

Consultation on Improving Access to Health Worker at the Frontline for Better Maternal and Child Survival

REPORT



Intercontinental Hotel, Nairobi, Kenya; 25-27 June 2012



**African Platform On
Human Resources For Health**
Advancing Africa's Health Workforce



UNH4+

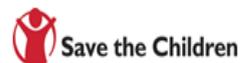


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Communiqué of the Consultation

Improving Access to Health Workers at the Frontline for Better Maternal and Child Survival

Background

The *Consultation on Improving Access to Health Workers at the Frontline for Better Maternal and Child Survival* was held at the InterContinental Hotel in Nairobi, Kenya from 25 to 27 June 2012. The meeting was organised by the Norwegian Agency for Development Cooperation (NORAD) together with the Regional Network for Equity in Health in East and Southern Africa (EQUINET), IntraHealth International, UK Department for International Development (DFID), Save the Children, Global Health Workforce Alliance (GHWA), East, Central and Southern African Health Community (ECSA HC), UNAIDS, UNICEF, Partnership on Maternal, Newborn and Child Health (PMNCH), UNH4+, African Platform on Human Resources for Health (APHRH), African Centre for Global Health and Social Transformation (ACHEST), African Medical and Research Foundation (AMREF) and a number of other stakeholders who supported the initiative in various ways. EQUINET, through the University of Limpopo, was the secretariat for the Consultation, while financial support was received from Norad, DFID/GHWA and Intrahealth International.

The objective of the consultation was '*to speed up and scale up country responses to the human resource needs of both the UN Global Strategy for Women's and Children's Health (Every Woman Every Child), and the Global Plan towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive (Global Plan) as a key aspect of both plans*'. The intended outcomes of this consultation were broadly stated as:

- a. Identification of concrete opportunities for progress as well as obstacles to such progress
- b. Documentation of experiences on successes and failures

Process

There were 97 participants from 33 organisations and 17 countries, including ministries of health in 10 priority countries¹ for both EWEC and Global Plan, UN agencies, faith-based organisations, academic institutions, health professional organisations, global and international organisations, and civil society organisations. The Consultation sought to strengthen collaboration between state and non-state providers, community networks and local organisations based on the realities on the ground in priority countries. The opening ceremony was graced by the Kenyan Minister for Medical Services, Hon Prof Peter Anyang' Nyong'o and featured a woman living with HIV in the opening panel.

Through a combination of interactive sessions, the Consultation reviewed progress at country level, what technical support exists, and good practices within the countries. The participants agreed that the definition of "*health worker at the frontline*" had to be contextual, but that it should necessarily apply to those at the first level of contact with the health system in relation to maternal and child health. The Consultation took cognisance of proven cost-effective, high impact interventions, which in the ethos of Primary Health Care, as reaffirmed in the Ouagadougou Declaration, provide viable options for improvements in

¹ The countries represented at the Consultation were: DRC, Ethiopia, Ghana, Kenya, Malawi, Nigeria, Tanzania, Uganda, Zambia and Zimbabwe

maternal and child survival, and identified opportunities, experiences and challenges to guide further action.

Opportunities identified included:

- Improvement in the training, employment and deployment of health professionals through innovative approaches, such as use of ICT and the ECSA colleges without walls for training, and rapid hiring programmes;
- Existing plans and frameworks on health systems development within the countries;
- Continental platforms, such as the African Union Commission (AUC) and the APHRH, and regional institutions such as ECSA HC, West African Health Organisation (WAHO), Southern African Development Cooperation (SADC) and Coordination Organisation for the Fight Against Endemic Diseases in Central Africa (OCEAC), which provide space to share best practices and forge solutions for the effective use of available resources; and
- Increasing evidence of impact of various cadres being deployed in health systems.

Edifying experiences shared included:

- Implementation of the World Bank Rapid Results Initiative/Appraisal (RRI/A) to identify what needs to be done and to step up performance;
- Paired-up consultant approach, through which countries which are doing well visit those that are not doing so well to strengthen the latter's capabilities;
- Mobilisation of support from lawmakers, civil society organisations and academia;
- Role of community health workers in empowering communities with knowledge and increasing the demand for health services, including maternal, neonatal and child services; and
- Varied performance of leadership of health systems across countries, coupled with annual human resources for health audits, and national HRH conferences.

The Consultation also noted a number of challenges, including the lack of role definition for community health workers, inconsistent compensation schemes and the low density of skilled health workers which often translates into poor supervision for the less skilled health workers, the low morale of health workers, and the lack of incentives for health workers in many of the countries.

Recommendations

The Consultation underscored the need for ministries of health, continental mechanisms such as the AUC, regional organisations such as ECSA HC, SADC, WAHO and OCEAC, development partners, FBOs, funding agencies, academic and research institutions, and civil society organisations to give priority to efforts towards increasing access to health workers at the frontline for better maternal and child survival. The consultation recommended, among others, that:

- Deliberate efforts be made by countries to ensure optimum service integration at the frontline, guided by identified competence needs and appropriate skill mix in context.;
- Development partners be encouraged to work with countries to roll out promising practices and high impact interventions towards achieving MDG 4 & 5;
- Mutual accountability and support mechanisms for access to health workers at front line services be addressed, with accountability to communities, community management structures and local government, in addition to accountability by health

authorities to national government and accountability to regional and global policy commitments;

- Indicators for health worker access in the context of EWEC and the Global Plan need to recognise continuity in access to all health professionals and to auxiliaries and lay workers across the continuum of care of maternal, neonatal and child health services;
- Civil society, academia, FBOs and other non-state actor need to work with countries to strengthen the evidence base on the impact of initiatives and interventions at the front line;
- Countries should strive to improve supply of health workers, which should be complemented by community awareness of and demand for the services available at the frontline;
- All stakeholders need to focus on workers at the front-line of services and their functions, recognise their value in the system in ensuring equitable access and the need for health workers at other levels of the service delivery system to enable and support their front-line role;
- Promote shared learning based on what works within the region, through strategies such as well-performing countries visiting poorly-performing countries and participation in regional forums such as the ECSA Best Practices Forums; and
- Priority countries, global and regional organisations, and within countries stakeholders should together develop mechanisms for the translation and adaption/adoption of global and continental initiatives to specific country contexts and needs. This should always include clear monitoring and evaluation processes.

At the conclusion of the Consultation, the participants made a call to all stakeholders, at all levels, to use these recommendations as a basis for further action in improving access to health workers at the frontline for better maternal and child survival, and build on them as appropriate, tailored to specific policy and implementation contexts. Country delegates and stakeholders should optimize existing in-country structures to inform policy makers and sensitise other stakeholders on the outcomes of the Consultation, including the need for the necessary dialogue and country collaboration frameworks on HRH in each country. In tandem, other delegates were charged with the task to include feedback from the Consultation into regional and global processes and arenas, such as the accountability mechanisms for EWEC/CARMMA, the AU, the African HRH Roadmap to be discussed at the WHO AFRO Regional Meeting, the HHA meeting to be held in Tunis in the first week of July 2012 and the International AIDS Conference in Washington DC later the same month.

Executive Summary

Key Messages

- i. There is need to develop a team approach of facility based and community based health workers in each place, and this report contains evidence of best practice to this effect.
- ii. There is need to find ways to bring the different type of community based workers into a policy framework tailored to ensure their regulation, supervision and remuneration, as each situation demands, within a coordinated national health workforce effort.
- iii. Priority should be given to filling gaps in and to provide support to front line teams of community based and facility based health workers.
- iv. There should be established national and district level dialogue and partnerships on HRH with all key stakeholders aiming to get a shared understanding of gaps and priority measures to deal with critical issues step by step.

The *Consultation on Improving Access to Health Workers at the Frontline for Better Maternal and Child Survival* was held at the InterContinental Hotel in Nairobi, Kenya from 25th to 27th June 2012. The meeting was organised by the Norwegian Agency for Development Cooperation (NORAD) together with the Regional Network for Equity in Health in East and Southern Africa (EQUINET), IntraHealth International, UK Department for International Development (DFID), Save the Children, Global Health Workforce Alliance (GHWA), East, Central and Southern African Health Community (ECSA HC), UNAIDS, Partnership on Maternal, Newborn and Child Health (PMNCH), UNH4+, African Platform on Human Resources for Health (APHRH), African Centre for Global Health and Social Transformation (ACHEST), African Medical and Research Foundation (AMREF) and a number of other stakeholders who supported the initiative in various ways.

The overarching objective of the consultation was to speed up and scale up country responses to the human resource needs of the *UN Global Strategy for Women's and Children's Health* (Every Woman Every Child) and the *Global Plan towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive* (Global Plan) with a particular focus on 10 African countriesⁱ with a high burden of HIV and maternal and child mortality. The two global initiatives recognise the importance of strong health workforces and call for additional commitments on human resources to be made.

The theme for the consultation was "*Acting on what we know*", in recognition of the fact that there is already a lot of information available on what works in terms of improving access to frontline health workers. Similarly, the consultation recognised the need to build on existing initiatives in the African Continent including the Maputo Plan of Action, Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA), WHO-AFRO-led HRH Roadmap and the on-going work of the African Platform on HRH.

The consultation therefore aimed to fast-track solutions by sharing knowledge, good practices and innovations; encouraging greater collaboration between partners; identifying

unresolved issues and barriers; and recommending actions for accelerating country responses.

Why health workers at the frontline?

