Newsletter no. 72

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Human Resources in Healthcare
Under pressure?

1. Introductory

This is the second time that we send the newsletter by electronic mail. It took some time since we mailed the last one. As most of the publications of Medicus Mundi are published on our website www.medicusmundi.org the need to publish separately a newsletter has diminished. However, there is news and this way of communication keeps up the attention.

The Kampala meeting of last year, an anglophone African consultation of bishops responsible for church health institutions, with the technical assistance of Medicus Mundi, has been successful. Especially the motivation and good willingness of the participants was special. An extensive report you can find on the MMI website. Important now is the follow-up: what implementations and decisions have been applied in the period after, what are the restraints, how do the bishops deal with difficult questions and how do they communicate? The first follow-up meeting is planned for next May under guidance of the Uganda Catholic Medical Board.
This was an anglophone meeting. The same kind of conference is planned for the francophone and lusophone African countries. This will take place in the month of June of this year 2005, in Cotonou. Technical support again is given by Medicus Mundi; the local logistics are delegated to AMCESS, our member organisation in Benin. The conference is officially convened by the regional bishops conference of francophone/lusophone Africa.

Modern times request modern strategies. Which organisation that wants to keep up in the rat race of survival does not formulate her strategies these days? So does Medicus Mundi. A strategic plan is developed and nearly ready for agreement and publishing. Health for All, Millennium Goals, Sector Wide Approaches, Priority Programmes, the AIDS Epidemic absorbing resources, they all urge you to adapt the strategies of the PHC concept. Sometimes it makes you a bit depressed: every decennium a new generation of development workers preach a new approach to save the world, sometimes drastically abandoning old good ideals. The dilemma stays: what to keep of the good and which goals have to be changed. Dr Guy Kegels, Medicus Mundi Belgium,

has thoroughly reflected on the health systems development in sub-Saharan Africa. “The kind of world we live in”, a background paper for the strategic plan.

Primary health care is more than ever under pressure. The scarce human resources quit the basic health services, for a better living, leaving their country for greener pastures, sometimes just because of stress and overwork, or to join a more profitable job in a Priority Programme, or just to cultivate the land and care for family members suffering of AIDS.
A Uganda case study by Cordaid’s Christine Fenenga gives some important remarks on the pressure of human resources in basic health services. Synergy or Antagonism?

Human resources development is one of the spearhead themes of Medicus Mundi. A research will be done, restricted to the human resources in the health systems and the relation with the HIV/AIDS epidemic. The announcement by MMI’s president is a beginning of a plan that will be worked out for the coming years.

Finally, a new Board has been elected.

Strength, optimism, confidence, together with efficiency, impregnated by friendship. What more can we wish you for the year 2005?

Sake Rypkema

2. Background paper. The health systems and the kind of world we live in.
Dr Guy Kegels

Background

Although it remains possible to look at the world and, at times, conclude that it is good and beautiful, this is probably not the most customary nor the most appropriate way to observe and interpret reality for an international NGO specialising in health and health care. If our self-imposed mission is to contribute to better health in this world, and more specifically in the poorer parts of it, we cannot ignore the many obstacles there appear to be for people to attain a state of reasonable well-being. Nor should we ignore the institutional environment in which organisations such as MMI evolve and which they partly co-create. This rapid overview of the present situation will be organised in three parts. The first part will attempt to summarise the challenges in terms of needs and demand: the burden of ill health. The second part will summarise some essential elements of the supply side: the health systems. The last and most hazardous part will attempt to describe the background to this background chapter: the kind of world we live in.

Needs and demand: the burden of ill health

Poverty, inequality, violence and injustice have always been at the root of ill health and death everywhere, but most visibly in most low-income countries. They still are.
The universal objective of health for all, called for by the World Health Organisation (WHO) and

its member states in the Alma Ata Declaration of 1978, has not yet been reached. According to the WHO (World Health Report 2004) in 2000 under-five mortality rates (U5M) were still above 10% in 48 (of 192) countries and above 20% in 11 countries; maternal mortality ratios were higher than 1000 per 100,000 live births in 18 countries. HIV/AIDS is the leading cause of death among adults aged 15-59 years worldwide. It has killed more than 20 million people already. An estimated 34-46 million others are living with HIV/AIDS. In Africa about one in 12 adults has HIV/AIDS. In some regions it is probably more than one in three. At present trends it is to be foreseen that the huge and dense Asian populations will contain absolute numbers of HIV infected people that surpass those presently found in Africa.

With these few figures we touch upon the most visible and most advertised problem families that are currently documented: (1) epidemics that are out of control (HIV/AIDS, TB, malaria, and some others to the extent that they can be lobbied into this hit parade), and (2) little or too little progress in mother-and-child health. These are also the focus of the three formal Millennium Development Goals, decided upon during the Millennium Summit in 2000 that pertain to health issues. These huge health problems have every right, rationally speaking, of being called ‘priorities’, concentrating misery as they do, but this should not obscure the fact that lots of other things are going on. Apart from the traditional and endless list of other diseases and health problems (from which mental health should not be absent), there is the important phenomenon of the epidemiological transition, linked to demographic and nutritional transitions currently observed in low and middle income countries also – or at least in those segments of their populations that take part in these transitions – leading to shifts from a pattern of mainly acute and infectious disease to an increasing burden of illness from the more chronic and degenerative diseases. Especially the middle-income countries are getting it both ways.
The global perspective that has been taken here should not let us forget that there is a high degree of diversity, geographically and inside societies, in the burden of ill health. Geographically the most striking concentration of disaster is probably the HIV catastrophe in large parts of sub-Saharan Africa, where whole societies are imploding. Socially there is the striking fact that inside the same country, ill health is very much linked to socio-economic status (or poverty), and especially in the poorest countries, only the ‘richest’ quintile (one fifth) of the population seems to ‘escape’ from the general trend of totally unacceptable mortality and morbidity indicators.

