’, provides around-the-clock, real-time, standardized medical information (e.g., where is the nearest eye specialist?), and expert advice (e.g., I have a fever, is this serious?) and qualified counseling (e.g. on matrimonial discord, depression, chronic diseases, HIV/AIDS, etc.) through a toll-free telephone number that anyone call anytime. It also arranges hospital appointments, fields and follows up on complaints vis-à-vis the public health system/provider (over 92% satisfaction rate), and maintains a medical history database of those wishing it to be available on-line.

It currently employs 400 qualified doctors and paramedics, more than 500 software engineers, 50 management personnel and several PhDs. ‘104 Advice’ services are based on 140 directories, 400 algorithms and 165 disease summaries that are used for providing information and advice. Interestingly, because of feed-back from people, the service has also been able to identify epidemics and, thus, helped concerned authorities stop them before they could spread. The hotline currently receives over 60,000 calls a day (90% of which are from the rural areas) and is already the world’s largest health contact centre.

HMRI’s ‘104 Mobile’, which was launched in February 2008, is a fixed day health service that uses 475 state-of-the-art mobile medical units to reach those living beyond 3 kilometers from any public health service provider. The program complements the existing public health system

to create a framework for comprehensive and easily accessible healthcare delivery. It leverages information and communication technologies, together with modern management practices to take healthcare to the last mile.

The mobile units, which are staffed by paramedics, pharmacists and lab technicians, carry on board X-ray and ultrasound machines, together with a pathology laboratory and other necessary equipment. They provide 4 hours of service every month to habitation with around 1,500 people. These include anti-natal check ups, height and weight monitoring, nutritional supplements for mothers and children, basic blood and urine lab investigations and screening, advice, and medicine dispensation for chronic illnesses such as diabetes, hypertension, epilepsy and anemia.

The vehicles carry cold chain facilities for specific drugs, facility to store blood/urine samples for testing, medicines and a television for public health education. The operations are powered by state-of-the-art software to enable effective and efficient delivery of basic healthcare to rural citizens. Each unit covers 2 habitations in a day and 56 villages in a month. They not only provide easy access to regular, preventive health checks and health education but also greatly diminish access-costs of healthcare (wage loss, travel costs, etc.).

The program also includes training over 50,000 ASHA workers (women health volunteers) in rural communities and equipping them with specially designed mobile phones that are extremely robust and easy to use (because of voice based software in the local language). At the moment, the cell phones are used by the workers during their neighborhood rounds to provide 24-hour access to '104 Advice'. Eventually they will be connected to hand-held blood pressure, ECG, blood sugar, and other portable machines - so that patient data could be monitored in real-time by doctors who could then provide more precise advice.

In addition to the above, HMRI's Public Education team has developed a series of short health awareness films, audio albums and publications to target rural beneficiaries of the 104 health services. It also uses a hybridized version of street plays and sound-and-light shows to directly interact with the public. The audio-visual screen on 104 Mobile units are strategically and effectively used to transmit health awareness messages to rural folk, especially those who mill around waiting to avail the health services of the mobile units. HMRI has also developed collaterals across all media platforms, has identified new platforms and is networking with existing media and extension entities, including the state and central government.

HMRI's experience and expertise is available for sharing with others.

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## 1. G8, human security, and health system strengthening

A Japanese working group on "Challenges in Global Health and Japan's Contributions" has just finished a phase of its research and dialogue activities aimed at making policy recommendations for ways in which Japan and other G8 member countries can better contribute to improving the health of individuals and communities around the world, trying to address some of the questions that have been raised in this e-forum. While our research looked primarily at the role of the G8 in health system strengthening—particularly focusing on only three of the building blocks of health systems, namely health financing, health information, and health workforce—we believe there are several conclusions that came out of this process that might be relevant to this discussion:

1. There is much more awareness now in the global health field that decision makers in partner countries, both in the governmental and nongovernmental sectors, need to be empowered to decide for their own countries and communities what the health priorities should be and how they should be carried out. However, actually acting on this awareness has been difficult. This is partly due to the habit within many donor agencies to impose solutions, with good intentions, on their developing countries partners. But, we also need to acknowledge that local capacity for making informed decisions on health is often weak, which further discourages domestic decision making in planning and management of health systems. Therefore, donor countries should invest in capacity building for health sector decision making at the national and local levels at the same time that they encourage stakeholders in partner developing countries to drive their own planning and implementation processes. This is not a situation that can change overnight, so we need long-term investments in human resource development, not only of healthcare workers but also of those who are in decision-making positions.
2. There has been a fair amount of discussion on this forum about the need for more of a focus on the community level in understanding needs, determining priorities and strategies, and actually implementing programs. We have found this to be very much in line with the human security approach, which Japan has been promoting in its foreign policy. A human security approach begins with individual people and communities as the starting point and requires looking at the way in which they experience vulnerability and insecurity on a daily basis. Looking at global health in this way, it is clear that, for example, for many communities around the world we cannot determine if the emphasis should be on fighting major communicable diseases or strengthening health systems; both need to happen together if we are going to see any long-term improvement in the health of those communities. A human security approach also targets the intersection of protection and empowerment, making sure that people get the services they require but also making sure that they are a part of the decision-making process because they are the best placed to understand their own needs and to determine what strategies will work in their own communities. Considering the many complex ways in which health-related decisions and actions by one individual or community can affect other individuals and communities, active

engagement of all sectors of society, from the household level to the global level, need to be engaged in both designing and implementing global health policies.

3. Another lesson that we learn from human security is that we cannot ignore the complex ways in which health challenges interrelate with other human security challenges. This is particularly salient, for example, in the discussion about the health workforce. If we are going to understand what we need to do to encourage people to enter the health field and to practice in the communities that most need them, we also need to understand all of the push and pull factors that affect their decision of where to practice, such as standard of living, opportunities for promotion, sense of community, education and professional opportunities for family members, and safety, to name a few.

(Anyone interested in learning more about this project or in reading the full report, can find more information at [http://www.jcie.or.jp/thinknet/takemi\\_project/index.html](http://www.jcie.or.jp/thinknet/takemi_project/index.html), and if you have any comments on the recommendations, please send them to [globalhealth@jcie.org](mailto:globalhealth@jcie.org).)

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## **2. Significant roles of non-state actors for service delivery: Policy and capacity development support examples**

Below is a contribution I would like to make in this very interesting e-discussion.

According to some statistics in Africa, the informal sector agents represent more than 75% of the labor force and only 2% of economic agents have access to credit. Non State Providers (e.g.: local private sector, Civil Society Organizations, Faith-Based Organizations, Community-Based Organizations, etc...) of basic services, constitute an important component of the informal sector and in real life they are delivering whether governments want it or not, a variety of basic services including basic health care, education, water, sanitation, to name a few. Therefore, it is simply obvious that any efforts for the improvement of the delivery of these basic services cannot be done without finding more sustainable ways and mechanisms to involve those Non State actors. Despite these hard facts of life, in many developing countries, government policies and regulation governing service delivery, continue to ignore the role of Non State Actors and therefore these service providers are still operating in a total policy and regulatory vacuum without any form of service quality control or oversight from the public authorities or services users.

Therefore it is imperative find innovative ways to improve the level and quality of services provided by these informal actors and something needs to be done to bring them into the policy and regulatory framework that governs the delivery of these basic service and also provides them with incentives in terms of recognition by government, developing their capacities to better perform and meet minimal basic service standards, access credit to improve their operations.