Health workers at the frontline are the first level of contact between a person and the health system. They provide vital services where they are most needed and often come from the communities that they serve. Many are community health workers (CHWs) and midwives, though they can also be pharmacists, nurses, clinical officers or doctors. The consultation did not therefore focus on any one category of health workers but rather on how health workers at the frontline – both those working at the community level and in facilities – can work with together as a team to increase access to quality maternal and child health and HIV services and also increase demand and use of these services.

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Challenges and barriers to improving access

The overall shortage of skilled health workers and inadequate skills mix across Africa is compounded by unequal distribution of health workers, particularly in rural and remote areas. Furthermore, low health worker motivation and morale – caused by factors such as low pay and difficult working conditions – often translates into sub-optimal productivity, poor quality of services and high turnover of staff. In addition to these well-documented issues, consultation participants shared many of the challenges they have experienced in improving access to health workers at the frontline at the national and regional level, including:

- Delays in the translation of best practices into policy, and policies into action, due to insufficient political priority and overall underinvestment in healthcare;
- Lack of role definition and guidance around task-shifting, particularly for CHWs (important both for training needs and integration into health system delivery);
- Insufficient coordination of CHWs and between CHWs and other cadres;
- Inconsistent and inadequate compensation schemes for CHWs and overreliance on non-governmental partners to provide health workers with incentives;
- Poor supervision and regulation of non- and para-professional health workers;
- Insufficient training capacity at the national and regional level;
- Resistance from professional cadres to receive referrals from CHWs and integrate CHWs into the formal health system;
- Other demand-side barriers to access were also noted including large distances between communities and facilities; inadequate transport and infrastructure; negative attitudes of some health workers and out of pocket payments for healthcare.

Opportunities and best practices

Despite the challenges experienced by countries, the consultation also showcased many opportunities and best practices from across the region that gave cause for optimism. Notably, most African countries have already developed national health worker strategies and plans and many have developed complementary guidelines on CHWs. Similarly, many governments have made public commitments to strengthen health workforces through Every Woman, Every Child and other initiatives. Continental platforms, such as the African Union Commission (AUC) and the Africa Platform for Human Resources for Health, and regional institutions such as East, Central and Southern African Health Community (ECSA HC), West African Health Organisation (WAHO), Southern African Development Cooperation (SADC) and Coordination Organisation for the Fight Against Endemic Diseases in Central Africa

(OCEAC), provide space to share best practices and forge solutions for the effective use of available resources.

Participants exchanged information about different initiatives to improve access to health workers at the frontline, contributing to a growing evidence base about the impact of various cadres being deployed in health systems. Similarly, participants shared different approaches that have been shown to enhance the impact of community-based providers as well as the acceptance and support of CHWs by both the community and formal health system. Many participants highlighted the potential of ICT and new technologies such as virtual training colleges for improving the training, employment and deployment of health workers at the frontline across the region.

Discussions highlighted the important role that different partners – such as parliamentarians, faith-based organisations, NGOs, regional bodies and the private sector – can play in supporting the delivery of government-led HRH strategies. The need for strong national coordination platforms such as HRH observatories and Country Coordination and Facilitation (CCF) mechanisms was recognised as key for facilitating communication between actors and engaging them in different decision-making and accountability processes.

Recommendations for action

Many of the actions required for improving access to health workers at the frontline are well documented; the challenge is often closing the gap between evidence and action. The consultation therefore underscored the need for national governments, continental and regional organisations, development partners, funding agencies, academic and research institutions and civil society to all improve collaboration and give greater priority to increasing access to health workers at the frontline for better maternal and child survival.

Recommendations were made for action at the national level and also to regional and global actors:

National

- Countries should accelerate efforts to improve the supply and equitable distribution of health workers;
- Improved supply and equitable distribution of health workers at the frontline should be complemented by efforts to increase community awareness and build demand for quality health services available at the frontline;
- Optimum service integration at the frontline and strong teams should be promoted, guided by identified competence needs and context-appropriate skill mix;
- Regulatory frameworks should be developed for all cadres of health workers and standardised training and guidelines on supervision and task-shifting produced for health workers at the frontline, including community health workers (CHWs);
- CHWs should have established career pathways with opportunities to develop professional qualifications and become part of the formal health workforce;
- Sustainable incentive structures should be developed for health workers at the frontline, including CHWs, that are commensurate with their skill set and responsibilities;
- New technology and other innovations should be embraced to build training capacity and support health workers in their work at all levels;
- MoUs should be developed between governments and NGOs/FBOs to formalise and regulate the role that these organisations play in improving access to health workers at the frontline;
- Ministries of Health should engage other sectors including Ministries of Education, Finance and the Public Service in efforts to strengthen the health workforce;

- Where they do not already exist, inter-agency coordinating committees on HRH, such as the Country Coordination and Facilitation (CCF) mechanism, chaired by Ministries of health, should be established;
- National HRH conferences should be organised to share best practices and facilitate closer coordination between partners;
- Health workers, communities, civil society and sub-national level health services should be involved in the development, monitoring and accountability of national health plans in order to increase national ownership;
- More parliamentarians should be encouraged to engage in HRH issues and hold governments to account for their commitments;
- Governments should disseminate information about progress towards HRH commitments/policies (including commitments to Every Woman, Every Child, the Global Plan and WHO Code of Conduct on International Recruitment of Health personnel) through the media, national coordination mechanisms, civil society networks, and other relevant channels;
- Governments should increase overall investment in healthcare, in line with the Abuja target of 15%, and allocate a sufficient proportion to HRH and to services at the frontline;

Regional

- Continental and regional bodies should create and facilitate platforms for countries to share learning and best practices for improving access to health workers at the frontline;
- Regional organisations should also facilitate efforts to standardise CHW practice, harmonise training curricula and task-shifting guidelines across the region;

Global

- All stakeholders should recognise the vital work of health workers at the frontline and their value in ensuring equitable access to key health services;
- All stakeholders should work together to develop mechanisms for the translation and adaptation/adoption of global and continental HRH initiatives into specific country contexts and needs, including clear monitoring and evaluation processes;
- Development partners, technical agencies and research institutions should work with countries to build a stronger evidence base on the most effective ways of improving access to health workers at the frontline and maximising the impact of different cadres of health workers;
- Development partners and donor agencies should increase financial and technical assistance to support countries to develop evidence-based policies and implementation of HRH commitments and plans.

A call to action

It was agreed that business as usual would not be enough to achieve the breakthroughs required in maternal and child health and HIV. At the conclusion of the consultation, participants made a call to all stakeholders to use these recommendations as a basis for further action in improving access to health workers at the frontline for better maternal and child survival, and build on them as appropriate, tailored to specific policy and implementation contexts. Participants committed to inform decision makers, colleagues and partners about the outcomes of the consultation and to feed these recommendations into maternal and child health policy and accountability processes at regional and global level.

1. Background

The *Consultation on Improving Access to Health Workers at the Frontline for Better Maternal and Child Survival* that was held at the InterContinental Hotel in Nairobi, Kenya from 25th to 27th June 2012, was the culmination of months of intense discussions and other preparations by a diverse group of stakeholders. The idea was initiated by the Norwegian Agency for Development Cooperation (Norad), as part of the commitment of the Norwegian Government to the realisation of Millennium Development Goals (MDGs) 4 and 5, and in the context of the UN Secretary General’s Global Strategy on Women’s and Children’s Health (*Every Woman Every Child, EWEC*) and the Global Plan for Elimination of new HIV Infections among Children by 2015 and Keeping Their Mothers Alive (*Global Plan*).

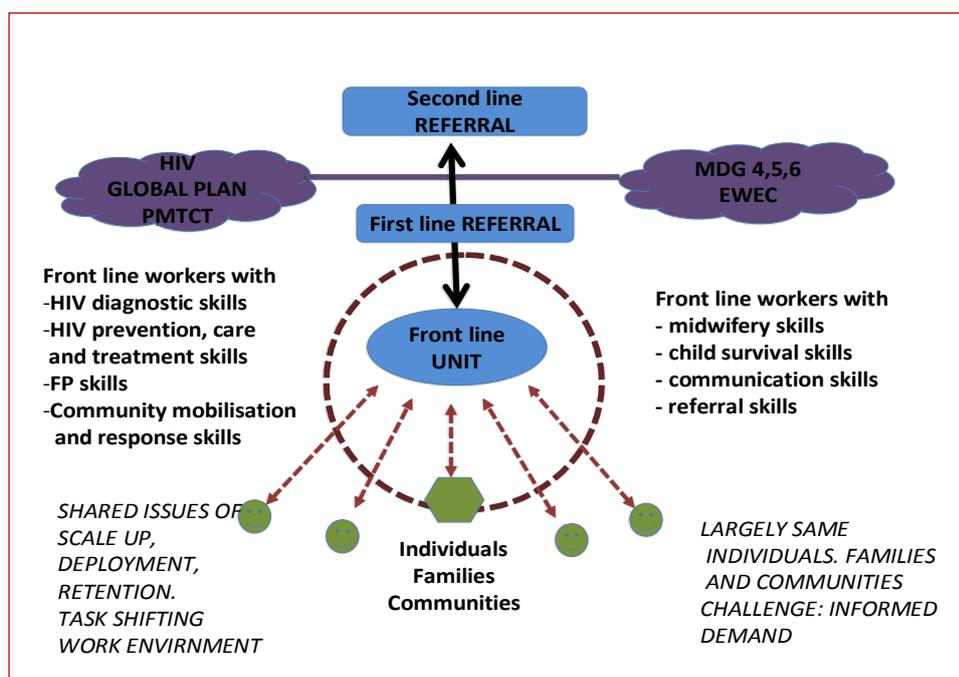


S Møgedal Norad/ UNAIDS

Ambassador Dr Sigrun Møgedal (Norad/UNAIDS) gave momentum to the idea, and with her wealth of experience and networks, in the words of Bjarne Garden, “The idea caught fire.” With the involvement of the UNH4+ partners, PMNCH, GHWA, EQUINET, the African Platform, ACHEST, ECSA HC and others, the Working Group for preparation of the Consultation was formed. EQUINET, through the University of Limpopo, accepted to serve as this Secretariat for the preparatory work. The initiative for the Consultation was in recognition of the health worker crisis facing many countries in Africa. The HRH crisis is a binding constraint to the achievement of development targets such as the MDGs in many countries, and is characterised by an overall shortage of skilled health professionals, inappropriate skill mix, mal-distribution of existing health workers and weak HR management systems.