The supply side: health systems

WHO defines three essential aims for a health system: (1) improving health; (2) responding to expectations, and (3) providing financial protection from the consequences of ill health. To the extent that ‘improving health’ depends on providing health care, this statement can be reduced to: seeing to it that all those in need have access to good quality care. This requires resources and an adequate organisational format.
Estimates of how much expenditure is needed in order to make health care available to all those who need it (or at least an acceptable, ‘reasonable’ package) are notoriously difficult to make. In 2000 the Belgians and the Dutch spent some 2260 International Dollars (PPP) per capita on health (close to 8.5% of GDP). In the same year, 50 and 32 International Dollars (PPP) were spent per Zambian and per Malinese, respectively (5-6% of GDP). In the majority of countries in the WHO Afro-region, total health expenditure was below 50 Int. Dollars p.c., but, within this cluster, life expectancy at birth varied between 35 and 60 years (an impressive variation in

'performance'), without any correlation with expenditure within this (very) low expenditure group.
We may not really know how much money it takes to provide an acceptable service, but there is clearly a dramatic underfunding in most low income countries, even if the different systems appear to be able to obtain vastly different results with such small amounts (which points to the importance of the organisational format and functioning of the supply systems). The issue of the underfunding has been increasingly recognised these last years with, as a result, a very significant investment effort (see GF/ATB, WB, GAVI, PEPFAR, Stop TB, Roll Back Malaria, …) complementing the rather waning ODA from the OECD countries. This is structurally further embedded and structured in the HIPC initiative (very significant debt reduction for 'Heavily Indebted and Poor Countries') and the Poverty Reduction Strategies (PRS) approach promoted by WB over the last five years. So the funding prospects are potentially improved these days (with the proviso that the availability of more money will result in better outcomes only if there is sufficient absorption capacity at the receivers' end), although the challenges remain formidable.

In terms of organisational configuration of these health systems, many are seeking their way away from centrally led State health care bureaucracies toward something else, ranging from still public, but smaller, decentralised or devolved health bureaucracies (the decentralisation and 'New Public Management' paradigms) to fully privatised systems (the full neo-liberal paradigm). This highly complex and very context dependent evolution, coupled with changing balances between the use of pooled resources vs. direct, individual, out-of-pocket expenditure, carries a lot of theoretical potential but also a lot of uncertainty and risk. It is self-evident that reforms can only be as good as the quality of the problem assessment on which they are based permits. If the present tendency is one of evolving toward more market-oriented mechanisms in health care provision, it will be necessary to find ways to regulate this highly imperfect market in terms of access to 'expert knowledge' (which is what medicine is about, essentially) – and it may be assumed that such regulation is likely to be successful only if the regulating authorities have shown to be capable of regulating less difficult markets. Of particular concern is the increasing recognition of the link, not only between poverty and health, but also between poverty and health care consumption. This works two ways. Poverty can of course reduce (needed) health care consumption, leading to suboptimal health and downright health crisis. This is the classical problem of access to care for the poor. Increasingly, however, it is recognised that *health care consumption can lead to poverty* (called 'iatrogenic' poverty by some). A virtually unlimited and aggressively marketed health care supply appears to induce a lot of overconsumption in unregulated health markets by unprotected clients. This is highly visible in several countries that are in economic transition from centrally planned state economies toward a market economy, where often the 'transition' was a clean break with the past and health care became a privatised commodity business (officially or unofficially) almost overnight (see Vietnam, Cambodia, China,…). But it is by no means restricted to these situations.

We cannot end this part without referring to the issue of human resources for health (HRH). Situating the problems here in the domains of *availability*, *competence* and *motivation* is not new. What is to be examined in the present context is how they are brought about and how they are articulated. A particularly worrying problem (in terms of availability) is the *brain drain* in all its forms and varieties – locally and globally. It is quite likely, however, that this problem, worrying as it is, is totally invulnerable in the present world, and that other solutions will have to be found.

Another problem with HRH lies with quality and motivation in our post-modern more consumerist environment, in which formerly existing (?) social contracts, regulating health care provider behaviour vis-à-vis vulnerable patients, sometimes are seen to completely evaporate – or appear never to have existed.
In our societies this 'reasonable' provider behaviour, founded in the social contract, is usually understood to be part of the notion of 'professionalism', and thought to be self-evident among health care providers who have interiorised this behaviour through a long socialisation process at the time of their (also long) training. As we are beginning to realise, it appears that this is neither a universal nor a historically stable feature.

2004: What kind of world is this?

Often used keywords – or 'container-concepts' – that describe this world are *globalisation* and *post-modernism*.
The globalisation issue, according to a widespread reading, equals the victory of the all-pervasive neo-liberal organising principle, emphasising individual utility and competition in the market as the organising mode of human activity. This can be connected with a radical transition in the perception of the role of the State, especially in the formerly centrally planned economies, and with the abolition of the idea of the state as a core health care provider. We have referred to this issue in the previous part.

Related to the above is the fact that we are not living anymore in 'modern' times (with their 'great stories' or ideologies, in which the notions of good and bad, 'progress' and 'development' had a clear and reasonably stable meaning for almost everybody within the same ideology, and in which most people were embedded in and identified with some 'vertical' social structure – family, village or town, nation – which provided meaning and protection). Instead we are in a 'post-modern' environment of pluralist, socially constructed 'truths', in which the individuals are increasingly seeking what social integration they can get in 'horizontally' structured networks (of their own choice), more free than before, but also less protected, more uncertain and often very alone. This transition is quite clear in our post-industrialist societies (if one looks through the appropriate kind of glasses), but is emerging everywhere where significant wealth and social mobility appear together. It probably also explains part of the brain drain problem, mentioned above.

In this environment, the meaning of the word 'development' has become increasingly unclear – or insufficiently shared – (just like the word 'progress' in the absence of utopistic ideologies), which has contributed to its gradual rarification and to its replacement by concentrated efforts to do something about very specific problems. We are living in a world dominated by Global Fund ATM (HIV/AIDS, TB, malaria), Roll Back Malaria, Stop TB, GAVI (vaccine initiative), PEPFAR (AIDS), '3 by 5' (AIDS treatment), etc., and the discourse has changed from 'development' to 'poverty reduction' and from 'Health for All' to MDGs. This is not just a change in terminology; it is something much more fundamental in the present *Zeitgeist*, just like the replacement of the word 'patient' by 'client', then 'citizen' and finally 'consumer' can hardly be neutral (or the shift from 'health workers' to 'human resources', for that matter).