A number of experiences in both Africa and Asia have demonstrated the growing role of Non State Providers of basic service without which the delivery of some basic services including health care services in a number of developing countries would have been disastrous and create the conditions for political and social instability.

The main issues here remain now how government policies and regulations, take into account these informal and formal Non State Providers and develop an enabling policy, regulatory and institutional framework conducive for their greater integration and oversight/control of the service they provide to communities.

In terms of what development partners could do to support developing countries address the above mentioned challenges and improve the delivery of basic services to the poor including health care, I would indicate the followings:

1. Support government to assess its own basic service delivery policies and governing regulations and see how they are conducive to non state providers' involvement.
2. Support government to assess its own capacities to address identified limitations in its policies, regulations and institutional set up.
3. Support capacity development for government to put in place enabling policies, regulation and institutions that ensure that quality standards in health services are met consistently and support the establishment of oversight and accountability systems that enable service providers and users to constantly dialogue and voice their needs and preferences in terms of level of services, affordability and devise joint solutions to address them in a inclusive and transparent manner.
4. Support government to enact enabling policies that ensure that non state providers have greater access to credit to finance the development of their businesses and be able to meet required services standards and preferences of users and mainly the poorest among them.
5. Capacity development support package to enable government (national and local) to:
  - o Be able to clearly identify segments of basic services continuum where Non State Providers could be involved and make a positive difference for the poor users.
  - o Assess Non State providers' capacity to ensure sustainable provision of delegated deliver services and to enable them to operate sustainably and deliver services that meet minimum standards and that are accessible and affordable to the poorest section of society.
  - o Develop capacity of governments (at national and local levels) to enable them to engage non state providers of services, monitor their performance and ensure better compliance to minimum service standards and quality.

Because health care services have a cost attached to them, it is critically important that costs associated to each level of services be known and to ensure that adequate level of subsidies needed are taken into account in a sustainable way to ensure its affordability by the poor users. To improve the delivery of health care services, remain critical to develop the capacity of governments (both national and local) and service providers to enable them to know real costs of services provided (infrastructure and services) and the ability of the poor users afford it through a smart combination of public resources (governments and donors' support) and where need have the right subsidies or cross-subsidies systems in place to make services affordable for the biggest poorest section of society.

Hope this is useful and will add to the debate in a very difficult development topic but which is very essential to address if the various MDGs targets are to be met.

Kind regards.

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### **3. Incentive schemes for health workers and doctors in rural areas: Lessons from the Niger Delta, Nigeria**

In an effort to provide quality health services as part of corporate social responsibility (CSR) to their host communities, major oil companies operating in the Niger Delta area of Nigeria have created models of health delivery systems, which could be used to compare with government health services to test some health reform issues especially in the area of human resources for health. Although not intended for such a purpose the situation has as all the elements of an experimental design or a comparative study.

A typical case is one where the oil company takes charge of a government hospital or health centre in its area of operation. Apart from refurbishing the physical infrastructure, the facility is equipped and provided with seed drugs and supplies, which serve as capital for a drug revolving fund. Health workers and doctors are drawn from the same pool that supplies staff to all the health facilities. However, those posted to the hospitals and health centres that are supported by the oil companies are provided with top-up allowances and have comfortable accommodation with utilities such as water and electricity linked to the industrial activities.

We observe a better utilization of services in facilities assisted by the oil companies in relation to those directly run the government. The health workers are always available and they tend to have better disposition towards their patients and their work. Because of the better working environment there is always a high demand among health workers and doctors requesting to be posted to these health facilities compared to the rest in the government service. We have also

seen situations where posting to one of these better supported hospitals and health centres is used as reward for staff within the health service.

Short of obvious methodological limitations we can lay claim to identifying the critical elements in the incentive scheme deliberately provided by the oil companies to health workers and doctors in order to attract and retain them in remote areas - for the benefit of communities around their areas of operation. These include: an enhanced take home pay (top-up allowance); good living environment (accommodation with functional utilities); tools to work with (equipment, drugs and supplies); and a worthwhile job (better service utilisation). We note that while these may be considered as a basic minimum – we also recognize that due to widespread lack of these essentials, their presence could make a huge difference in improving the human resources for health situation in rural areas.

This observation is supported by experience from similar support provided to health facilities through the PEPFAR support for ARVs treatment centres. Some commentators may find this as an issue of creating a two-tier health system in an already dysfunctional system facilitated by donors. But in an attempt to find innovative ways of unblocking some of the constraints of a poorly performing health system we have seen how some of these ideas could be tested within specific contexts – to demonstrate how things can be done differently to achieve results.

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#### **4. Ageing population: A good practice in Africa**

A good example of the need to revisit health system performance in the light of global change is the rapid emergence of a global ageing population. “Agequake” are the words used by Ambassador Julia Alvarez at the UN a decade ago to when calling the UN to take this global phenomena seriously. Never before has life expectancy in all groups of society been as high, even in vulnerable or fragile populations forcing policy-makers to rethink the broader financial and health system. Just a few examples to illustrate:

- Today there are more persons aged 60+ than 15- with more multiple health problems, chronic diseases and disabilities which requires multiple responses and polymedication and treatment than any other age group
- From 2000 until 2050, the world's population aged 60 and over will more than triple from 600 million to 2 billion. Most of this increase is occurring in developing countries - where the number of older people will rise from 400 million in 2000 to 1.7 billion by 2050.
- in 2007 Japan counted 30'000 centenarians, with now 4 to 5 generations living together, challenging the health care system and migration policy
- the increase in ageing prisoners in the world is revolutionizing the prisons management and financial system,



- life expectancy with diseases has also challenged the legislative system by bringing new groups of pensioners to claim health and pension benefits the Netherlands has open its first pensioner house for retired junkies, the first couple affected by the Down Syndrome a few years ago in Switzerland made the case for new legislation, etc.

Demographic ageing is shaping the world today and has become one of the most important issues of the 21st Century.

Ageing is not only a matter of numbers but of adaptation of social, financial and health policies to the reality of the current world population. One of the alarming symptoms is reflected by the recent high priority set for chronic diseases which very rarely mentions that the first statistically significant group to be targeted is the older population, and the very old – fastest growing population all over the world.

It is often said that "The developed world became rich before it became old, while developing countries are becoming old before they become rich." Despite this fact and the demographic data, the scope of the challenge ahead of the specific consequences of ageing, at the individual and at the population level, remain mostly unaddressed at the global level in international UN agencies and multilateral institutions. Just a few shocking facts: the MDGs do not mention ageing or old age, the last update of the Global Burden of Disease stops presenting and commenting the numbers at age 59 years, the World Bank has only issues one document on ageing for Eastern countries and never counts old people in their poverty data and programmes, the whole UN systems has only 2 key persons working on ageing with no budget, WHO has one person working on ageing who is not a doctor nor specialised in ageing, the right to health for old people and the rights of older persons is not addressed, the WHO international bioethical guidelines do not mention old people and end-of-life issues, etc. etc.

There is an urgent need to bring key specialists who will address the impact of a continuously increasing ageing population on health systems and some of the solutions in different areas and implement it in the UN system as a priority programme while mainstreaming the issue.

To the questions posed

1. *What are incentives schemes for health care workers and doctors to work in rural areas?*

The number of older persons in rural areas is particularly high due to strong migration of young adults to urban areas, therefore it is a good example of the need to shape up primary health care and family/community support including the ageing population specificities

*Have there been any innovative ways tested in specific contexts that demonstrated promising results?*

On ageing, there is a vacuum of organized health care in the developing world (physical, mental and social health care). In particular, mental health care (ie depression, neurodegenerative diseases, Alzheimer disease, etc) is still neglected as many international reports demonstrate. As long as health care is not delivered and financed in response to the epidemiologic, social and demographic reality, it is bound to partial inefficiency, the neglect of the ageing population is a good example, especially in the developing world which lacks infrastructures and is going through a very rapid demographic, epidemiological and social transition.