Health workers at the frontline are the first level of contact between a person and the health system (see Figure1 below).

Figure 1: Mutually enforcing skill set required at the frontline of the health system



Source: Møgedal S (2012), Concept Note for the Consultation, Norway

Frontline health workers provide vital services where they are most needed and often come from the communities that they serve. Many are community health workers (CHWs) and midwives, though they can also be pharmacists, nurses, clinical officers or doctors. The consultation did not therefore focus on any one category of health workers but rather on how health workers at the frontline – both those working at the community level and in facilities – can work with together as a team to increase access to quality maternal and child health and HIV services and also increase demand and use of these services.

Whereas it is recognised that some innovative approaches are being applied in a number of countries to address these challenges and provide a ray of hope, and that there is a growing body of evidence on what works, it is also true that a lot remains to be done. Promising practices include the effective use of community health workers, task shifting and development of new cadres, essential high impact interventions, and integrated service delivery models. That reality is that even with the significant investments that have been made to strengthen the capacity of governments to train doctors, nurses, midwives and other types of health workers, further investments are required to ensure that all people across Africa, particularly the poor and those that live in remote areas, have equitable access to skilled health care providers.

The two global initiatives alluded to above – *Every Woman Every Child (EWEC)* and the Global Plan – recognise the importance of strong health workforces and call for additional commitments on human resources to be made. EWEC, for instance, calls upon countries to strengthen health systems to deliver integrated, high quality services, and calls upon partners to work together to address critical shortages of health workers at all levels. The Global Plan has embedded in its approach the need to strengthen the human resources for health. Both EWEC and the Global Plan are dependent on the same workforce with same range of skills: midwifery skills to deliver comprehensive reproductive, maternal, newborn and child services, and for HIV testing and appropriate HIV treatment, prevention, care and support.

At the same time, the effort made by the African continent to improve maternal and child health, including the Maputo Plan of Action, the Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA), and in addressing the HRH crisis, such as the WHO-AFRO-led HRH Roadmap and the on-going work of the African Platform on HRH, were recognised as central to any further steps towards improvements in maternal and child survival in Africa.

The preparations for the Consultation were thus guided by the need to build on existing initiatives and plans in the African Continent, the need to build strong and coherent health systems within the countries, the need to avoid duplication of effort or competition with existing national processes but rather aim for complementarities. It was also clear that no separate or parallel structures would be created, and that whatever was agreed would respond to country needs, such as implementation of national roadmaps and plans.

The theme for the Consultation was **“Acting on what we know”**, in recognition of the fact that there is already a lot of information on what works, and yet not much is done. The focus of the Consultation, therefore, was on action-oriented steps for the way forward.

1.1 Organization

The Consultation was organized by Norad (Department of Global Health), with the Regional Network for Equity in Health in East and Southern Africa (EQUINET), IntraHealth International, DFID, Save the Children, GHWA, WHO, East, Central and Southern African Health Community (ECSA HC), UNAIDS, UNICEF, PMNCH, UNH4+, African Platform on Human Resources for Health, the African Center for Global Health and Social Transformation (ACHEST), African Medical and Research Foundation (AMREF) and a number of other stakeholders and partners who supported the initiative in various ways. EQUINET, through the University of Limpopo, was the Secretariat for the Consultation, while financial support was received from NORAD, DFID/GHWA and IntraHealth International.



Y Dambisya, University of Limpopo /EQUINET

The Consultation was organized through a series of discussions between various stakeholders, facilitated by Dr Sigrun Møgedal, which resulted in the formation of a voluntary Working Group which included Norad, EQUINET, UNICEF, UNAIDS, PMNCH, WHO (HQ), GHWA, AMREF, African Platform/ACHEST, Save the Children and ECSA HC. The working group operated through weekly teleconferences, frequent emails and other telephone and Skype contacts, as the need arose. Based on preliminary work by EQUINET, the Working Group endorsed Nairobi as the venue for the Consultation, and the arrangements proceeded in earnest.

The preparations for the Consultation took into consideration other meetings of a similar kind that were due to take place earlier in Amsterdam (KIT), Washington DC and Addis Ababa, but felt strongly that the proposed Consultation differed in significant ways from the other three, and that it would extend some of the initiatives from the other meetings. Coming as it did as the last of a series of meetings, the Nairobi Consultation was seen as an opportunity for the findings from the three meetings to be presented and discussed a well.

1.2 Rationale for the Consultation, Objectives and Expected Outputs

The consultation sought to catalyze national multi-stakeholder action-oriented movements to strengthen health workforces and improve access to and quality of reproductive, maternal, newborn and child health (RMNCH) and prevention of mother to child transmission (PMTCT) services, particularly for the poorest populations. The intention was to bring together partners to identify:

- (i) Key barriers to improving health workforce quantity, quality and distribution,
- (ii) Viable solutions that could be shared as good practices for implementation,
- (iii) Areas to highlight and strengthen collaboration between state and non-state providers, community networks and local organizations.

The Objective of the Consultation was to speed up and scale up country responses to the human resource needs of both the UN Global Strategy for Women's and Children's Health, Every Woman Every Child and the Global Plan towards the Elimination of New HIV Infections Among Children and Keeping their Mothers Alive (Global Plan) as a key aspect of both plans.

Specific Objectives

The Consultation was guided by the following specific objectives:

- To kick off an action oriented movement that can align forces across the key strategies for improving access and quality coverage for MNCH and PMTCT with a focus in Africa
- To fast track solutions by sharing knowledge and good practices, exploring unresolved issues and targeting gaps and synergies
- To Highlight and strengthen collaborations between state and non-state actors, community networks and local organisations

The Expected outputs from the Consultation were:

- Identification of progress in improving health workforce coverage and related barriers in participating countries,
- Shared knowledge, good practices and innovations targeting increased access to health services, innovative measures to improve and information on opportunities for progress,
- Identification of country specific next steps to address obstacles and identify monitoring and accountability mechanisms for accelerating country responses.

1.3 Participants

The Consultation was attended by 97 participants from 18 countries, and 33 organisations, including ministries of health from 10 priority countries for the two global initiatives (DRC, Ethiopia, Ghana, Kenya, Malawi, Nigeria, Uganda, Zambia, Zimbabwe, and Tanzania), FBOs, NGOs and academia. African institutions/organisations were represented through AMREF, UZIMA Foundation, ACHEST, African Platform on HRH, African Institute of Health and Leadership Development and EQUINET; while FBOs included the Christian Health Association of Malawi (CHAM), Church Health Association of Kenya (CHAK), National Catholic Health Services (NCHS) of Ghana and Uganda Protestant Medical Bureau (UPMB). Intergovernmental/regional organisation included ECSA HC, the Human resources Alliance for Africa (HRAA) and Southern and Eastern African Parliamentary Committees on Health (SEAPACOH). Among professional organisations were the Kenya Nursing Association, the East, Central, and Southern African College of Nurses (ECSACON), and Southern African Network of Nurses and Midwives (SANNAM), while Academic Institutions were the University of Limpopo (School of Health Sciences), Makerere University (College of Health Sciences), Kenya Medical Training College and Royal Tropical Institute (KIT), Amsterdam. To complete the picture were participants from Global organisations such as UNICEF, GHWA, UNAIDS and the Global Plan Secretariat. International Organisations included Norad, DFID, Save the Children, Intrahealth International, CapacityPlus, EgpaF, Columbia Ecobac Centres Africa, International Medical Corps, M2M. National parastatal and non-state organisations including the Health Services Board of Zimbabwe; National AIDS Councils from Kenya and Zambia; WOFAK and World Vision (Kenya) also attended. A full list of the participants and their affiliations is presented in Appendix 1.



Conference delegates Opening session

2. Proceedings of the Consultation

2.1 The Opening

The Consultation was officially opened by the Minister of Medical Services, Republic of Kenya, Hon. Prof Peter Anyang' Nyong'o'. The opening session was chaired by **Dr Peter Ngatia** (AMREF) who reiterated the importance of health workers at the frontline including community health workers in service delivery particularly for poor communities. He noted that there was sufficient evidence of the efficacy of community health worker based initiatives, and that it was incumbent upon the participants to ensure that such evidence was used



Dr P Ngatia (AMREF)

to inform policy. The session was earlier addressed by Prof Yoswa Dambisya (University of Limpopo/EQUINET), Ms Caroline Odada (Women Fighting AIDS in Kenya, WOFAK), Dr Barbara Stilwell (Intrahealth International), Mr Bjarne Garden (Norad) and Prof Miriam Were (GHWA Board and UZIMA Foundation).