Furthermore, in line with the above, a clear *institutional* evolution is going on that is also the

expression of the ‘new’ globalisation and post-modern climate (and that has created a whole institutional industry to cope with it). Some key words in this evolution are ‘result orientation’, ‘accountability’, ‘transparency’ and the like. They apply in the first place – but not exclusively – to the allocation and use of public resources. Features include:

- Blurring boundaries between ‘public’ and ‘private’, ‘for profit’ and ‘not-for-profit’. In actual practice there is less and less difference between a consultancy firm and an NGO; more and more they have to operate according to the same (profit-driven and competitive) business principles; even if NGOs are not expected to be profit-maximisers, they must be profit-seekers in order to survive.
- A growing enforcement of ‘transparent’ procedures, aimed at creating a ‘level playing field’ for all competitors. The price to pay for this consists, i.a. of growing administrative and bureaucratic complexity and therefore sharply increased transaction cost (preparing proposals for programmes or projects, negotiating contracts, etc.).
- Strong accountability requirements, with a focus on measurable results. This also increases the need for ‘professionalisation’ within the organisations’ management and results in increased administrative cost.
- The abovementioned evolutions all contribute to sharply increased general overhead cost which tends to weed out organisations that have insufficient critical mass (small may be beautiful, but it is no asset for survival).
- Imposition of ‘relevance-ensuring’ procedures, justifying the expected results of proposed action through logical frameworks that are based on a linear logic that is understandable for non-experts. This evolution is paralleled by an increase in the management-oriented component of the workforce in (inter)national funding organisations (and international NGOs), at the expense of thematic or sectoral expertise which tends to be much more experience-based and grounded in an implicit, professional logic of complex judgement.

Last but not least, there is the emergence of significant initiating and implementation capacity in the non-government sector in the South, and the decentralisation of funding allocation as observed in the EU policies. Northern NGOs’ roles in the international development landscape will have to be rethought, as well as their relations with their ‘partners’ in the South. The traditional roles of operational, fund finding and/or brokering NGOs in the North, though not entirely gone or obsolete, will have to be replaced by something else, or at least the focus will have to shift. Things like educational activities, information dissemination, watch dog functions, advocacy, lobbying, … come to mind, but that territory is, for many NGOs in the North, unknown or ill explored.

A final comment is that the traditional vocabulary of the aid and development business needs some critical rethinking. Terms like ‘humanitarian aid’, ‘emergency assistance’ ‘rehabilitation’, ‘structural development’, ‘financial sustainability’, ‘substitution’ and the like are not as useful anymore in structuring, assessing and mapping the activities in today’s world. They were fundamentally rooted in a vision of ‘development’ that was quite optimistic (‘modern’) and based on the principle of (strong) economic growth as the long term rule, and emergencies or disasters as the temporary short-term exceptions.
Today we need to acknowledge that in large parts of the world these metaphors and implicit paradigms do not correspond to reality. Large parts of Subsaharan Africa are in a state of ‘chronic emergency’ and the AIDS problem, especially in Southern Africa, is bringing them on the brink

of complete social involution or implosion (solving this problem will require radically original thinking). If adequate health care for those in need of it is to be considered as a *right*, then we will have to accept that systematic transfers from the rich (us), to the poor (them), will have to be continuous and sustained for a long time to come. The corollary of that is that the traditionally 'sound' vision of orthodox development agents/agencies focusing on strategic investment (in the final analysis based on a cost-effectiveness approach, rather than on a rights-based approach) will have to be critically re-examined. North-South transfers for recurrent expenditure (not only investment) will have to be admitted as the 'norm'.

This, in the proverbial nutshell, is a plausible interpretation of the present world. Against this background, MMI will have to position itself in terms of vision and mission.
The above-mentioned developments and changes have serious implications for basic health care providers in the South. In order to continue to provide accessible, equitable and affordable basic health care they will have to reposition themselves within the changing (local and global) context and in certain cases challenge national and international developments.

3. "Priority Programmes and Health Systems: Synergy or Antagonism?"

Case study Uganda: Disease Targeted Initiatives and Human Resources in Health

Presentation by Christine Fenenga, Programme Officer CORDAID[1]

Background
In Uganda Health Sector Reforms started around 1993, following reforms of the National Constitution, Public Administration and Macro economic Policies. The MoH started the development of the new Health policy in 1996 in consultation with the main development partners. In 1997 the Sector Wide Approach was introduced and consultative meetings, with all partners and stakeholders, were held to elaborate the HSSP early 1999. The National Health Policy and the Health Sector Strategic Plan 2000/2001 – 2004/2005 were adopted in 2000. At the moment they are working on the second HSSP.
The goal of the HSSP is:

> to reduce morbidity and mortality from the major causes of ill health and reduce the disparities within the populations and among the regions.

Health services are provided by public and private providers and organised through the de-centralised system. At district level this means that all health partners participate in the development and implementation of district health plans.

The resource envelop for health amounted, in the year 2002/03 to 9 USD per capita.
The sources of funding are:

- Government taxations and PAF funds for health;
- Development partners budget support;
- Development Partners health sector budget support

[1] Input for this presentation was provided by Br. Dr. Daniele Giusti, Executive Secretary of Uganda Catholic Medical Bureau and Dr. Sam Orach, Technical Advisor of the Global Initiative Fund Management Unit of Uganda Catholic Secretariat.

These contributions amounted to 189 billion Ush for the year 2002/03 (9% of central GOU budget).
The remaining contributions were funded through Development Partners project finances; PNFP contributions and contributions of patients (user fees)
Calculations indicated that a rapid increase to 28 USD per capita, in 2010, will be needed to ensure provision of basic health services. These findings correspond with the calculations of the WHO Macro Economics and Health Commission.