One example of best practices that starts to work in Africa is the positive contribution of older persons as caregivers of the orphans of HIV/AIDS deceased parents, which not only is bringing psychological comfort and a role model to children but is also keeping them from becoming street children in large urban areas or slums, it also lower financial costs for the health governance and maintains active ageing for older persons – therefore it is important to keep them healthy and support them financially as much as possible. Older persons can be a strength as caregivers but must also have the right and deserve the respect to be taken care of and have access to health until the end of their lives...

This example answers some of the questions below

*2. Let us consider this hypothetical but perhaps prevalent example: a doctor in country X who works in a typical district of 50,000 people with the following attributes:*

*a) What policies would universally be effective to address such a situation in order to reduce inequities and achieve universal coverage and renew PHC, regardless of other socio-economic parameters?*

Distributive justice between all generations – the socio-demographic distribution must be one of the primary basis to address adequately the needs of a population – poverty for example transmits from generation to generation and so does in many cases health behaviors and thus disease patterns

*b) What can and should the international community do to support national efforts?*

Health education and strategic planning tools should be provided to the main health care providers, be it the primary health care workers, the community, and the people themselves but also to the local or regional governments can find adequate and adapted solutions. Technology and mobile health could be some of the solutions to scale up training and adjusted health systems.

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Secretary general of the European Region Association of Geriatrics

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## **5. The Hypothetical Case: Country X**

The scenario painted by this hypothetical case is the development challenge that confronts all those who work in resource poor countries across the globe. And the fundamental issue that requires a solution is – How can health services be planned and executed to provide the maximum return in human welfare from limited resources of money and skills? Clearly what is required are ‘new mind sets’ in getting policies into action.

The following policies could prove quite useful:

1. Re-orientation of health workers

Apart from starting at the preparatory stage, all health workers in particular doctors and nurses should be trained (and re-trained) to possess a 'mix of aptitudes' to carry out the range of services that health settings must deliver to meet relevance, quality, cost-effectiveness and equity in health. For example, the appropriate role for a doctor in a poor district looking after 50,000 people in addition to undertaking medical duties should be like a 'coach' – who provides leadership and direction to a team of health workers and others who are focused on achieving results – better health outcomes for the entire population. Similarly, a health worker trained in microscopy should be capable of identifying malaria parasites in a blood smear as well as detecting mycobacterium in sputum – and could be skilled in leading a drama group to disseminate health messages apart from being able to set up an intravenous line or assist the doctors in carrying out a caesarian section.

## 2. Effective use of community resources

Many communities already have resources that are readily available for use by the health service to reach a much wider population with essential services such as immunisation, child spacing, behaviour change communication etc. These include: buildings such as schools, churches/mosques, market stalls and community halls; persons such as teachers, religious leaders, store keepers, women and even school children who could be effective in many ways – social mobilisation and advocacy, distribution of health commodities such as insecticide treated bed nets, condoms etc, and peer education.

## 3. Use of Appropriate Technology

Appropriate technology in this context refers broadly to include practical simple 'things' – such as tools, instruments or machines – which people can make, use and repair themselves using local resources, as well as 'methods' – ways of doing, learning, and problem solving, which are adapted to people's needs, customs and abilities<sup>[1]</sup>. This is actually one of the concepts that underpin the philosophy of PHC. When effectively utilised, this notion will not only help in finding practical solutions to renewing PHC but will be vital in providing answers to some of the development challenges.

### ***Mechanisms for financial risk protection***

The major determinant of ill-health in Country X as in many resource poor countries in the world is poverty. Therefore unless options for financial risk protection are put in place, many people will not be able to use health services and this will further increase in-equity. Moreover, the cost of paying for health care will further exacerbate the poverty situation of majority of people. The mechanisms to be adopted should be those that will enable people access basic health services 'free at the point of delivery'. As much as possible non-cash options such as vouchers, health cards, and exemptions should be adopted. The health service providers should be reimbursed for services provided on the basis of these financial risk protection instruments. Funds accruing from this should be retained at the facility level and be used to meet recurrent expenses. This is one practical means of overcoming the lack of recurrent budget from the government.

### ***Engaging in the development process***

Progress in the health sector is a critical to the whole development process, but an effective development agenda also leads to significant improvement in the health sector – more like a 'catch 22 phrase'. However, deliberate actions such as the starting of a school or improving the standards of already existing ones in the rural areas; the resourcefulness of the spouses or

partners of health workers in the socio-economic activities of the district; the creation of support network of health workers; and engaging in the political process of the district – although not directly health related could be potentially effective in overcoming the infrastructural challenge. This will improve the welfare of the health workers, who will in turn have a better disposition to their work and their patients.

*What can and should the international community do to support national efforts?*

Many of the countries like Country X have critical constraints in renewing PHC in order to achieve universal coverage. Apart from lack of resources, which leads to many of the problems confronting the health system, there is still weak capacity for planning and execution of health programmes especially at the district level.

Rather than undertaking 'global initiatives', which has been the traditional approach, the international community should support broad policies generated through 'new mind sets' as outlined above in addition to finding mechanisms for 'competencies transfer' to national interlocutors. Finally, the international community should support a 'global movement for better health for all' not in slogans or declarations but through actions that discourage support for one issue, health problem or vertical intervention.

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## **6. Incentives for Health Care Workers**

No Ministry of Health or international organisation scheme will have the capacity to radically and rapidly increase the numbers of doctors per head of population.

My observations of rural district health officers (DHOs, who were doctors) in Nepal (over my 9 years there 1995-2004) includes issues like:

- \* Out in the district - doctors missed out on the 'political scene' of the capital city, and they felt they were 'out of sight, out of mind' re. promotions, training opportunities. This issue might be partially addressed with internet communications technology.
- \* Local schools were not thought of as ideal for doctors' children.
- \* The district's main town was an adequate setting for private practice that enhanced doctors' incomes, but reduced their capacity to take time to travel around their districts.
- \* Some DHOs had good working relationships with their more mobile team of Health Assistants, who, in turn, supervised the village health post level Clinical Medical Assistants
- \* Fostering team spirit at these different levels was key.
- \* Doctors, Health Assistants and Clinical Medical Assistants tended to put greatest interest and energy into direct patient cure and care (this is understandable - because of short term rewards).

\* I observed a few notable exceptions - clinicians at different levels who were motivated to work at promoting community level participation and change. Often, however, these enthusiasts were not in post long enough to see the slow process of community development emerge.

\* Doctors (I am one) find it difficult to think beyond curative paradigms to see root determinants of health. But when they do (I know several colleagues - myself included - who have experienced a 'conversion' to community-health-thinking) they are some of the most effective (and motivated) players in fighting for political / socio-economic change that can modify health determinants.

The visionary (and faith-based) organisation PRIME (<http://www.prime-international.org.uk/>) has worked at raising doctors' awareness of health and wholeness (not just clinical cure of disease). A similar approach could foster community-health-thinking amongst doctors and other health workers.