Opening session



Prof Dambisya U Limpopo, EQUINET

Prof Dambisya welcomed the delegates to the Consultation, gave a brief overview of the preparations for the Consultation, which had been largely through virtual meetings and preparatory discussions. He appreciated how effectively communication technology had been used by the Working Group in preparation for the Consultation – an example of acting on what works.

Mr Bjarne Garden (Norad) provided the background to Norway's interest in the Consultation as arising from Norway's current global health policy which calls upon "every minister to be a minister of health", and for health to be reflected in every policy for every ministry. It was from that perspective, he indicated, that the focus on MDGs 4 and 5 arose, and then the involvement of Dr Sigrun Møgedal (Senior Adviser) provided the necessary energy to get the idea off the ground. He was happy that the idea had found resonance with other partners, and that EQUINET had agreed to handle the arrangements for the meeting. He emphasized that Norway recognized the diversity among countries, and called upon the delegates to look for common areas for collaboration and dialogue.



Mr Bjarne Garden , Norad

In a passionate address, **Ms Caroline Odada** (WOFAK) challenged health workers to re-examine their attitudes and especially how they handle vulnerable patients and clients such as HIV positive women and children. She outlined some of the work her organization had undertaken, the gains made, and how much more needed to be done. She indicated that hers was a group of people that were ready and willing to work with the health professionals for the betterment of their health



Dr B Stilwell, Intrahealth Int

On behalf of Intrahealth International, **Dr Barbara Stilwell** was happy to be a part of the consultation, and extended Intrahealth's hand of cooperation to the rest of the delegates. She outlined the history of engagement and achievement her organization already had in many of the countries represented, and looked forward to working closely with all

for better child and maternal outcomes through supporting and strengthening health worker initiatives.

In her address *Where is Africa in the countdown for child and maternal health towards 2015?* **Prof Miriam Were** reflected on the progress towards attainment of the MDGs in the priority countries, and in all instances it was clear that a lot remained to be done. She noted that Africa with about 10% of the global population provides 51% of maternal deaths and 51% of child deaths (UNICEF 2009 data base). Most of these deaths occur in communities in rural areas or in communities situated in urban/peri-urban slums. To change this situation, people need to access good quality health care services in their communities through their involvement, saying, *“If it doesn't happen in the community, it doesn't happen.”*



Prof Miriam Were

Prof Were reported on encouraging progress in countries such as Eritrea and Malawi where significant achievements had been made in both maternal and child survival. Prof Were emphasized the need for hope to remain alive so that all can contribute to the realization of the dreams for a healthy Africa. She was nostalgic about the optimism that characterized the 1970s and to some extent the 1980s when “Health for All” was the rallying call. Prof Were affirmed that it was possible to rekindle that spirit.



Mr C Rakoum, MoMS Kenya

The Minister was introduced by **Mr Chris Rakoum**, Chief Nursing Officer, Kenya, who welcomed the focus on HRH and thanked the Consultation organisers for choosing Kenya to host such an important meeting. He recalled an earlier meeting organized by the African Platform on HRH during which important recommendations were made.

The Minister of Medical Services, **Professor Peter Anyang' Nyong'o, MP**, was delighted to see Norad “back in Kenya”. The Minister appreciated the challenge faced by lack of adequate skilled health workers, and how that negatively impacted on the progress countries in Africa were able to make in health.

The Minister reiterated his government's commitment to partner with various stakeholders to ensure the MDGs were met. He invited the participants to benefit from the experiences and expertise of the various participant organisations (global, regional or international), each of which had unique experiences to share; and to ultimately come up with tangible results such as workable solutions that governments could implement. He then declared the Consultation open.



Hon Minister of Medical Services Prof Anyang' Nyong'o



2.2 Day One: Consolidating Country Actions and Plans

Day one of the Consultation was designed to set the scene by “Consolidating Country Actions and Plans”. The presentations and discussions of the day provided an overview of the HRH situation in Africa in the context of the two global initiatives, and in the context of maternal and child survival as a whole. There were two plenary sessions, a group work session and a feedback session on the group discussions at the end of the day.

2.2.1 Setting the Scene

Moderated by P Kadama ACHEST

The first session of the consultation was chaired by **Dr Patrick Kadama** (ACHEST/African Platform on HRH). He reminded the participants that Africa was already doing a lot through its institutions and mechanisms. He, however, regretted that there was little coordination happens between initiatives, sometimes within the same country, and sometimes by different agencies from the same donor country. The challenge, as he saw it, was how to harmonise all the initiatives and activities utilising the same limited human resources available in the countries. Dr Kadama called for a greater appreciation of the untapped potential of community based health workers who had been instrumental in some of the most significant achievements in public health the world over.



Dr P Kadama ACHEST

Prof Yoswa Dambisya (University of Limpopo/EQUINET) scoped the Consultation over the three days, emphasising the links between activities in Day One to subsequent discussions. Day One would focus on country policies, positions and plans, with a view to identifying common ground, common challenges and common approaches. He encouraged delegates to ask: *What can we do together, and what do we differently?* He asked delegates to find ways of pulling in the same direction, in the Kenyan spirit of “Harambee”. He stated that the opportunity existed in the programme to review some of the other initiatives addressing health workers at the frontline, and to look at global and regional initiatives. He asked them use group work sessions to interrogate experiences, plans and challenges. He stated that all stages of the Consultation should be seen as opportunities for the identification of (any) recommendations.

The focus on Day Two would be on “What we Know”, and Prof Dambisya asked the participants to explore areas such as *“How are we acting on what we know?”*; the need to *put the HRH crisis in the context of EWEC and the Global Plan*; to review how countries had responded - progress, challenges and opportunities. He further stated that that would be complemented by group work to identify major issues and make recommendations. He invited delegates to the market place of ideas on models and innovations, an opportunity for a more relaxed and informal setting where members would explore issues to greater depth on the evening of the second day.

Prof Dambisya indicated that Day Three would then be devoted to overcoming the gaps identified; and would address aspects of education/training, financing, legislation as they affect the health workforce. That would be buttressed by a panel discussion and group discussions that would ensure that suggested actions were in keeping with country plans. There would be discussions towards a common statement or position which would be adopted at the conclusion of the Consultation.

Dr Sigrun Møgedal (Norad/UNAIDS) then set the scene by emphasising that the Consultation was about making a difference, and urged participants to view it as a

conversation between key people responsible for ensuring access to services for maternal and child health, for preventing new infant HIV transmission and for keeping their mothers alive. Whereas those were not new challenges, she observed, there was new momentum, renewed energy and new opportunities to succeed. The focus, therefore, should be on access to motivated and supported health workers at the front line of service delivery, which should be viewed as being in the communities and primary care health facility levels.

Dr Møgedal agreed that a lot had been done on Community Health/Village Health Workers and how they could effectively provide essential services. She cautioned, however, that the Consultation would not focus on any one category of health workers, such as Community Health Workers or midwives, but on how health workers at the frontline, both in the health units and in the community together could form a team, fit for the purpose of maternal and child survival, stopping new infant HIV transmission and keeping the mothers alive. “The core objective is a conversation about access, quality, demand and use of these services, with a health worker lens,” said Dr Møgedal.



Dr Møgedal reminded the Consultation participants that the challenges of maternal and child mortality were not new, and alluded to the ups and downs of Village Health Workers, the universal child immunization and various approaches to management of childhood diseases. She also the obstacles through which some of the health services had to struggle to ensure access, in terms of quantity, continuity, reach and service quality. The struggle, Dr Møgedal emphasised, was where the health worker was often not available where needed, and if available had too heavy a workload, with hardly any tools of the trade. That led to imbalances in the possible responses, resulted in controversies around task-shifting and made creating a functioning team of health workers in facilities together with those in the community an uphill task.

She commended the efforts and response by Africa through a focus on women and children’s health, and in particular maternal mortality through the CARMMA strategy which was agreed in the AU even before the Secretary General’s strategy was launched. The challenge, she reiterated, was in ensuring a continuum of care in each place where MNCH and PMTCT service were required; and her call was for ensuring that access to health workers at the frontline was given priority in the broader policies, strategies and plans for HRH in each country. She welcomed efforts such as that of WHO AFRO that was working with countries on an HRH Road Map, and hoped that participants would think about ways the Road Map may help to focus the specific needs at the frontline, in order to link what was discussed in Nairobi to deliberations at subsequent forums, such as the WHO AFRO Regional Committee meeting.

Ms Victoria Kimotho (AMREF) gave a summary of the main issues at the USAID-convened *Global Health Evidence Summit on Community and Formal Health System Support for Enhanced CHW Performance (May 31 – June 1, 2012)* which intended to address the need for an evidence-base to support of CHWs for optimal performance and utilization of resources at all levels.

Ms Kimotho reported that there was a focus on community support, exploring areas such as activities that improve the performance of community health workers; how community and formal health systems are structured and/or operationalized to improve CHW performance; health system support for CHW performance; and combining community and health systems approaches to enhance CHW performance. She further reported that evidence presented showed that communities were a major resource, not just a target, for CHW programs, that there was a role for community partnerships in enhancing CHW performance, that community



Ms V Kimotho AMREF

partnerships could contribute to programme design, CHWs selection and CHW programme implementation, and that community monitoring had potential for optimizing CHW performance. There was also reportedly evidence that appropriate training, on-going supervision, and provision of supplies by formal health systems ensured long-term community support, and that inclusion of basic curative services into CHW roles enhanced long-term acceptance and support of CHWs by the community.