The trained health workers are both inadequate in numbers and inappropriately distributed. The Nursing and Midwifery staff shortages form the largest problem. This has been worsened by a decision of the Nursing Council in 2004, when they started to apply very strict entry criteria to the Nurse Training Courses. As students in rural areas have grave difficulties in obtaining the credits and passes required, the Nursing Schools are experiencing a considerable drop in the number of students. Nationwide the drop in number of nurses being trained, could form an obstacle to achieve the HSSP objectives.

Priority programmes
Extraordinary initiatives like the GFATM (for AIDS, TB and Malaria), PEPFAR (for AIDS, USAID-fund (for AIDS) are difficult to integrate in the National Strategic Plan and to implement in Uganda's decentralised structure. Such initiatives are vertical in nature and guided by their own policy- and implementation framework. Thus causing inherent contradictions to a sector wide approach to health sector development.
With regard to the GFATM Uganda was forced to change their initial "cross cutting system building proposal" into disease specific components, contributing to a project approach to setting up the fund in Uganda. This approach is very much alike the Selective PHC of twenty years ago and shows the same bottlenecks, of which HR is one of the most important.

Ownership
The above donor decisions along with the health sector budget ceilings undermined subsequent country ownership of the Global Fund process. In general one can say that in Uganda the agenda for priority programmes is set by donors with some involvement of the central government. Districts are not really involved in prioritising. The national Country Co-ordinating Mechanism (CCM), in which some civil society organisation take seat, only got involved towards the end of the proposal preparation process for the GF. It was viewed by Government as a genuine public private partnership, while there have been major complains about lacking of civil society representation.
In 2004 donor architecture had become more complex due to parallel effects of several initiatives of HIV/AIDS control. Early lessons on the capacity limitations at the district level were emerging from the WB MAP and USAID funded AIDS initiatives. Civil society, especially PNFP (faith based groups) saw new possibilities for support through the US initiative PEPFAR.
In most cases these funds are disbursed with sophisticated pull mechanisms. The agency holding the money advertises the award of money to the best bidder for ART provision, for PMCTC etc. which induces a selective demand.
This multiplicity of initiatives carried potential risks as well as benefits. Several funding agencies do compete for a limited number of high capacity implementing agencies. The influx of significant levels of new external funds for disease control have mixed effects: it can enable civil society involvement and galvanising national efforts, it can also undermine Government

commitment, which might consider new funds as “substituting for” rather than “additional to” Government spending on health.

Effect of Priority Programmes on Human Resources in Health

HIV/AIDS, malaria and TB have been in Uganda for some time and have all been treated by the health personnel in the health system. The impetus brought by the global initiatives mean changes at various levels:

National level:

National organisations are involved in **time consuming planning** sessions for each disease separately. They have to be part of the process if they want to have and maintain a “say” in what’s going to happen with the funds: how to obtain part of the tasty cake. They also have to make sure that adequate monitoring systems are put in place to follow the implementation of programmes. Often the funds are tightened to specific criteria and monitoring requirements, often not in line with the national system.

Specific skills are needed to fit these new requirements into the existing system, which ask for **high and often expensive expertise**.

District level and sub district level:

Developing good quality programmes at this level, meeting the criteria for GF initiatives requires **competent project developers and managers too at this level**. Although Uganda has worked hard on building management capacity at district level, the average quality of district managers varies strongly. This shortage of skilled project managers makes it difficult to deal with GF in terms of developing quality programmes and safeguarding sufficient attention for other health needs.

Global initiatives require an increased level of activity; also **an increased demand on labour-hours (HR)**. Activities like VCT, PMCTC and ART provision require a lot of labour-hours spent per capita of clients. For every expectant woman receiving nevirapine in some of the Ugandan hospitals, the health worker would have started with the counselling. Then a small number accept to be tested. Of the few positives some may not accept the nevirapine treatment. But the process to reach this would have been long. The same and even more tideous is getting and maintaining clients into ART.

The system in Uganda already deals with a lot of strain on the HR by the “traditional” health care activities. In Uganda currently only about 68% of approved posts of trained health professionals have been filled. However even the approved levels have not been based on a prediction of this increased demand by Global Initiatives. There is also a wide variation from district to district; In some districts only 30% of the positions are filled.

The manner in which the initiatives are carried out so far is vertical and very short time bound, so that the implementation becomes labour intensive. This demands diverting attention of a lot of staffs away from their already heavy traditional tasks.

In order to cope, some PNFP hospitals have had to recruit extra HR specifically for HIV/AIDS. In some cases these may then be paid specific allowances from the GI funds.

Complications however are:

- These staff are seen by other health staff as HIV/AIDS staff. Others are reluctant to take on their roles when "GI" staff are on leave or are sick because they don't get special money/allowances for it.
- "Integration" of priority programmes without adding extra HR often means redistributing HR. Reach the targets of the priority programme is achieved at the expenses of other services.
- Other staffs, not involved in GI's, get to know relatively less and less and become practically unable to assist in absence of those employed for those activities. This is already observed in immunisation services, where in many health facilities it is left to some nurses only.
- What will happen when the GI or project funds are not there (anymore)? Will these "specially" recruited staff just be fired because the institutions are unable to pay for them? Will they accept lower allowances than paid now by the GI's? For PNFP it is worse at a time when government is carrying out salary enhancement for civil servants.(as is currently announced by the UG 2004)
- Often the "special" staffs feel they are "special" or "overburdened" and hence deserving extra pay. They do not see it as an enhancement of their knowledge, skills and jobs.
- Funding of training is very often geared towards disease specific training: in other words if the training is too general and does not carry the flag of the right disease, it cannot be funded.
- There are examples of health staff being forced to attend outdoor courses for months, without taking into account the health units lacking nurse or doctor.
- A lot of training of existing staff takes place but little attention is paid to the effect of constrained HR carrying out outreaches in the ARV programme.

Community level:

The health centre-community network systems for palliative and home care are relatively strong in Uganda. This network can be used as vehicle for TB DOTS and home based management of fever (HBMF) for malaria etc. Unfortunately very few districts and dioceses have had persons trained to plan, lead ad provide hospice care programmes through translating it to community networks.