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## **7. Community oriented training, leadership, and call center approach to health, etc.**

Into the last lap of the Phase I of the discussion, I would like to add a couple of my thoughts:

- 1) 3 discussion points, 1 quote and 1 solution which interested me much more than the others are:
  - a. Strengthening health systems is paramount
  - b. Beware of "(systems) which allows the short term goals to be met, and hope that the long term problems take care of themselves"
  - c. Need for Community Oriented training or rather community based training for all cadres of health services
  - d. "the real barriers now are deficiencies in our leadership abilities, management, logistics, the ethics of business practices, and an infrastructure needed for the practical application of our science and technology."
  - e. Call centre approach to Health and health system issues
- 2) The suggestion of an "appropriate and sustainable remuneration for health personnel in rural areas" seems farfetched. I would not like to comment on the highly motivated health staff who take it up as a personal mission and overcome challenges of many kinds (who by the way are few); excepting this small group, for an average health staff any amount of remuneration is always inappropriate and would never be sustainable for a health system. We need to learn from history otherwise there would not be such huge wage bills which account for nearly 80 to 90% of the total programme costs.

3) In this context I am reminded of the comment by George Bernard Shaw “all professions are a conspiracy against the laity” in his drama Doctor’s dilemma

4) When we refer to issue of ensuring access to health services, concerns of equity, primary health care, absence of public health perspectives there seems to be something more systemic that needs to be addressed. During one of our interactions with the postgraduates many remarked that excepting a miniscule proportion (probably less than 5%), majority float into a medical school because of so many reasons and pressures (prestige, better income and returns etc.,). Over the years of training while passing out of the medical school they attempt imbibing the needed value systems demanded of health care. But again they are caught in the conflict and revert back when selecting post-graduation. This seems true of not just doctors but also of other health professionals.

5) In the absence of any real immediate solution, the recommendation of WHO Commission on Social Determinants of Health of bridging the divide and bringing about an equitable health system in a generation’s time seems very pragmatic.

6) Exploring possible solution, the Andhra Pradesh experiment of Public private partnership using the call centre approach to manage health issue seems very promising and seems potentially a successful one; that is only if it does not get embroiled in needless political one-upmanship. I would recommend that the Economic social council closely monitor this programme and nurture against political interference. It has the right mix of many things: technology and people empowerment; public and private mix and also possibly private and private mix; alternate employment possibilities to existing health staff, scalability, providing the much needed transparency and leadership in health, standardizing and codifying health procedures / interventions / advices, more appropriate and suited to primary health care. Most importantly, it could give the already fatigued health personnel a fresh challenge and also possibly the much needed incentive of job satisfaction.

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**Dated: February 12, 2009 – Vol. 10**

## **1. Remunerations for health workers: An example in Kenya**

Doctors and other health care workers are mainly a forgotten lot when it comes to remunerations. Motivational schemes mainly favor those in urban areas forgetting the ones in rural areas. Service training could be one of the schemes to benefit them. This can be done when schools are closed in the rural so that the health workers can get an opportunity to attend. The in-charges at the Provincial/State level may come up with a plan to be implemented by all and ensuring all is catered for. Use of solar to make internet available for the rural facilities can be another incentive for the health workers who can be enrolled online in distance learning courses. This will ensure that they are not left behind in upgrading their skills. In Kenya, health workers in hardship areas receive what we call "Hardship allowance" It is important to review

the allowances as the cost of living goes up. They should also be paid for the extra time they spend at the health facility working beyond the normal working hours.

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## **2. Shortage of health workers: The case of “cross-border” healthcare and the Advanced Nursing Studies (ANS) Programme**

In response to the question of health inequities, I would like to bring attention to the case for “cross-border” health care. Health indicators, including levels of maternal and infant mortality, are very different in adjacent geographical border areas. One example of this is the differences in health indicators of Afghanistan, Pakistan and Tajikistan. In the rural province of Afghan Badakhshan, the region has a high maternal mortality ratio (6,507 per 100,000 live births) and a high infant mortality rate (217 per 1,000 live births), compared to Gorno-Badakhshan Autonomous Oblast which is on the other side of the Oxus River in Tajikistan. Here, there is a very low maternal mortality ratio (54 per 100,000 live births) and infant mortality rate (28 per 1,000 live births). The Northern Areas of Pakistan has seen a substantial decline in its health indicators over the past 20 years; the maternal mortality ratio has decreased from 550 to 68 per 100,000 live births and the infant mortality rate has decreased from 158 to 31 per 1,000 live births.

The difference in the health indicators of these bordering countries demonstrates the influence of varying factors, including political, economic, social and cultural factors. Development in all areas is needed for seeing a reduction in maternal and child mortality. A policy promoting “cross-border” health programmes can make resources available in one country readily available to a neighbouring country (or countries). The Aga Khan Development Network is working in all above-mentioned areas and has found benefit in using human resources across borders, as people speak the same language and share a common cultural background. Patients may also have access to health care services in bordering countries if they are not easily accessible in their own countries. Although the concept of “cross-border” health care is practical, it comes with its challenges, including the trust that needs to be built between neighbouring countries. However, more rapid progress can be achieved if human and financial resources can be shared amongst countries in shared geographic locations. For the full article on this topic, please click on <http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.1000005>

In response to the concern of developing health human resources within their countries of residence and promoting their retention, programmes which involve communities within training programmes would be beneficial. The Advanced Nursing Studies (ANS) Programme being implemented by the Aga Khan University in East Africa is an example of educating nurses according to the needs of the community in which they are based. The core activities of the ANS are related to research, tuition and community participation which together reflect the concept of *Academic Citizenship*, the practical implementation of knowledge gained through tuition and

research in society. Through developing programmes which involve the communities where it operates, ANS allow nurses to gather information on specific needs, enabling them ultimately to serve the community in an appropriate manner with the necessary skills and knowledge. Some of the programmes offered are through distance learning, using e-health approaches, due to the need to reach and improve the skills of nurses working in the community as well as those based in hospitals.

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### **3. Environment, water, transportation, education and public administration for health: Suggestions to ECOSOC**

Health inequities reflect overall socio-economic inequities. The first step is to place the health-related issue in context. "Health" represents a very broad set of challenges spanning across all developmental stages. In this regard, a successful "health" experience in a successful socio-economic context may not be immediately applicable to a poor and corrupted environment. Most countries implement universal health care through legislation, specific programmes, regulation and/ or taxation. In this regard, health-related issues are not related to medicine only, but do engage community issues, public administration issues, environment issues, education issues, transportation issues, among others. As we all know, the quality of health may be much more related to the quality of water than to the number of doctors and hospitals available. To treat health only within the confines of MDGs could result in limited approaches.

I would like to recall the Cuban experience called "Family Doctor Programme", which, in my understanding, placed young doctors in charge of primary health care in peripheral lower-income areas, so that each dweller could receive basic health orientation and care. There was person-to-person individual knowledge about which health care worker was handling each community. The idea also promoted the decentralization of the primary health care system by establishing basic small-scale health care centers in peripheral areas. Another experience is "US Doctors for Africa", which organized mobile health centers in Ethiopia, Tanzania, Uganda, Sierra Leone for primary health care, education, vaccination and other small-scale concrete actions.

At the policy level, from 2004 to 2007, Brazil created a special "temporary contribution on financial transfers" (CPMF - Contribuicao Provisoria sobre Movimentacao Financeira) representing an additional tax of 0.38% over every cheque issued privately and publicly in the country, resulting in annual resources of the order of approximately US\$ 16 billion to be destined for health-related issues. The problem is that apparently the idea was so successful that financial resources were used for many other purposes, not just health. There are other examples.