Ms Kimotho provided examples of good practice from India and Nepal where community activities were structured and operationalized to improve CHW performance, for instance through formal structures which recognised the voices of women, children, marginalized groups and the poor are heard.

A key message of her report was that without strong health system support, CHW programs were not scalable or sustainable; that CHWs systems need strong linkage with the formal health system; that role definition was important both for training needs and for integration into health system delivery; and that training was necessary but not sufficient to translate knowledge into practice. She emphasised the need for motivation of the CHWs to ensure productivity and quality of CHW performance.

Ms Kimotho then outlined a number of policy recommendations in areas of community support; for health system support for CHWs; and for combining community and health systems approaches to enhance performance; and for further research to broaden the evidence base.

In conclusion, Ms Kimotho stated that there was enough evidence to show that CHWs contribute significantly to the health of communities; that well trained and supported CHWs will be needed for a long time to come in middle and low income countries; and that CHW programme must be “community grown” and supported to be sustainable.

Discussion

A brief discussion that ensued addressed the need for clear role definition for community and other health workers at the frontline, and on the need to move away from expectations that CHWs work voluntarily, forever. It was agreed that there would be opportunities during the rest of the consultation to explore the issue at length, especially during the group work sessions.



2.2.2 Opportunities for Global and Regional Cooperation and Synergies

Moderated by Dr Ken Sagoe (MoH, Ghana) and Dr Angela Mushavi (MoHCW, Zimbabwe).

Mr Ernest Manyawu (ECSA HC) gave a brief background of ECSA HC as an inter-governmental regional organization that provides a regional platform for building consensus on health priorities, review of progress on international commitments, networking, and brokerage. He indicated that HRH had featured constantly in resolutions of ECSA Health Ministers Conferences over the past decade, addressing among others, curricular development/harmonization, increasing training capacity, task shifting/sharing, institutionalization of HRIS, leadership and performance management, innovative ICT solutions and integration.

Mr Manyawu discussed some of the steps that ECSA-HC had undertaken to address HRH bottlenecks. These included supporting curricular review and harmonization, supporting higher education institutions to adopt advanced midwifery and nursing courses, building the capacity of professional colleges – the ECSA College of Nursing (ECSACON), the College of Surgeons of East, Central and Southern Africa (COSECSA), the College of Pathologists of East, Central and Southern Africa (COPECSA), the East, Central and Southern African College of Obstetricians and Obstetricians (ECSACOGS) and the College of Health Sciences which was under development – development of a regional prototype practice package for expanding access to RMNCH services, the Human Resources Alliance for Africa (HRAA), and dissemination of the WHO Global Code of Practice on International Recruitment of Health Personnel.



Mr E Manyawu, ECSA HC

He emphasised that regional and global cooperation reduced the cost of doing business; and that ECSA-HC's strategic plan for 2012-2017 sought to strengthen cooperation with international agencies, other regional blocks and the private sector in the area of HRH capacity development. One of the ECSA's comparative advantages, according to Mr Manyawu, was that it provided policy dialogue platforms for regional networking and cooperation – the Health Ministers' Conference (HMC), Forum for Best Practices and the Directors Joint Consultative Committee (DJCC) meeting. He invited participants to the next BPF/DJCC slated for 14th to 17th August 2012, where health workforce issues could be championed.

Mr Manyawu mentioned some of the challenges identified by ECSA HC, such as controversies around task shifting and sharing, producer-consumer relationship between ministries of education and health in some countries, compensation of community health workers, HRH retention strategies, translation of best practices into policy and action, and effective participation of low and middle income countries (LMICs) in international health diplomacy. He accordingly made some recommendations for further action in a number of areas.

He concluded that progress towards international commitments for maternal and child survival would not be attained without addressing the attendant HRH challenges; that the HRH problems afflicting countries were simply too many and too complex to be solved individually; that opportunities for regional and international cooperation to address the problems existed but they had to be specifically sought for; and that fruitful cooperation required effective advocacy and political will.

Dr Patrick Kadama, on behalf of the African Platform on HRH, underscored the importance of having one common voice for HRH in the continent. He advocated for the culture of decision making based on evidence, knowledge and information, mobilization and facilitation of country action while tracking progress on global and regional commitments. He outlined some of the steps taken at high level by the AU and some of the regional economic communities (RECs), such as ECSA, WAHO and OCEAC, all of which needed to be factored into any new initiatives. He suggested that critical issues, such as how Africa coordinated and organised mechanisms for advocacy and resource mobilisation, needed to be considered in order for harmonised and coordinated responses to be formulated.



Dr Barbara Stilwell (IntraHealth International) discussed the roles and the future of CHWs, looking at new evidence for their roles. She suggested that technological innovations, for instance e-health, could be used to support community health workers. Though CHWs should be enabled to do complicated tasks, Dr Stilwell emphasised that more complex

health care services should not be transferred to them. She also cautioned that care should be taken while deciding what CHWs are best at, considering their education, noting that CHWs were still critical as a bridge between communities and the health system. Dr Stilwell alluded to the complexity of the health care systems in which differently prepared CHWs often had to work – the inherent complexity of the health system made it dangerous to predict the outcomes based on the inputs (training), and therefore the best way to get the maximum benefit from the CHWs would be through constant supportive supervision and periodic review of their performance.



Ms Kathy Herschderfer of the Royal Tropical Institute (KIT), Amsterdam, reported on a recent meeting on community based providers (CBPs) that was held at KIT. The two-day meeting in May 2012 was reportedly organised by KIT, Cordaid, UNFPA, UNICEF, WHO and University of North Carolina and had the participation of 10 country teams from Afghanistan, Bangladesh, Burkina Faso, Democratic Republic of Congo, Ethiopia, Ghana, India, Malawi, Nepal and Rwanda. The rationale for the meeting was the growing emphasis on CBPs due to low numbers of skilled professionals, and emerging evidence of the effectiveness of CBP programmes for MNH.

The presenter stated that new guidance on the evidence base for sharing/shifting MNH interventions to CBPs was required, as more and more MNH programmes that involve CBPs were being initiated. In the context of the KIT meeting, she stated, a CBP was defined as any health worker who performs functions related to healthcare delivery; who was trained in some way in the context of the intervention; but who has received no formal professional or paraprofessional certificate or tertiary education degree.

Ms Herschderfer reported that a number of enablers and barriers to CBP initiatives were identified, including barriers such as lack of policies for continuity, consistency and coordination, decentralisation, lack of comprehensive policy framework, and lack of clarity of roles and tasks. Among the most critical enablers she listed political commitment, sufficient supplies and adequate working conditions, teamwork and quality assurance mechanisms.

The next steps, Ms Herschderfer averred, would include coordination and collaboration between countries, development of training curricula which was being led by UNFPA, feedback on implementation of task shifting guidelines for lay health workers for improving postnatal care to be provided by WHO, and reporting and sharing between global meetings on CBP programmes and liaising with other HRH initiatives.

Dr Muhammad Mahmood Afzal (GHWA) discussed **Global and Country Collaboration for HRH** from the perspective of the Global Health Workforce Alliance (GHWA). He stated that the mission of the Alliance was to advocate and catalyse global and country level actions to address the HRH crisis, and achieve the MDGs and the vision of health for all. He emphasised that the Alliance was a common platform for the work of 335 Alliance Members and 29 Alliance Partners, representing developing and developed countries, health professional organizations, academia, NGOs and the private sector.



Dr M Afzal, GHWA

Dr Afzal discussed the three core functions of the Alliance in support of country actions – the ABC of **A**dvocating for keeping HRH issues high on the global agenda, catalyse investments, and to facilitate the adoption of evidence-based solutions; **B**rokering knowledge to share examples of good practice and evidence of what works to contribute to the development of a skilled, motivated workforce; and **C**onvening all stakeholders to promote

synergy among partners and members for joint actions towards the sustainable development of HRH at country, regional and global levels.

The presenter also showed how GHWA was involved in generation of evidence for action through studies on CHWs and mid-level health workers (MLHWs), which had led to identification of interconnected strategies to strengthen leadership for an evidence-based response for in-country retention of personnel.

Dr Afzal then gave an overview of the Country Coordination and Facilitation (CCF) approach which was conceptualized in 2009 as a multi-stakeholder coordination around HRH agenda at national level, based on principles of building on existing mechanisms, representation of HRH stakeholder constituencies, defined roles and joint actions, coherent HRH strategies linked with health policy and links with other coordination mechanisms like IHP+. He reported that the concept had been validated in four regional consensus-building meetings. The CCF process, he noted, was centred on the development and implementation of a comprehensive, costed, evidence-based HRH plan, embedded in and linked to the national health strategy.

Dr Afzal echoed the need to develop synergy in response to multiple meetings all focusing on similar issues, and indicated that GHWA had convened dialogue sessions among organizers and partners so that consensus on a common response out of the different events may be reached.