In areas were community volunteers are paid allowances through the priority programmes, other community programmes depending on voluntary work are likely to collapse. Again certain risks as mentioned under district level apply here (e.g. specialised volunteers)

In terms of perception: in general terms a lot of people are happy with priority programmes and the arrangements to realise these. The programme officials certainly are, as their bread and butter depend on the programme. Those staff that get allowances too. Those who do not get allowances will not be happy. Already clear is that units managed by very responsible managers the unit budget will have to carry the cost of balancing the remuneration in order to keep everybody happy. In those managed by less capable people, anarchy will likely start reigning. When things get out of hand the umbrella organisation UCMB will be called to play a role of fire brigade.

In terms of perception by organisations: the intermediate organisations (TASO, JCRC, AIDS information centre) are quite happy too. They are placed in a strategic position when money

started flowing. Now they sit on sizeable chunks of money. They are heavily recruiting and to make their employment attractive they pay much more than "generalist" organisations can pay. One example: recently a specialised NGO dared to organise a meeting for potential employees within the walls of a University Hospital, attracting a lot of hospital staff for much higher salaries than the hospital could ever offer….

Relation to reaching the MDG

In Uganda the MDT's have set the overall agenda of the Government. IMR and HIV/AIDS are specific MDG's: the Global Fund for AIDS, TB and Malaria (GFATM) are directly focussing on these MDG's. GAVI takes care in some ways of IMR. The Reproductive Health Programme of the MoH suffers from under-funding as it does not fall within the criteria of the "fashionable funds".

The WHO has announced their "3 by 5"plan, to scale up ARV programmes so that 3 million people will be on treatment by the end of 2005, in Uganda translated to 60.000 people. And because the bread and butter of some lucky health staff and some well positioned organisations will depend on whether the target is going to be reached or not, everybody is ready to use shortcuts…

Funding of health services and priority programmes

Macro-economic implications of global initiatives are a matter of concern; especially if earmarked funds from a global initiative unintended squeeze out funding for highly prioritised activities such as reproductive health.

In reality the priority programmes are encroaching on other health needs. This means that in order to achieve the target for which the disease specific funds have been awarded, they absorb also health resources mend for other diseases.

This became clear in a survey of Dr. Orachi, portraying the various disbursement modalities for the disease specific funds.

Suggestions for action

- Let government and donors encourage integration of the initiatives into the existing activities of the implementers and make changes in volume of activities systematically.
- Either the speed of scaling needs to be reduced, or government/international donors work harder to increase the volume of HR that be trained for public and private providers.
- The marginal time person for one additional unit of output must be known to make a better calculation of HR needs and how to scale up activities. Develop a tool, which units can use to calculate what they could accommodate through more efficient use of time and the threshold of additional staff if they wanted to go further.
- Organisations at service delivery point (the interface with the patients) need to set their targets and time frames. Meaning it is not the national and international political agenda's who should set the targets at delivery point.
- Implementers should be conditioned to involving as many of their staffs as possible so that everybody in the institution is an equal player.
- Mechanisms for monitoring not only the programme outputs must be in place, but also those to detect crowding out caused by staff shift to priority areas.

- The issue of Macro-economic instability and need for budget ceilings should not be applied rigidly. If government cannot be allowed to recruit more staff and be paid to work in that integrated service, Uganda shall not succeed to get near to any MDG.
- Community network strengthening need to get more attention in order to assist in assisting in palliative / home based care. That network can also be used for TB-DOTS and Home Based Management of fever (HBMF) malaria strategy. This can be done to get people trained in each district/diocese for various tasks in palliative and home care, strengthening of network models etc especially upcountry.

4. Impact of HIV/AIDS on Human Resources in health care delivery.

Research by MMI

Medicus Mundi is actively involved in HRD related to HIV/Aids. Besides the "Improving of health care facilities by the way of Contracting", HRD related to HIV/AIDS is the second spearhead of MMI strategies. It is in close relation to the healthcare development activities. Via the many partners, particularly in Africa, a first inventory would be feasible. A desk study will soon taken up to inventarize the impact of HIV/AIDS on health personnel. This will clarify the need for more exhaustive research on the issue.
The first MMI publication (ITG Antwerp 2003): "Which role for Medicus Mundi international in Human Resources Development?"can be found on: http://www.medicusmundi.org/

We give you three examples of relevant studies, one from Ghana (website Netherlands Society of Tropical Medicine), Uganda (links: British medical Journal), and Malawi (Links: World Health Report 2004).

- **Brain Drain in the Health Sector of Ghana by Dr. A. Nsiah-Asare of Komfo Anokye Teaching Hospital**

Keynote speech of the congres of the Netherland Society of Tropical Medicine13th october 2004, based on the presentation of Dr. A. Nsiah-Asare, MB ChB (Ghana), FAChirg (Saar), FGCS (Ghana), Chief Executive of Komfo Anokye Teaching Hospital, Ghana / Consultant General Surgeon; edited by Esther Jurgens

http://www.nvtg.org/MT2004-6

Ghana has an estimated total workforce of situation is continually worsened by lems of internal mal-distribution of the about 43,000 in the health sector. This is alarming migration of trained health health professionals remaining. The health woefully inadequate to meet health service professionals out of Ghana – the 'Brain sector in Ghana is therefore experiencing a delivery for a population of 20 million. The Drain' phenomenon together with prob-human resource for health crisis and if not arrested, Ghana like other sister developing countries will not be able to achieve the Millennium Development Goals.
The 'talent drain syndrome' is not exclusive for Ghana but appears to be a global issue. Between 1989 and 1997 more than 10,000 health professionals emigrated from South Africa. Over the past

decade more than 70% trained nurses left the Philippines. And strangely enough, also in the UK the same phenomenon is happening: more than 6,000 nurses left for greener pastries. Brain gain is a serious development even more so in a situation of increasing levels of HIV/Aids, malaria and other communicable diseases.