In terms of inter-Governmental learning, the basic foundation is political will. What percentage of national budgets is actually invested in health-related issues? If political will is confirmed, ECOSOC could consider the following:

- 1) A database of successful health-related experiences, to be disseminated through the United Nations Public Administration Network (UNPAN), WHO and other agencies.
- 2) ECOSOC could consider sponsoring a GA Resolution designed to promote enhanced inter-governmental cooperation along the lines of "Family Doctor Programmes", "US Doctors for Africa", "Doctors without Borders", others.
- 3) ECOSOC could consider sponsoring a GA Resolution proposing that a percentage of international financial transactions could be destined to enhance access to primary health care in less developed countries (LDCs). Transparent control mechanisms should be an integral part of this initiative, including in-kind contributions from the communities in less developed countries.

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#### **4. G8 and global health governance**

I would like to respond to the comment from Prof. Takemi on the G8, health system strengthening and global health governance. My comments are in reference to his posting but also to the views expressed in the recent *New England Journal of Medicine* article on the topic. I have considerable difficulty with the idea of the G8 taking on a larger global health governance role as proposed in that article. The view is expressed that WHO has difficulties in performing this role as well as it should. Even if that is accepted, at least some of the responsibility for the failure of WHO to fulfill this role adequately can be placed on G8 members who have responded negatively when WHO becomes a more open activist in global health governance and also when much of the financial support to WHO from G8 members is tied to specific projects rather than to over-all programmatic support. As problematic as WHO's governance is, at least there is a governance structure which is accountable to Member States. What would be the accountability structure of the G8 in global health governance? It is at great risk of being governance by the golden rule, i.e. those with the gold make the rules. I am sure that is not the intention, but I would be concerned that it could very well be the result. I should declare that I am a WHO employee, although this is a comment made as an individual, not on behalf of WHO.

Regards,  
Dean Shuey

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## 5. Need to remember a failure of “one-size-fits-all” approach: Global health governance bureaucracy

The summary of discussion so far, distributed on 10 Feb, looks good. I would like to add two comments:

- Need for clearer recognition of the challenges of addressing the social determinants of health, including inter-sectoral collaboration at all levels (local to global) and popular mobilization (from community action to social movement);
- Need to be careful about one-size-fits-all generalizations which focus on that which is common but ignores that which is unique to a community (or district or region).

The summary of the discussion so far appears to focus largely on health care and health care systems. In the years since Alma-Ata the role of comprehensive primary health care in addressing the social determinants of health has been neglected. Of course population health is largely determined before or beyond the health system but this does not mean that the health care system has no role in creating the conditions for better health. Three key principles provide guidance:

- Inter-sectoral collaboration at all levels from local to global; not healthiest imperialism but learning to speak the language of the other sectors and looking for win-win pathways which respond to the imperatives of health and the other sectors;
- Popular involvement (from local to global), to drive for reform, to promote transparency and accountability and to overcome the tendency for narrow vested interests to dominate decision making; not a panacea but better than its absence;
- Constructing health development as a partnership between the bureaucrats, the technicians and the various communities affected; let us not speak about “understanding people’s actual health needs” as if they are objects and we are the knowers; let us understand the processes of health development as a partnership with people and communities who are agents of their own destiny.

I am also discomforted by the flavor of the questions that we are invited to address at this stage of the discussion. I am referring to phrases like: “*Let us consider this hypothetical but perhaps prevalent example*” and “*What policies would universally be effective*”. I fear that this approach, looking for universally effective policies, risks slipping into the ‘one-size-fits-all’ mindset. We need to remember the failure of the ‘one-size-fits-all’ policies of the international financial institutions and their influence on economic policy (recall the IMF’s ‘advice’ to Indonesia in 1997) and on health policy. One of the clearest examples in health policy is the WB’s policy formulation of ‘autonomization > corporatization > privatization’ regardless of local circumstances.

There is a risk of assuming that there is a singular truth about health development which lies with the global health governance bureaucracy. The fact is that the global health governors do

not have the truth and do not know the correct path. In such highly complex situations predictability is not possible beyond a very close horizon. In these circumstances we must construct the challenges of health development as an exploration rather than in terms of universally effective policies and as an exploration undertaken in partnership with the possibility that there may be many different pathways.

Small example: Let us recognize that the poverty of the South is related to the over-consumption and individualist competitive materialism of the North. Is it possible that the spiritual stories / practices of indigenous peoples (the Cosmovision of the Mayans for example) might have something to teach the global governors? I think so.

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## **6. Strategies of improving health services in rural communities: An Indian experience**

India has embarked on a program of Community Oversight or "communitization" of the health services under the National Rural Health Mission launched in 2005. This entails the formation of

committees at various levels that oversee the working of the health workers. The committees are formed from the village level and have various representatives from the community including women and various caste groups participating. Thus there is ownership as also the identification at the local level. The committees are also allotted a small (but adequate) sum of money for use at their discretion. This is meant to be utilized for transport of patients as also conduct of village- level activities e.g. immunization days. Further the committee also validates the working of the health system and highlights deficiencies in the same. Thus the committee is empowered to examine how far the health system is fulfilling its roles and responsibilities and also to decide on the utilization of government funds to fulfill specific local needs.

It is seen that being accountable to the community has an enormous impact on the quality of services being provided. Government employees provide better quality of services and ensure that services are appropriate to the local situation. Furthermore, as the community comes to understand the constraints and needs of the provider, there is an increased sense of belonging which translates into assistance being provided to assist in the discharge of duties. For instance, nurses are escorted on their way to and from remote villages to ensure her safety. The future will show how far this will bring about changes in the health status of the people but immediately one can perceive an increased sense of ownership and also a concomitant increase in participation and a sense of responsibility that this entails among the members of the community who were so far only users of the services and also great critics of the system.

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## **7. Health posts and centers at the community level: Training local doctors in scaling up male circumcision services to prevent HIV**

What can and should the international community do to support national efforts?

The recent debate on scaling up male circumcision for HIV prevention in Africa is a good example of the ways international partnerships with African national efforts could be supportive in strengthening health systems.

The Jerusalem AIDS Project of Israel has partnered with national organizations in Swaziland to support training local doctors in scaling up male circumcision services. Information on this pioneer pilot could be found here: [www.operation-ab.org](http://www.operation-ab.org) . One important lesson from this effort, which was closely observed by WHO (the World Health Organization), CDC (the Centers for Disease Control), UNICEF (the UN Children Fund) and others was that new areas where high demand of medical professionals is needed (e.g. male circumcision) may not reach their goals if health systems infrastructure is left out of the equation.

As we all know, most programs now being developed for the fast roll out of male circumcision (MC) services in PEPFAR priority countries consider hospital-based services to best meet the challenge. This would mean that theater rooms in existing hospitals will need to accommodate for a growing number of non-patients (clients) coming in large numbers for MC under local anesthesia. The already over burdened operating rooms will need to cope with thousands of new clients per year. This may well hamper other (emergency or elective) utilization of the operating theaters. The better system in my opinion is to demand from donors, policy makers and implementers that MC programs will be based at community level clinics (health posts\centers) and that part of the funds allocated for MC will then be used to improve these facilities so that they could host patient operating theaters. In this way, not only that MC services could flourish without overwhelming already crowded operating theaters at hospitals, but bring closer to communities surgical services for other needs as well.

To advocate and facilitate implementation of such concepts a strong international community lobbying is needed in support of national efforts to reverse HIV infections through MC.

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## **8. Severe challenges facing the nursing workforce: Well-trained but unemployed nurses in Kenya**

Exodus of Nurses, with severe shortages in health institutions, especially rural settings where majority of Kenyans are and chronic apathy among the nurses is the usual scenario in Kenya!