Dr Karusa Kiragu (UNAIDS) introduced the *Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive*, emphasising the catalytic role of UNAIDS. She mentioned the main roles of the Global Plan, namely, that it:

- Creates the political space to foster leadership and ownership for complex agendas
- Provides the definitive measurement and validation for accountability
- Puts people at the center with a focus on human rights



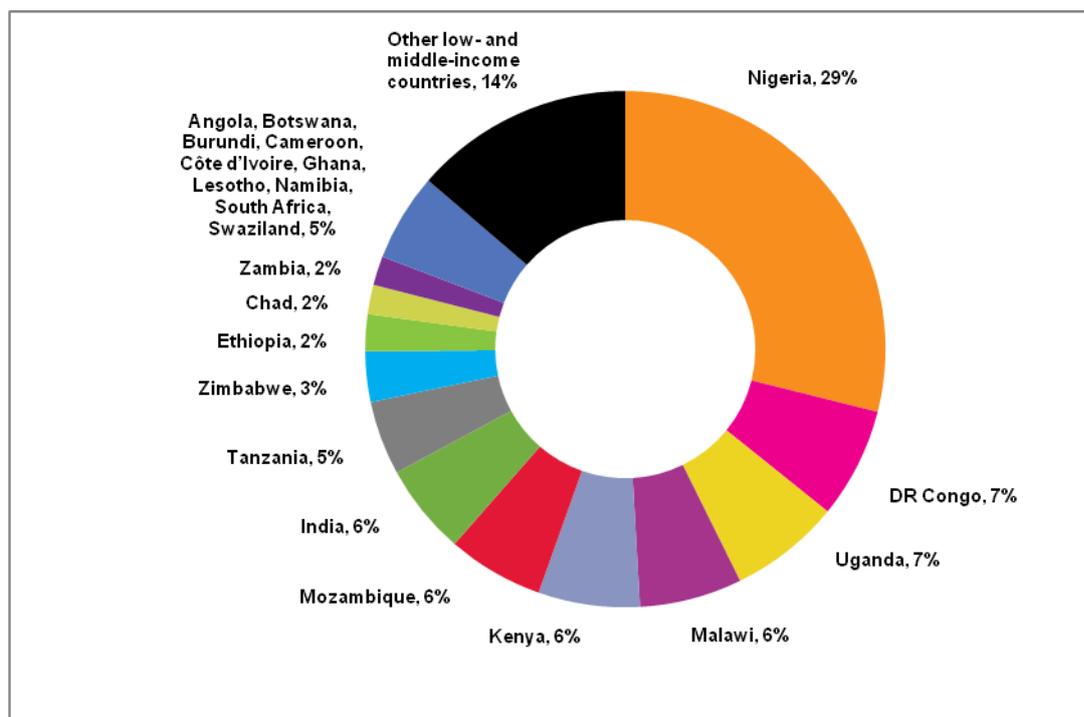
Dr K Kiragu, UNAIDS

Dr Kiragu reviewed the context of HIV and AIDS burden, with the largest numbers in Africa, and the 22 priority countries for the Global Plan representing 86% of the coverage gap in HIV and AIDS services for women and children, including PMTCT, in low- and middle-income countries largely from Africa (except India), as shown in Figure 2 overleaf.

The presenter then outlined the targets and Prongs of the Global Plans, being two targets -

1. Reduce new HIV infections among children by 90%; and
2. Reduce AIDS-related maternal deaths by 50%
which should be achieved through a four-pronged strategy:
 - i. Prong 1: 50% reduction in HIV infections among reproductive age women
 - ii. Prong 2: 0% unmet need for family planning
 - iii. Prong 3: <5% MTCT rate, 90% coverage of prophylaxis or therapy during pregnancy and 90% coverage during breastfeeding
 - iv. Prong 4: 90% of pregnant women receive therapy for their own health, Provide therapy to HIV-infected children leading to reduction in under-five deaths due to HIV by more than 50%.

Figure 2: Distribution by country of the coverage gap in HIV and AIDS services for women and children in low- and middle-income countries



Source: Presentation by Dr Kiragu, UNAIDS

Dr Kiragu mentioned the 10-point implementation actions, one of which was to enhance the supply and utilization of human resources for health. Health workers were thus critical to the success of the Global Plan, she stated, especially since the number of HIV positive women had stabilized (between 1 million and 1.5 million) in the priority countries, which would place a heavy burden on the health systems for PMTCT services, given high FP unmet need in priority countries (ranging from 13% in Zimbabwe to 38% in Uganda).

Dr Kiragu also commented on the wide gaps in access to ART by children compared to adults – in the priority countries whereas about 50% of adults received ART, only 20% of deserving children received it. She lamented that HIV still contributed to high proportions of maternal deaths in the priority countries – with 11 priority countries at 20% or higher, and Swaziland attributing up to 67% of maternal deaths to HIV.

From that perspective, she framed the task ahead as having implications for HRH to meet the goals; as requiring optimization of the contributions of the public and private sector; as involving definition of the appropriate skill and gender mix of health care providers. Dr Kiragu asked the participants to think about which other stakeholders should be engaged, who the political and social power brokers were that could influence progress in this regard; to think about ways of accelerating capacity building and professional development; and at the back of their minds to think about the impact of sector reforms and other reforms, such as administrative, labor or higher education, on health personnel requirements.

Discussion

The discussions that followed the two sets of presentations accepted that health workers at the frontline in the region were few compared to the populations they served. Moreover, they were mal-distributed despite the fact that the region carried a high burden of disease and suffered outward migration leading to low quality and inequitable health services in the

region. Therefore, a cadre that addresses common community ill-health challenges was critical to the improvement of health service delivery in the region.

Concerns were raised about the low institutionalization, compensation and supervision of community health workers, and the low training capacity in health professional education institutions. It was recommended that a harmonized curricula and prototype practice packages be developed at the regional level. It was suggested that a platform for collaborations and networks through existing bodies like ECSA HC, WAHO, SADC and OCEAC should be established since such bodies (already) provided space for sharing best practices and solutions for utilization of existing resources. It was also suggested that Ministries of Education should be part of the discussions regarding training of health workers.



There was an appreciation that CHWs were a permanent feature of the health systems in the participating countries, and that there was need to look into career ladders/paths for the community health workers. Finally, team work was emphasized to improve effectiveness through stronger task sharing and shifting policies, referral and supervision systems.

2.2.3 Group Work and Feedback: Day One

Participants were divided in three groups. Group I had DRC, Nigeria, Zambia and Uganda; Group II had Malawi, Tanzania, Zimbabwe; and Group III had Kenya, Ethiopia and Ghana; plus each group had members from the participating organisations outside the designated countries. The groups explored country experiences with action on HRH for EWEC and the Global Plan in the context of broader HRH and system responses with respect to planning, links between health facility based and community based workforce for RH/MNCH Services and PMTCT. The group exercise also sought experiences from non-state actors on regulatory and organizational issues, demand and continuity in services retention, and on skill mix and incentives.



Feedback from the Groups

The feedback session was moderated by Yoswa Dambisya (EQUINET/UL). The groups presented on what works, achievements/successes, what could be improved and challenges or Barriers. The main issues were consolidated as follows:

Successes

Despite the various nomenclatures such as community health workers, providers, extensors, village health teams, it was noted that most countries had developed strategies and plans, National policies and guidelines on community health services. Nigeria for example reported

that the CHWs had clear career paths to the level of community health directors and Kenya had a division of Primary Health Care and Community Health Services.

There was evidence from the groups that standardised integrated and comprehensive training curricula addressing various interventions were available. However, the training periods varied from a few days to years. Community health structures for monitoring and evaluation had been developed in most countries. Tools for data collection and reporting systems to the next levels also existed. Moreover, the health workers at the frontline were supported by the governments to do their work through provision of kits, housing and reducing unmet needs for family planning and antenatal care.

Challenges

Lack of role definition for CHWs and low numbers of professional health workers leading to inadequate supervision, low motivation/morale, high turnover rates and shortages were some of the challenges noted. It was also apparent that there was inadequate good will from the formal health workforce and resistance to community initiatives. Many CHWs were untrained and their trainings had inadequate infrastructure and materials. CHWs also lacked proper guidelines and regulations on task shifting or sharing of their services. It was evident that there were inadequate sustained incentives in most countries as some of these incentives were supported by partners and not national governments. Distances from the facilities were also a big challenge for CHWs to function as part of the health system.

Recommendations

The participants recommended that there should be:

- (i) regulatory frameworks for all cadres of health workers to make them accountable,
- (ii) standardised training guidelines for community health workers, and
- (iii) established career pathways for CHWs.

Furthermore, it was suggested that technology and innovations needed to be embraced to build capacity and synergies created by involving stakeholders like Ministries of Education, Finance and the Public Service.

Task shifting and sharing was also discussed as a growing tendency in health care provision. To realise the needs of women and children, strong teams were critical, something which was still not generally accepted in most countries. WHO, it was noted, however, was discussing task shifting and sharing at various levels with a view to providing guidelines on its implementation without compromising quality and safety of service provision. The Consultation opted to wait for the WHO guidelines which were then under development.

Conclusion

At the end of the day's deliberations, it was acknowledged CHWs played a critical role. Participants felt that countries should look at the various levels and coordinate professionals together with CHWs using different guidelines. This, it was noted, was because CHWs exist in the countries as part of the health care systems. *Health Workers at the Frontline* were defined contextually to apply to those health workers who were at the first level of contact with the health system. There was evidence of cost-effectiveness, high impact interventions in the precincts of Primary Health Care to provide viable options for improvements in Maternal and Child Health Survival.

2.3 Day Two: What We Know

Day Two started with the Opening Ceremony (*vide supra*, 2.1) at which the Minister of Medical Services was Chief Guest. After the opening Ceremony, the Consultation Facilitator, **Dr Percy Mahlati** (African Institute of Health and Leadership Development) took the participants through the programme for the day. He called upon the participants to focus on links between global and local initiatives as deliberations sought ways of strengthening partnerships amongst priority countries. He reminded the participants of the objectives of the Consultation, and called upon all to bear them in mind throughout the day's deliberations.