The Ghanaian situation is demonstrating two migration patterns of health professionals: internally, from the northern regions to the South and to the cities, as well as from the public to the private for profit sector and foreign NGOs. External migration is seen mostly to the US (with more than 1,200 Ghanaian doctors working in the States), the UK, Canada, Germany, and the Arabian Gulf. Some migration also occurs to other developing countries in Africa (Nigeria, Cameroon, Gambia, and others). It is known that there are more Ghanaian doctors working abroad than in their own country. The attrition of nurses has recently reached significant proportions. Ghana is estimated to have lost 50% of its professional nurses to the US, UK and Canada. The estimated vacancy level for nurses has more than doubled over the past four years (from 25% in 1998 to 57% in 2002).

What are the underlying factors that contribute to this development? We can distinguish *push* and *pull* factors. *Push factors* include a lack of structured professional training and career development opportunities; poor health care infrastructure in the country; low levels of remuneration and compensation for (health) workers; and inefficiencies in human resources management processes. Added to these factors is family pressure and a desire for better living standards.

Pull factors, factors that lie mainly outside of the Ghanaian society, include the high levels of demand in developed countries and the available global labour market for certain categories of health workers. For example, the US State department in a report estimates that by the year 2015 there will be a need for 500,000 nurses in the US; the UK will require 35,000 nurses in 2008. Similar figures can be shown for Australia and Canada. The likelihood that poor countries like Ghana can afford to meet such demands and keep their home services staffed is extremely unlikely. It is estimated that this trend will continue, threatening to completely collapse the health services in Africa. It is very unlikely that economic improvement in Ghana advances within the short to medium term. It is therefore unlikely that Ghana will achieve levels of revenue that can make public sector incomes compete with those in recipient countries. A doctor in the US is earning 22 times the salary in Ghana. Besides better salaries, developing countries offer better training and career opportunities and a better, modern, equipped health infrastructure. In addition to these pull factors is the existence of a proactive recruitment policy by a number of developed countries. Trade agreements made the removal of the barriers to global labour flows possible and last but not least: because the gap in educational standards has narrowed – in itself a positive development – labour flows could occur and obstacles to attract (health) workers from Ghana diminished.

Obviously, the costs of brain drain and the effect of these trends on the Ghanaian economy and infrastructure are enormous. The situation has worsened by the fact that the crisis in health intensifies with the advent of the HIV/Aids crisis. The outlook for the health sector in Ghana seems dim given the scenarios described as above. The loss of human capital is shown in the acute shortage of health professionals throughout the health care system. Poorly manned or even unmanned health facilities are on the rise. Hospitals are closing their doors because of shortages in health personnel. In effect the workload for the remaining health workers is overwhelming: 9,000 nurses are doing the work of 30,000. The workload for 3,000 doctors is done by not more than half the required number. All these factors combined are adding up to a loss of confidence in the health system and the poor quality of health care in the country. It is clear that Ghana is

loosing out on opportunities for sustainable development and is far from reaching the Millennium Development Goals.

Is it possible to turn brain drain into brain gain? In what lies the solution to this problem? Despite efforts undertaken by various governments, such as the expansion of training infrastructure in the health sector, employees have been leaving the system. Often because measures to retain the health workers are lacking. The key issues that need to be resolved should be aimed mainly at improving supply, attraction and retention, motivation and extending services in a cost effective a way as possible. This will mean developing, motivating and utilising human resources for health in ways that differ from the traditional methods of the past. Effective human resource management should involve going beyond the narrow issues of salary and training to consider broader incentives and systems for encouraging and managing good performance.

Solutions can be found in a variety of measures, such as decentralisation of training. Local governments should be allowed to locally manage training budgets, allocate resources and develop schemes to bond health workers for a period of time. In addition to increased training opportunities, there is a need for career development for all categories of health professionals. This can be done through reform of remuneration systems and the introduction of benefit and welfare schemes. Drain from the public health sector can be stopped, by allowing doctors to see patients in intramural private practices, while being part-time employed in public health institutions. Furthermore, good transport, housing and educational facilities have proven to be motivational factors for health workers to stay in the system. Non-fiscal and fiscal incentives can be introduced to attract people to invest in the health care system, for example through awards, tax relief and the introduction of home ownership schemes.

On the human resources management side, a number of measures form part of the solution, for example the redesign of the remuneration system. These systems need restructuring in order to improve and increase pay and allowances for health workers, while at the same time be linked to their performance and productivity. In order to solve the problem of future security the government will have to improve, and make the Welfare and Benefits Schemes transparent. A well-managed and fair pension, transport and housing schemes are motivating factors. The public sector retirement in Ghana is at 60 years. Specific efforts should be made to add another 5 years to retirees in specifically needed cadres to certain locations with added benefits. As done in some other countries, retention may be better served by recruiting older entrants into the workforce. The notion is that people already with established family links would be less inclined to leave the country. Bonding and Compulsory Service periods are to be introduced, as was recommended by the 2003 Human Resources for Health Forum. Reinstitution of bonding for health trainees needs to be insured with guarantors' collateral property or social security contributions (like University loans scheme etc). Diplomas and Certificates obtained should also be retained by government until the bond period has been served. These and other measures will have to form part of a National Human Resources Management Plan and other Administration Plans. And after completion of the plans: ensure their implementation and endorsement.