More often than not in key addresses given by seniors from the Ministry Health, Kenya Nursing workforce is referred to as the “backbone” of the health care delivery system.

My usual comment/reaction is to agree. But explain that it is indeed the Backbone except that it is a broken “backbone”. Hence the Nursing workforce is now on a wheel chair. Although not many understand what I mean, I wish to be understood by you the moderator. There is need to totally address the many problems/challenges facing the Nursing workforce. Improving remunerations, work environment, recourses as it has already been discussed by earlier contributors will not only go a long way to retain nurses but also rehabilitate the Broken “Backbone” of the Kenya Nursing workforce.

### ***Kenyan Experiences***

Nurses are trained to work in any setting urban and rural. They are also trained to be multiskilled. Three in one thus Kenya trained nurse regardless of the level of training can be a general Nurse (med/surgical) midwife and community Health Nurse. Their scope of practice prepares them to practice in the 3 areas. It is unfortunate that this is the type of Nurse who is out in the street unemployed looking for any prospective employer. Due to the frustration majority get employed in any health unity and be paid any salary (less than Ksh. 5000/= per month) [about US\$ 63 per month]. Sir, with such a salary in this economic crisis, how is anybody expecting such Nurses to survive? Let a one expect them to discharge their professional obligation well! It is no wonder that Kenya is among the countries whose nurse’s leave in large numbers to developed countries. Yet disease burden in Kenya is higher than in the developed countries. Health indicators such as maternal mortality & infant mortality are NOT comparable!

Nurses work more in the rural settings. The long waiting queue of patients because of having one nurse per health center or dispensary greatly influences the health seeking behavior of the patients and clients, majority of such clients are women/mothers, who can either be sick themselves or have brought children, or husbands or some relatives. Women are more found around health institutions than men, yet in Kenya, women are the ones who look for food for the family, till the land and grow food for the family. Keeping women out of the family chaos has multiply effects to the individual, family, community and entire nation.

### ***Key concerns/Suggestions***

1. Kenya has many well trained nurses that are un-employed! Can those countries that need nurses, be made to support pay salaries for an equal number of Nurses from the source country i.e. if 20 nurses leave Kenya to U.K. U.K supports/pays for 20 other Nurses to be employed in Kenya (source country). Currently, some government to government have been made to have some Nurses go to work in a specific country (Namibia). Though this creates

employment for the Nurses, it is outside Kenya just like many that leave Kenya seeking greener pasture.

2. Those who leave are the well experienced Kenyan Nurses. Very few naive/inexperienced are, usually taken by the developed countries; and in most cases if they take such they decide to re-train them! It is Kenya with the higher disease burden that requires higher experienced nurses as health care providers

3. Kenyan nurses retire at age 55; such nurse could be used to provide health care to the people in the communities with some small benefit. For example such nurses are the people who can do community midwifery-ensure safe home deliveries (MDG 4&5) home-based care to reduce long hospital stays due to chronic illnesses and they could also do early identification of disease

4. Let me acknowledge countries/organization that have in one way or the other facilitates employment of Nurses in Kenya and encourage many more to do the same.

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## **9. Strengthening the pharmacy workforce – addressing access to medicines needs for primary health care**

The contributions in this e-discussion have been read with great interest and we are pleased that the UN ECOSOC is providing this forum to enable the sharing of ideas and proposed recommended action. We strongly support the recommendation that the education of health workers should be aligned to the goals of primary health care. Education and training of health workers should be anchored to local needs so that education is relevant in preparing a workforce that is competent to provide required services to the community. To echo what has already been raised in this e-discussion, a primary health care team is an important concept which needs to be realised, not only to improve health outcomes but also to encourage retention by improving the working environment for healthworkers where the contribution of each profession and cadre is understood, recognized and promoted.

Firstly we would like to raise the subject of the underutilisation of pharmacists in primary health care approaches. Pharmaceutical services, the provision of services to ensure access to medicines and their rational use, is a core component of any health care delivery system. Pharmacists are competent to provide such care and to assume responsibility and accountability

for the outcomes of patients' medication therapy. With the expanding professional scope of practice of pharmacists, which includes primary health care roles, there is a strong potential for collaborative practice with other health professionals. The greater utilization of pharmacists has the potential to leverage far reaching health care gains by reducing fragmentation of care, enhancing medication use and therapeutic outcomes, and improving patient safety.

Secondly, with regards to human resource for health development, many countries worldwide face critical shortages of pharmacists and pharmacy technicians that are vital to the provision of pharmaceutical services. Shortages are particularly extreme in sub-Saharan Africa. The capacity needs to educate and train the required workforce should not be underestimated and innovative ways must be found to overcome shortages and ensure that entry-level competencies are achieved and maintained. There is a need to mobilise local and international stakeholder support for local efforts to provide appropriate training. There is also an urgent need for comprehensive pharmacy workforce plans in all countries that are integrated into broader human resources for health plans and take into account the distinct education and practitioner competency development needs of each cadre, scope of practice, career pathway, and retention and workforce development policies that aim towards self-sufficiency.

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The WHO UNESCO FIP Global Pharmacy Education Taskforce was launched in March 2008 with the goal of facilitating pharmacy education development to address healthcare needs. The Taskforce is a collaboration between the two UN institutions for health and education, as well as a professional body that represents pharmacists and pharmaceutical scientists.

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## **10. Role of middle level healthcare workers in the provision of quality primary healthcare**

The role of middle level healthcare workers is very important in the provision of high quality Primary Health Care and therefore developing their role in this struggle is very important. These people include Nurses, Nurse Practitioners, Clinical Officers(Medical Officers), Midwives, Allied Workers(Radiologists, Physiotherapists, Clinical Lab attendants, Nutritionists, Speech Therapists, etc).

We need these people for three main reasons;

- 1- Because people are living longer and diseases have shifted for Acute to Chronic. Most people with chronic illnesses therefore don't need doctors all the time instead they need Nurses around them. Increasingly as well, Old people are living in Hospices and need services of these nurses more often.
- 2- Modern medicine has become more complex and you need a lot of technicians as well as complex technologies and some of these are beyond doctors' knowledge

3- In order to appreciate the all the health care needs of society, you need to all the cadres, i.e doctors, nurses, clinical technicians etc.

These people especially the nurses have been faced with some problems all over the world some of which the major ones are;

- They have a poor image because they are mainly women and in some countries being one is already being disadvantaged.
- All over the world the nurses work under the direction of the doctors and even if the doctor is wrong and the nurse is right. So they cannot call themselves professionals.
- They are also poorly paid compared to the doctors. They don't even have
- housing like doctors do in some countries.

Nurse practitioners on the other hand are trained with more responsibility. These work like doctors and mainly in rural areas. They carry out pregnancy tests, pelvic examinations, breast cancer tests physical exams, medical history, x-rays etc.

If we are to get healthcare better therefore, we need to take into consideration the other health care providers other than doctors and recognize them more in this effort of Primary Health Care. Their pay should be increased, their work conditions improved because it has been found out that these people at the end of the day do understand patients more than the doctors do.

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## **11. FBO (Faith-based organization) Health Networks and Renewing Primary Health Care**

I have worked for more than 30 years in Africa (especially in DR Congo) with health systems strengthening. My work has included an emphasis on encouraging greater collaboration between faith-based and government in the co-management of health services. I've summarized my perspectives in the attached article, *FBO Health Networks and Renewing Primary Health Care*. The full article may be found at <http://renewingphc.org>. Below is the summary from that article:

FBO health networks are a special type of FBO association, usually at the national level, that is organizationally committed to the coordination of health and healing through the network of its members. That network, sometimes tightly and often loosely structured, usually includes facility-based, congregational-based and community-based health services.