Dr P Mahlati, AIHLD

2.3.1 Presentations on Every Woman, Every Child Moderated by Dr James Mwanzia, Intrahealth

The presenters were drawn from UNAIDS, Global Plan, UNICEF and CHAM, and the presentations focused on Every Woman Every Child, scale up and accountability, training, analysis of bottlenecks, achieving a coordinated response and the role of the non-government sectors.

Dr Karusa Kiragu (UNAIDS) demonstrated that of the 8 MDGs, MDGs 4 and 5 have made the least progress, and that most countries were not on track to achieve MDGs 4 and 5. That, she explained, was partly due to the fact that progress on MDGs 4 and 5 was dependent on progress in MDG 6, combating HIV; and that was how the **United Nations Secretary General's Global Strategy on Women's and Children's Health: Every Woman Every Child** (Every Woman Every Child) should be understood.

Dr Kiragu gave a brief overview of the Global Strategy - launched at the September 2010 MDG Summit, aims at saving 16m lives of women and children in the 49 poorest countries by 2015 – as the signature initiative of the UN SG and has put the health of women and children at the top of the global political agenda. She then outlined the six major elements of EWEC as:

1. Support to country-led health plans
2. Integrated delivery of health services and life-saving interventions to facilitate access for women and children
3. Stronger health systems with sufficient skilled human resources
4. Innovation in financing, product development and efficient delivery of health services
5. Promoting human rights, equity and gender empowerment
6. Improved monitoring and evaluation to ensure accountability of all actors for resources and result

The emphasis on HRH in EWEC was reportedly on health workforce capacity building, with partners required to work together to address critical shortages of health workers at all levels. At the same time, partners should provide coordinated and coherent support to help countries develop and implement national health plans, and partners must include strategies to train, retain and deploy health workers.

Dr Kiragu then alluded to on going global activities of key actors, with emphasis on advocacy, accelerating actions through commitments, securing additional resources, strengthening coordination and synergies, and information and accountability. She was gratified to note that 44 of the 49 low income countries in the Global Strategy had made firm commitments, and cited examples of commitments from Uganda (to reduce unmet FP needs from 40% to 20% and increase focused ANC from 42% to 75%); from Zambia (to increase

national budgetary allocation to health from 11% to 15%, and increases CPR to 58% from 33%), from Chad (train 40 midwives per year for next four years), from Burkina Faso (to spend at least 15% of budget on health, develop and implement HRH plan, and construct new school for midwives by 2015); from Liberia (to increase national budget spending on health from 4% to 10%, and ensure double the number of midwives trained and deployed by 2015); from Malawi (to strengthen HRH through acceleration of training and recruitment), and from Zimbabwe (to increase health spending to 15% of the health budget or \$20 per capita; and to establish a maternal, newborn and child survival fund by 2011).

Dr Kiragu indicated that monitoring those commitments would involve a number of initiatives, such as the recently launched Commission on information and Accountability (COIA), co-chaired by the president of Tanzania and Prime Minister of Canada which had made 10 recommendations, completed its work and led to the establishment of the Independent Expert Group (iERG). It is the iERG that is charged with the task of monitoring progress and the commitments under EWEC.



Dr N Muraguri, Global Plan Secretariat

Dr Nicholas Muraguri of Global Plan Secretariat revisited the *Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive* (vide supra under 2.2., Dr Kiragu), with emphasis on “bottle-neck” analysis. He stressed that systematic approaches were necessary to analyse frustrations of various efforts through equity focused bottleneck analysis. He reported that the Global Steering Group had coordinated and supported teams that concluded that regulatory frameworks needed to be coordinated as issues around HRH like shortages; skill mix and retention were common. The presentation further concluded that it was only through improved quality and supply of HRH that the region would attain the goals of the Global Plan which had further created another platform and opportunity to help in pushing the HRH agenda. Dr Muraguri noted that despite the challenges observed, many countries had innovated and engaged high level political participants such as presidents and the first ladies towards attainment of the goals of the Global Plan.

Dr Nande Putta from UNICEF called upon participants to consider male intervention, CD4 machines and integration of more efficient regimens with key elements being leadership and advocacy, coordinated efforts and leveraging of partners and resources. That, she stated, combined with the building blocks of health systems would enhance achievement of coordinated responses.



Dr Nande Putta, UNICEF

Ms Rose Kumwenda Ngoma of the Christian Health Association of Malawi (CHAM) gave the FBO perspective through her presentation on *The Role of Faith Based Organizations in improving Access at The Frontline for Better Maternal and Child Survival*. She reviewed Malawi's severe HRH crisis with very low density of HWs, and the role CHAM plays as second largest health care provider offering about 37% of all health care.

She outlined specific interventions by CHAM – including strengthening the training capacity for mid-level health workers through 10 training institutions that have been operational since early 70s, coupled with scaled up training of other cadres such as community midwives; documentation of what works and influencing policy; and strengthening partnerships with government and other development partners to train more Health workers. Ms Ngoma reported that there were good working relations with



Ms R Ngoma,

government which supported CHAM by paying salaries of health personnel and providing essential medicines and supplies.

Ms Ngoma noted that FBOs had improved access to health workers at the frontline through a number of initiatives such as recruitment of community health workers at grassroots level with involvement of communities themselves in the spirit of the Primary Health Care approach, identification of trainee nurse/midwives at community level to promote retention, and through strengthening district and community capacity to plan for health worker training and deployment. She also indicated that FBOs reinforced contracts and bonding system for those that benefited from scholarships, and encouraged volunteerism among retired health workers.

Ms Ngoma also outlined the FBO retention strategies for health care workers, including employing a combination of monetary and non-monetary incentives, such as provision of good Housing with access to electricity and safe water, provision of scholarships and interest free educational loans, recruiting trainees from communities around the health facilities, interest free loans in some hospitals, and provision of transport for monthly shopping. The challenge, however, was reportedly with promotions and grading of staff due to limited financial allocations and due to regulated staff establishment.

The presentation emphasised the role of FBOs in improving access to health care by addressing retention. The challenges raised included compromised quality of services, lack of monitoring and regulation systems and remuneration of health workers at the frontline. There were opportunities for improvement, such as availability of infrastructure; needs based training for service provision and ownership, which should be facilitated by political goodwill.

Ms Ngoma concluded with a call upon the Consultation to address the following issues:

- Regulation and legislation of community Health workers
- Career path and recognition of the community Health workers
- Service provision ensuring Quality of care is maintained
- Supervision, performance monitoring and follow up of graduates
- Incentives to keep the workers
- Continued professional development
- Documentation of good practices and scaling up
- General human resource information management

The discussions that followed re-enforced the main messages in the various presentations through sharing of experiences from the various countries and organisations.

2.3.2 Panel discussion on Country Responses, Overview of Progress and Challenges Moderated by Dr Karusa Kiragu, UNAIDS

The next session consisted of panellists from Malawi, Kenya and Zimbabwe under the theme: '*Country Responses, Overview of Progress and Challenges*'. The session started with a summary from previous day's country deliberations on what works, where we are stuck and why, and models and innovations and what makes them work. Nigeria reflected on the discussions from the last session of the previous day.

In the ensuing discussion, it was noted that a concise definition, meaning, differences, role and



relationship between CHWs and health workers at the frontline were needed. A framework that not only clearly defines where health workers at the frontline are located but also explained where the focus should be laid-on the frontline health facilities instead of individuals or community level, was provided and discussed. The issue of patient safety and safety enhancement through regulation and proper supervision was once again raised as a concern, and there was general agreement on the need for the quality and quantity of the services to be addressed, in addition to issues of referrals systems and conditions of service.

Contributions pointed to general agreement on the need for job security of the CHWs/health workers at the frontline; the need to ensure efficiency and accountability of CHWs; the need for strong evidence on practices that reduce gaps between evidence, policy and practice, and a robust mechanism for monitoring and evaluation should be part of the entire health systems. Such mechanisms, it was felt, would also lead to understanding what community health workers can really do and would serve as evidence and strong machinery for advocacy.

There then followed by presentations on Decentralization in Malawi and implications for HRH, Education as a service that needs to be shifted from Mother to Mother, and from the Zimbabwe experience with government collaborations with non-government players.

Mr Michael Eliya Ministry of Health, Malawi traced events in Malawi to 2004 when the country was going through an HRH crisis due to migration of HCW and poor working conditions, which in turn affected negatively provision of patient care. He then described the steps taken to reverse the situation, including definition of professional and non-professional cadres required, followed by high level consultations between the MOH and other ministries, regulatory authorities and donor partners. That was reportedly followed by development of a training plan with defined targets per cadre, Identification of resources and budgets, training institutions and recruitment and deployment strategies.



Mr M Eliya MoH, Malawi

Mr Eliya showed that the required change necessitated a review and change of policy in areas such as job description and task shifting, and that there was an increase in recruitment and intake into training institutions, refurbishment of training institutions and increased training of tutors. At the same time, the problem of retention was addressed through incentives such as salary top up, staff scholarships, filling of some staff vacancies, rural housing scheme for the staff.

The presenter gave a synopsis of task shifting approaches that accompanied the rescue measures, notably the greater involvement of health surveillances assistants (HSAs) in the distribution of some family planning commodities, community IMCI, management of minor



elements in the village clinics, HIV testing and counselling services, and DNA PCR sample collection. Nurses for their part had those of lower cadre allowed to do assisted delivery and to initiate patients on ART treatment.