International efforts should focus on the control, management of labour flows and to the return of migrants. The 'Dual Citizen Act' in Ghana is an instrument in the return of non-resident Ghanaians to the country. Over the past years a number of projects have been designed to use the Diaspora for strengthening the health workforce in Ghana. For example, the Migration of International Doctors Agreement Project is designed to facilitate Ghanaian doctors who work in the UK. The programme establishes the possibility for them to return to Ghana for a short period of time on condition of paid-leave. In such a way, non-resident Ghanaians can share knowledge and experience that is attained abroad with health workers back home. Additionally, there is a

need for negotiations and agreements with the recipient countries. Advocacy at the international level should be geared towards the formulation of policies to reduce emigration from developing countries, e.g. the Commonwealth agreement on ethical recruitment (WHA Resolution 57.19). The General Agreement on Trade and Services (GATS) provides the generic framework for these negotiations. The Human Capital Replenishment Assistance (HCRA) programme is geared towards the set up of education and research facilities in the developing countries to train personnel for recipient countries. This would enhance training opportunities in developing countries for a global labour market under condition that the recipient country invests in good training, education and research facilities. North–South Cupertino, through twinning of hospitals for professional development should be encouraged. Ghana may well decide to become and exporter of health workers, both as a way of raising morale but also to mitigate the numbers leaving at any particular time. This would involve negotiations and agreements with the major recipient countries. This system has worked between developing countries (e.g. Ghana/Jamaica/South Africa/SADC) but has not received any interest with rich industrialized countries that are the main recruiters of Ghana's professionals. A rotational system for persons, who have served their bonds, could be facilitated by the government and designed to also gain critical experience and training for staff that go out. How have we fared so far? Locally there are mixed outcomes: still doctors and nurses are leaving Ghana for greener pastries. Temporary there is a slowing rate of attrition for selected groups of professionals. Doctors are more inclined to stay but the nurses are leaving. On the international level there are very poor outcomes. Agreements have tended to be one-way conduits: agreements are mainly profitable for donor countries. There are some ethical codes of practice and resolutions, however they are not legally enforceable yet.

In conclusion: capacity building is a strong instrument in turning brain drain into brain gain. Policy makers should initiate strategies to attract and retain health professionals and mitigate the effects of the brain drain, as suggested in the above. The creation of opportunities for local training and career development is crucial in this, however is not the only component. In the international setting, governments of developing, as well as developed countries will have to understand the dynamics and trends of the international labour market in health and act responsibly. It is time to direct 'Bilateral Transfer Programmes' towards meeting potential local and national demands, rather than 'poaching' health workers from poor, disadvantaged developing countries.

From the British Medical Journal 2004

- **The fate and career destinations of doctors who qualified at Uganda's Makerere Medical School in 1984:**

retrospective cohort studyYoswa M Dambisya

Little information exists on the career paths and destinations of graduates of medical schools from developing countries,1 in contrast with many such reports from the developed world.2 3 I present here perhaps the first report on career paths taken by graduates of Makerere Medical School in Uganda.

From the World Health Report 2004:

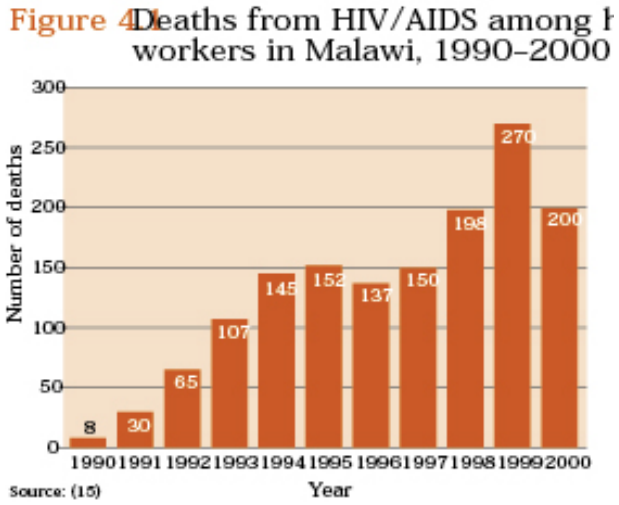
- **Health system resources,**
  the human resource crisis

The capacity of health providers to deliver services is determined by the resources they can deploy. These can be divided into tangible resources such as buildings, equipment, staff and supplies, and intangible ones - the management systems that control their deployment. These are all often severely defective in high-burden countries, and will need substantial investments. It can be argued that deficiencies in human resources most severely constrain the capacity for effective service delivery.

The human resource crisis

It is widely recognized that there now exists a health workforce crisis throughout the developing world. It is characterised by a shortage and maldistribution of trained health workers caused by elevated attrition rates from, among other things, voluntary changes of occupation and emigration from poor to richer countries, a shortfall in the production of trained health workers (in part attributable to a shortage of candidates qualified by general education attainment to enter pre-service training), and a tendency to focus training efforts on the higher-level, internationally recognised cadres.

This has been a crisis in the making for several decades, and certainly existed well before the advent of HIV/AIDS, but it has been exacerbated by the epidemic. There has been a dramatic increase in deaths within the health workforce, attributable to AIDS (see, for example, In Malawi, 44 deaths occurring in 1997-1998 among nurses represented 40% of the annual output from training; in Zambia, 185 deaths in 1999 represented 38% of the annual output from government training schools. Absence because of ill health has also dramatically increased. One study of laboratory workers in Malawi found that nearly half of total working time was lost to sickness and related causes. A secondary effect is increased absenteeism, as health workers need time to care for sick relatives and to attend funerals.



Systemic solutions to the workforce crisis

Human resource specialists now agree that the crisis will only yield to systemic solutions such as substantial improvement in the basic package of pay and benefits, an expansion in the volume of pre-service training, decentralisation of some aspects of personnel management, a programme of management training focused on supportive supervision, and adequate protection of the workforce against the risk of occupational exposure to HIV infection.

Systemic solutions need to link improved rewards to improved productivity. One way to do this is to make payment conditional on the meeting of performance criteria. A good example is Médecins Sans Frontières' incentive payment scheme in Thyolo District, Malawi. The incentives

are given to all health workers, not just those directly involved in activities supported by Médecins Sans Frontières; payment of the incentives is discretionary and dependent on performance criteria; and the scheme is administered by local managers, thus empowering their supervision of the workforce. This isolated example illustrates reform principles of system-wide relevance.

Given the prevailing shortages, massive expansion of human resources is needed to permit scale-up of antiretroviral therapy without excessive damage to existing programmes. This implies a large number of actions including: emergency recruitment, in some cases from abroad; relaxing fiscal constraints related to public sector hiring; introducing new cadres; increasing community input; initiating treatment-focused in-service training on a large scale; and expanding pre-service training. Although the benefits of expanded pre-service training will inevitably accrue outside the short timescale of 3 by 5, delay in tackling this crucial bottleneck will impose insuperable obstacles on efforts to maintain the momentum of expanded access.