FBO health networks, and individuals working through them, have played an important role in the development of the concepts of primary health care. Today in sub-Saharan Africa, national FBO health networks often provide 25-50% of health services. This paper draws primarily from the experience of FBO networks in DR Congo where they currently not only provide 50% of health services, but also co-manage around 40% of Congo's 515 health zones. Their work is examined with respect to three conceptual frameworks: 1) Alma Ata and the principles of



Primary Health Care; 2) Framework for building an integrated PHC Health System; and 3) Korten's Four Generations of NGO Developmental Strategies.

Concluding recommendations for strengthening National FBO health networks, and to build on their experience for renewing primary health care, are that:

- 1) National Faith-Based Health Networks should be treated as a not-for-profit public sector partner to the Ministry of Health, rather than as a private sector competitor.
- 2) The role of national FBO health networks in health systems co-management as part of a decentralized health system should be recognized and developed.
- 3) Health system assessments and planning should always examine the potential of roles of National FBO Health Networks.
- 4) Partnering and funding agencies should broaden their vision, and funding to include capacity-building of National Faith-Based Health Networks.
- 5) Donor agencies should consider opportunities for capacity building of National Faith-Based Health Networks to strengthen collaboration with MOHs.
- 6) National Faith-Based Health Networks should develop their capacity to manage umbrella projects on behalf of their members and the national health system.

Regards,  
FRANK

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## **12. Incentives: Hospital – academia partnership**

I have been enjoying the discussion and learning from the various experiences shared so far; and felt urged to share a couple of points for that address the issue from another dimension.

A simple conceptual analysis emphasizes that PHC should be complemented by public health and social interventions in order to make a change in the health determinants and ultimately influence the health outcomes in a community. Practically, the approach has been followed in many parts of the world, but should be reinforced.

Strategically, PH policies and subsequently programmes should integrate PH services within social packages for efficiency, effectiveness and accessibility reasons. International funding/ aids can be a vehicle to mainstream PH dimension within social and development programmes by applying and reinforcing the concept of health impact assessment on planned development projects that should account for measures to mitigate potential harmful effects that might emanate from them.

Obviously, channeling volunteer's efforts to advocate for healthy lifestyle and convey simple but effective messages to local communities is essential and practical. Building capacity is needed though.

As for the health workers, a lot has been shared in terms of incentivizing the health professionals to move into rural or developing countries, as well as attracting students and the public to major in a health related field. Obviously there is an escalating global need for nurses. Many are the hindrances for students to join the nursing programmes. Successful programs are based on partnerships between hospitals and academia (H-A), whereby students are offered free RN degree provided he/she sign an employment contract upon joining the program. Government should build on such initiatives and encourage such H-A partnerships.

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**Dated: February 13, 2009 – Vol. 11**

## **1. The role of IT and future primary health care**

A century old fixed infrastructure for medical care is not adequate for the Low and Middle Income Countries (LMIC) in this century. In the same way that LMIC leapfrogged over fixed lines for telephone services and entered the mobile phone era directly, using satellites, the new health care system can only provide PHC for all if it is mobile. GK, the founder of the People's Health movement had to overcome cultural and religious dogma to have its female nurses and PHC provider do their round on bicycles. And today they even have physiotherapy in PHC in rural areas thanks to PT Mannikandan. Today, globally there are IT technologies, GPS, mobile labs, mobile surgery clinics etc, why not adapt GK's method and add modern IT technologies? This is the health care of the future. And it is the opposite of triage of the kind proposed today in various schemes. Further, fixed health care big hospital white elephants are dangerous: hotbeds of nosocomial infections. China, supported by the majority of LMIC countries has just placed the Multidrug Resistant Tuberculosis (MDRTB) and the Extremely Drug Resistant Tuberculosis (XDR TB) on the May 2009 WHA agenda. It's a right decision. But let us say it out loud: XDRTB primary reason for spreading is the collapse in infection control. 20 to 70% of patients may contract a hospital acquired infection according to research conducted throughout West Africa by the International Network for Quality and Safety in Health in Africa (RIPAQS), a network of public health people working hard to restore good functioning systems to prevent nosocomial infections. And the health system of the future must have patients on board, not as passive recipients of 'errors' or better care, but as active partners to elaborate a better system, a safer system, a more equitable system, alongside the struggle of the health care people, the nurses, the cleaning staff, all the personnel who deserves better pay, pay on time, better working conditions and more respect.

Such is my humble opinion.

In the Executive Board of the WHO, 2 weeks ago, the LMICs argued vehemently for a code of practice that respects the Right to Health of their populations, and not only the right of the individual health professional migrant. What do they ask of rich countries presently vacuum

cleaning their personnel? As Sri Lanka, or Oman said: at least well to do countries should train sufficient number of doctors, nurses, and specialists, so they stop pumping LMIC trained health care personnel! In France, while we are not internationally the worst offenders in terms of attracting LMIC doctors, some of us involved in the advocacy for health care for all, say, with Professor Grimaldi: we must lift the limit of 5000 doctors licensed every year while our national needs are for more than 9000. This will mean better health here also, as not just math nuts will succeed in hopelessly difficult 'concours', but also youth interested in literature, philosophy, psychology will be able to study medicine!

Brazil is proposing to organize in 2009 an international conference bringing together governments and civil society on a "universal health care system", it is an interesting initiative, perhaps the debate can continue there?

Garance Upham

Safe Observer International - This opinion is my own.

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**Dated: February 17, 2009 – Vol. 12**

## **1. The G8, global health governance and accountability**

To add to comments of Professor Takemi, Mr. Yamamoto and Mr. Shuey regarding the role of the G8 in the governance of global health, I add the following.

Both the product and resulting discussion generated by the Japanese working group on "Challenges in Global Health and Japan's Contributions" have added immensely to reinvigorating policy discussions at the highest levels on global health issues. This initiative was timely not only because it coincided with the Hokkaido G8 summit, but also because its deliberations took place at a critical time during a continuing period of profound change in the practical realities of global health governance.

Arguably this period of change is a result of an unprecedented surge of civil society demand that has insisted for two decades that global health mechanisms respond more aggressively to the global AIDS epidemic. No matter what the reason, the proliferation of multiple global health initiatives is evidence enough that previous ways of confronting global health crises are insufficient.

The lessons learned by the Japanese working group and imparted by Professor Takemi and Mr. Yamamoto—that empowerment, community focus, and the interrelationship of health with other social needs—are the salient points to this discussion. These lessons are the same ones that have long been key elements of the global AIDS response.

But as *The Lancet* article has been raised, it is important to draw attention to Professor Takemi's distinction between the G8 process and the emergence and importance of the "Health 8," which as the article notes, "...creates an opportunity for enhanced communication, collaboration, and consensus-building for global health policy, including interactions with the G8."

Mr. Shuey worries over “What would be the accountability structure of the G8 in global health governance?”—a key focus of civil society G8 lobbying for nearly five years. The Hokkaido G8 summit took steps that have the potential to address this question by creating *a follow-up mechanism to monitor progress on G8 health commitments*.

Just how effective this follow-up mechanism proves to be will also be a test of the Health 8’s leadership. If the follow-up mechanism reports become nothing more than a means to window dress lagging progress or the broken commitments of member states, then credibility of both the Health 8 and the G8 will suffer. On the other hand, if the follow-up mechanism establishes a means to conduct candid assessments and put forward *recommendations for future G8 action* as was called for at the Heiligendamm summit, then the G8 can make use of its unique position and through power and vision help shape the global health agenda and priorities.

The Hokkaido Summit also produced the *Toyako Framework of Action for Global Health* that will undoubtedly play a prominent role in future G8 and Health 8 deliberations. The Framework’s principles for and actions to be taken on health are ambitious, but the G8 has pending health commitments that have yet to be realised.

First and foremost is the G8’s signature commitment to provide Universal access to HIV prevention, treatment, care and support by 2010. For the G8 to have any credibility in leading on global health issues, it must produce a credible, costed, time-bound plan to fulfill the promise of universal access. Keeping this promise should be a commanding feature of the work of the G8 follow-up mechanism, the Health 8 and the G8 itself.

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## **2. Health related human resources strategy and results of incentive measures in Burundi**

To follow-up on the latest query from the facilitation team suggesting that attention be focused on experience sharing to improve access to health care for rural communities as well as to ensure greater availability and a fair geographical distribution of the existing qualified human resources of the sector, I wish to share the experience of Burundi on this same issue which constitutes one of the critical challenges of the country.

First, capacity building in production, mobilization and management of health-related human resources (HRR) for an efficient and fair distribution as well as their stabilization is one of the priorities of the national health policy for 2005-2015. To implement the policy, a national health

promotion plan has been developed for the 2006-2010 period and in human resources the following strategies have been adopted:

- Development and implementation of a HRR promotion plan through capacity building in production with a special focus on programming and the introduction of new courses by improving the quality of training and adopting an approach based on the involvement of training experts;
- Setting up of stabilizing and incentive mechanisms for health staff through the development of specific statutory arrangements and the creation of a framework for dialogue with development partners concerning the salary standards applicable to all the contract staff of national health facilities;
- Improvement of resource management through staff redeployment in view of harmonizing geographical distribution.

As for the incentives introduced to facilitate the relocation of health staff and doctors in rural areas, the main following measures have been adopted, albeit with uneven results:

1. With the support of its partners, the Ministry of Health has entered into attractive and well-paid agreements with specialist doctors to entice them into working outside of Burundi's capital city (Bujumbura). The mechanism is still operating on a limited scale but its delivery of results has been sometimes hampered by a lack of equipment and medical apparatus in some hospitals
2. The empowerment of hospitals in terms of management which started some years ago favors staff stability since salaries as well as other living conditions such as housing, availability of schools in the neighbourhood are on a positive trend in certain provinces. Nonetheless, the increasing costs of services and treatment in a more or less generalized context of poverty, demands that these health units be supported resource-wise in order to be able to care for vulnerable groups and for those groups that are eligible under the government measure taken in 2005, i.e. free care for pregnant women and children under 5 .
3. The process of entering performance-based contractual agreements has produced very good results within the units where it has been undertaken. It helps to motivate staff and improve the quality of the health services delivered to the general public in a fair manner. The mechanism, which has been established in collaboration with some NGOs, uses a system of performance criteria for staff working at the level of the province and for health centres as well as a system of bonuses following assessment at the level of the Provincial Health Bureau (PHB a decentralized body) by a team from the Ministry of Health.

The implementation of the strategic plan in Burundi is supported by an efficient «Health Sector Group» which provides a functional platform for the dialogue around the priorities in this field and brings together representatives from government, technical and financial partners (TFP), and CSO and NGOs working in the sector. A « Basket Fund » fed by several donors has been set up to fund priority actions. The support of the TFP both at the level of the dialogue process and, above all, at the level of funding is a major reason for the success recorded given the weakness of national resources.

Best regards  
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[Original version in French] Chers collègues,

Suite au dernier message de l'équipe de facilitation demandant de focaliser les échanges sur les expériences des pays pour améliorer l'accès des populations rurales aux soins de santé et pour assurer l'augmentation de la disponibilité et de la répartition géographique équitable des ressources humaines qualifiées dans ce secteur, je voudrais partager avec vous l'expérience du Burundi sur ce sujet qui constitue un des défis majeurs au Burundi.

Tout d'abord, le renforcement des capacités de production, de mobilisation et de gestion des ressources humaines de santé (RHS) pour une couverture effective et équitable ainsi que leur stabilisation constitue une des priorités de la politique nationale de santé 2005-2015. Dans la mise en œuvre de cette politique, un plan national de développement sanitaire 2006-2010 a été élaboré et en matière de ressources humaines, les stratégies suivantes ont été adoptées :

- Elaboration et mise en œuvre d'un plan de développement des RHS en augmentant la capacité nationale de production avec un accent particulier sur la programmation et la création des filières inexistantes, en améliorant la qualité de la formation et en adoptant une approche mettant à contribution des experts formateurs ;
- Mise en place des mécanismes de stabilisation et de motivation du personnel de santé par l'élaboration des dispositions statutaires particulières et l'instauration d'un cadre de dialogue avec les partenaires au développement sur les normes de rémunération pour tout le personnel contractuel national de la santé ;
- Amélioration de la gestion des ressources par un reploiement du personnel en vue d'une répartition géographique équitable.

Concernant les mesures d'incitation mis en place pour que le personnel soignant et les docteurs puissent aller travailler en milieu rural, les principaux mécanismes déployés avec des résultats variés sont les suivants :

1. Avec l'appui des partenaires, le Ministère de la santé a signé des contrats rémunérateurs et motivants avec les médecins spécialistes pour qu'ils acceptent de travailler dans les provinces en dehors de la capitale du Burundi (Bujumbura). Ce mécanisme fonctionne encore à petite échelle mais sa performance au niveau des résultats s'est parfois heurtée au manque d'équipements et de matériel médical dans certains hôpitaux
2. La mise en autonomie de gestion des hôpitaux opérée depuis quelques années permet la stabilisation du personnel dans la mesure où les salaires s'améliorent ainsi que d'autres conditions de vie comme le logement et la disponibilité des écoles pour les enfants dans certaines provinces. Cependant, la hausse des tarifs des services et soins, dans un contexte de pauvreté plus ou moins généralisée, exige que ces hôpitaux soient appuyés en termes de ressources afin de servir les groupes vulnérables et ceux subventionnés par la mesure adoptée par le gouvernement depuis 2005 à savoir, la gratuité des soins pour les femmes enceintes et les enfants de moins de 5 ans.
3. Le mécanisme de contractualisation basée sur la performance a produit de très bons résultats dans les entités où il est appliqué. Il permet de motiver le personnel et d'augmenter l'efficacité dans la prestation des services de santé à la population d'une façon équitable. Ce mécanisme, mis en place avec la collaboration de certaines ONGs, est basé sur la fixation des critères de performance du personnel au niveau provincial et les centres de santé ainsi qu'une distribution des primes après une évaluation au niveau du Bureau Provincial de Santé (BPS qui est une structure décentralisée) par l'équipe du ministère de la santé.

L'application de ce plan stratégique au Burundi est soutenu par un « Groupe sectoriel Santé » performant qui constitue un cadre de dialogue efficace sur les priorités du secteur et qui regroupe les représentants du Gouvernement, des partenaires techniques et financiers (PTF),

des OSC et des ONG qui opèrent dans le secteur. Un « Basket Fund » financé par plusieurs bailleurs de fonds a été constitué pour financer les actions prioritaires. L'appui des PTF aussi bien au niveau du dialogue et surtout au niveau du financement constitue un facteur majeur dans les succès enregistrés compte tenu des limites des ressources nationales.

Meilleures salutations  
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