Box 4.2 Incentives to health workers in Malawi

In Malawi, Médecins Sans Frontières is working in partnership with the Thyolo District Health Office to control tuberculosis and reduce the transmission of HIV; they also provide medical care, treatment, nutritional and social support for people living with HIV/AIDS, tuberculosis or both, and respond to nutritional or medical emergencies.

As part of this collaboration, Médecins Sans Frontières has sought innovative ways of tackling human resource constraints, focusing specifically on reducing staff attrition rates within the district and improving staff management, motivation and performance.

This work includes:

- ensuring that infection control measures and materials are in place;
- using non-clinical staff to conduct activities such as health promotion and voluntary counselling and testing;
- extending its workplace policy on antiretroviral therapy to all district health staff;
- piloting a performance-related incentive to all district health staff;
- using this incentive as a mechanism to encourage and supervise staff.

Incentive payments range from US$ 6 to US$ 22 per month, adding roughly 10% to basic government salaries. They are dependent on a monthly review of performance carried out jointly by the district health management team and Médecins Sans Frontières programme managers, using a common evaluation checklist that assesses working hours, discipline, accuracy in carrying out tasks, management of resources (equipment, medicines, supplies, food) and cleanliness. Médecins Sans Frontières proposes that these innovations be carefully evaluated and considered for adoption at the national level.

The experience of the pilot sites delivering antiretroviral therapy provides only limited guidance for the optimum staffing of future services, since they have generally been intensive in their use of human resources. New patterns of service delivery and staffing, such as those recommended by WHO, need to be implemented; they should entail less frequent patient contact with the provider system, rely less on skilled labour inputs, and optimize the use of inputs other than those from the formal delivery system. These new patterns imply maximum delegation of tasks within the formal health care team, and maximum involvement of community resources. On the basis of standardized treatment guidelines, competency-based training (ensuring better alignment between training and practice), adequate supervision mechanisms, and improved management systems would contribute to productivity gains. Chapter 3 described how volunteers drawn from people living with HIV/AIDS, who may already be receiving antiretroviral therapy, constitute a resource that can be deployed to good effect.

Different issues arise in the settings of middle-income countries and countries in transition, where resources are less severely constrained, the numbers of trained health workers are generally

higher, and the basic capacities of health facilities are more secure. The emphasis therefore lies on ensuring, through appropriate collective financing mechanisms, universal entitlements to care that include the most vulnerable and stigmatized populations. Subsidiary concerns include reducing the cost of treatment regimes, establishing reliable diagnostic and drug distribution networks, and improving surveillance.

From: http://www.who.int/whr/en/

5. MMI Strategic Plan. Main outcome and priorities for the next five years.

Strategic Plan 2005 – 2009
The plan is "under construction", discussed by the members and modified several times. The final draft will be ready after de general Assembly of MMI in March 2005.
As introduction and motivation of the five-years plan we publish the text of the president of MMI concerning the future MMI strategy.
The Strategic Plan of MMI is in the final stage. As soon as the General Assembly has modified and approved the plan, it will be published on the Internet. www.medicusmundi.org

6. Cotonou Conference 2005.

The conference for bishops of francophone Africa, responsible for health institutions in their diocese, is planned for next June 2005 in Cotonou. MMI member Amcess of Benin has taken the responsibility for the organisation. Official convenor is the regional episcopal conference of francophone and lusophone Africa.
The introduction and documents are on the MMI website.

Alors, en bref, voyez le but et la philosophie du congrès:

But
Les Conférences Régionales des Evêques de l'Afrique Anglophone et leurs Partenaires Internationaux de Développement souhaitent consulter les Evêques responsables pour les soins de santé, et les co-ordinateurs de la santé afin d'améliorer la réalisation de la Mission de Guérison en rapport avec les développements régionaux et nationaux.
Une assistance technique de facilitateurs est nécessaire pour préparer, organiser et faciliter la Consultation.

Objectifs
Les facilitateurs techniques assistent les organisateurs afin d'assurer que les participants puissent:
1. Revoir et confirmer le Ministère de Guérison dans la perspective des défis que les Unités Catholiques de Santé rencontrent et les solutions que les gouvernements nationaux réalisent afin d'améliorer les services de santé pour la population (Réformes des Secteurs de Santé, "Sector

Wide Approaches in Health");
2. Établir comment les Autorités de l'Eglise peuvent assister et consolider les Unités de Santé Catholiques et comment faire augmenter leur efficacité et accomplir leur Mission en partenariat avec les acteurs principaux dans la provision des soins de santé.
3. Consolider le réseau de l'Eglise entre pays afin d'améliorer et échanger l'expertise

Toutes les informations sur la conférence on trouve sur l'internet:
http://www.medicusmundi.org/Cotonou2005.htm

7. From the Executive Board

Farewell to Miguel Argal as President
The General Assembly of May 2004 (Geneva) relieved the Executive Board.

Mr. M. A. Argal resigned as President and thanks the members for the work done in the past period. He calls the members for the new Executive Board and presidency.
Mr. G. Eskens is unanimously elected for president.
He honours Mr. M. A. Argal.

New Board, confirmed for the next period:

President: Guus Eskens
Mr. M. A. Argal, Medicus Mundi Spain
Mrs. Edith Boeckraad, Cordaid
Prof. F. Castelli, Medicus Mundi Italy
Mr. B. Pastors, Action Medeor
Dr. G. Pellis, CUAMM
Dr. E. Widmer, Medicus Mundi Switzerland

The Assembly agreed with the candidates.

The Assembly expressed her gratitude for the support of the stand-bys, Dr. T. Puls, Dr. S. Rypkema and Prof. H. Van Balen.

Dr. Widmer stressed that an important part of the program will be to strengthen the bonds between MMI and member organizations.
The Fatebenefratelli becomes full member.
Medicus Mundi Poland will first strengthen the organization in Poland before being a full member.