Regarding lessons learnt in the process, Mr Eliya stated that the health sector was able to decentralize and scale up services even to rural areas; that decentralization was very helpful to patient follow up in clinical settings; and that decentralization

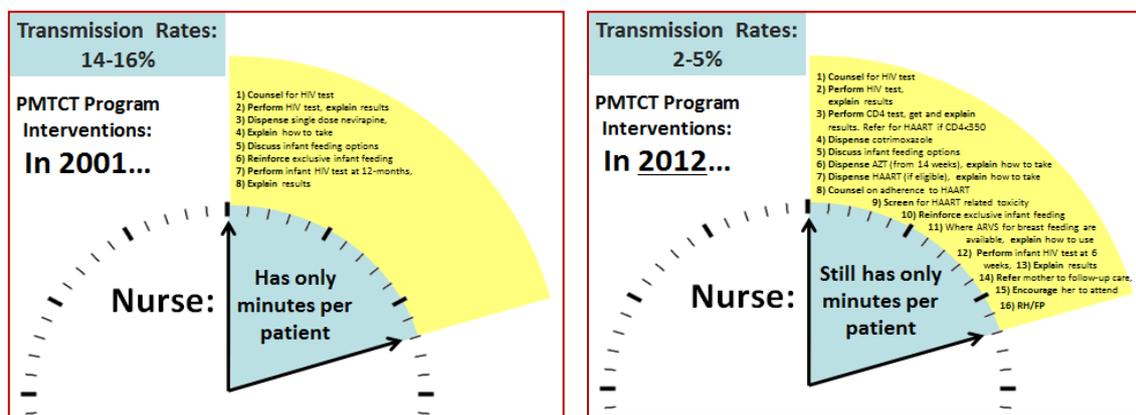
requires financial resources for capacity building of staff, such as initial and refresher trainings and for mentoring and supervision; and that decentralization requires improving the capacity of training institutions. His conclusion was that the health sector had a human resource gap, that efforts through government and partners allowed training of more staff, that addressing some working conditions assisted in staff retention, that task shifting assisted in scaling up services and that decentralization had allowed more patients to access services.

Ms Nicole Sijenyi Fulton (m2m) talked on the topic: *Education is a Task that Needs to be Shifted - The Mentor Mother Model*. She Reviewed the global HIV prevalence, disparity in global disease burden and health workers; the low health worker densities in SSA countries. She then showed the increasing demands on the nurse's time, and yet between 2001 and 2012 a lot more demands have been placed on the nurse's time; illustrated as shown below:

Ms Fulton referred to the preface to the task shifting guidelines with a call to seek innovative ways of harnessing and focusing both financial and the human resources that already exist. She then introduced the concept of mentor mother - a mother living with HIV who is trained and employed as part of a medical team. The mentor mothers, she explained, were involved in educating other mothers in similar situations themselves, and in helping out in facilities offering MNCH services. She emphasised that mentor mothers did not perform HIV testing, provide medication or perform clinical duties; rather they supported medical staff that carry out those functions. Among the objectives of the mentor mothers' programme, were:

- 1) Quality peer support services are available for women and their infants (through the integration of Mentor Mothers in the health delivery team)
- 2) Mother-baby pairs seek timely MNCH services (through community-based activities by CHWs)
- 3) Mother-baby pairs are retained in care and adherent to available services (through facility-based activities by Mentor Mothers).

Figure 3: The Increasing demands on the nurse's time, Africa, 2001 - 2012



Source: Presentation, Ms N Fulton's

Dr Angela Mushavi Ministry of Health and Child Welfare, Zimbabwe, presented the Zimbabwe experience. The context of her paper were figures from the latest Zimbabwe DHS (2010/11), showing that 90 % of pregnant women receive antenatal care (ANC), but only 19% attended in the first 3 months of pregnancy, which was a missed opportunity for PMTCT and safe motherhood interventions; that 65% of live births in the preceding five years took place in a health facility; that skilled birth



Dr A Mushavi
MoHCW, Zimbabwe

attendance was at only 66%; and that contraceptive prevalence rate (CPR) was 66% and unmet need for family planning (FP) was 13%.

Regarding HIV, Dr Mushavi reported that there were 45,623 HIV infected pregnant women expected in 2011 out of about 412,122 expected pregnancies (2009 HIV estimates); that in the previous 10 years, MMR had increased from 555/100 000 (2005/6) to 960/100 000 (2010/11); and that a leading cause to this high MMR was HIV/AIDS in 26% of deaths. Concomitantly, 21% of the under-five mortality rate (<5MR) was allegedly attributed to HIV/AIDS as the underlying cause.

Part of the response to the above challenges in maternal and child survival, according to Dr Mushavi, was the involvement of NGOs who have to be registered to practice in the country, must have a Memorandum of Understanding (MOU) with MOHCW. Such NGOs, she elaborated, need to be formally introduced to the part of the country where they will be working in through a formal letter of introduction from the Permanent Secretary for Health to the Provincial Administrator and Provincial Medical Director.

The presenter cited numerous ways through which NGOs supported HRH, for instance through direct recruitment to the NGO concerned, then staff work for the NGO and give technical support to MOHCW, or the NGO recruits staff (upon request from MOHCW) with a certain level of competency and second such staff to Ministry to support program implementation at National, Provincial and District levels. There were also reportedly links between NGOs and Global Fund (GFATM) through top up salaries of staff within the public sector, such as retention allowances to doctors, nurses and other personnel.

Dr Mushavi also presented various forms support for community health workers takes, such as the Village Health Worker (VHW) which was a cadre on the government payroll, provided with a bicycle, uniform and VHW kit which enhance their recognition and status in the community. In some instances, she stated, NGOs pay the stipend (USD15) for the VHWs as MOHCW had not been able to foot the bill in the last few years. She emphasized that VHWs were a MoHCW priority, with a national VHW revitalization effort that included many stakeholders.

She also explained that VHW training modules had been revised to strengthen PMTCT scale up towards eMTCT through ZVITAMBO and EGPAF with emphasis on community based client support, preventive and curative health service delivery, able to reach every child initiative (maternal and neonatal care) and community involvement/mobilization such as for IYCF and promotion of breastfeeding.

Other community health workers mentioned in Dr Mushavi's presentation were community based distributors - responsible for distribution of FP commodities, including condoms, but also trained to address HIV and AIDS in efforts to scale up FP/HIV integration; including eMTCT activities, and behaviour change facilitators (BCFs) that drove activities for primary prevention and advocate for safer sex, targeted multiple concurrent partnerships, transgeneration sex; and were critical to tackling primary prevention even in the context of a comprehensive 4 pronged approach to eMTCT according to EWEC. She noted that there were also home based care workers, field officers, mentor mothers, community mobilizers, male champions, and that most of these categories were also supported by NGOs especially those funded for HIV and AIDS.

The biggest challenge for all, according to Dr Mushavi, was the lack of standard training: each trained for a particular program and no standardized incentive system for all of the above

2.3.3 Group Work and Feedback on Day Two. **Moderated by Ernest Manyawu, ECSA HC.**

In the final session of the day, three groups were formed and moderated by different partners namely; Save the Children, NCHS (Ghana) and Makerere University. The assignment focused on EWEC/Global Plan needs and opportunities, challenges related to local, national and global interactions in strengthening leadership for action and results. The following is a summary of the discussions at the feedback session, presented as opportunities, best practices, challenges and recommendations for further action.

Opportunities for synergies included:

1. Moves towards integration of service delivery
2. Multi-skilled community health workers such as those in Tanzania, Malawi, Kenya, Zimbabwe, DRC and Ghana
3. Existing National Strategies and HRH plans.
4. Broadening the investment countries have made in establishing health facilities within walking distance.
5. Some countries have invested in training community health nurses.
6. Investment in training to support health systems such as leadership and governance, and information systems.
7. Advocacy for interactions using locally available data.
8. Health Workforce Observatories in several countries which bring on board many HR and health service providers for planning.
9. Inter-agency coordinating committees chaired by Ministries of health.
10. Availability and use of WHO code on international recruitment of health personnel and dissemination of this code
11. Governments support on scale up activities to increase the numbers of health care workers.
12. Providing essential medicines and supplies to FBO facilities e.g. Vaccines, ART Collaborations in Training between different players

Best Practices shared included:

1. Non state actors support for government health systems
2. Resolutions, which are based on best practices, are appropriately packaged and shared with government and regional political bodies.
3. Technical working groups are task-oriented such as in Malawi and in Kenya.
4. Establishment of national platforms for learning from innovations (e.g. best practices, use of cell-phones for MNCH).
5. NGOs supporting and providing technical leadership for innovations through pilots e.g. Save the Children developed minimum package for HAS adopted by most districts in Zambia; and the m2m model in SSA.
6. Governments provide policy and legal framework to govern partnerships, such as comprehensive MOUs between Governments and NGOs/FBOs with respect to training, recruitment, rewarding and retaining HRH resources for HRH.
7. Governments plan, implement, monitor and evaluate health care initiatives and outcomes jointly with other players at all levels (i.e. PPP).
8. Partners such as NGOs pro-actively in engaging government on health care initiatives.
9. Enhanced competencies in government on private sector resources

Challenges and Gaps identified were:

1. Long distances to Health facilities;
2. Inadequate skills among community health care providers to handle emergencies;
3. Inadequate transport logistics in remote and rural areas;

4. Inadequate investment in health care services;
5. Inadequate skilled health workers (such as midwifery and nursing personnel) with appropriate skills mix
6. Cultural and attitudinal issues have been identified as barriers to accessing skilled HRH.
7. User fees are a barrier to the available skilled HRH.
8. HRH Policy is not being put into action because of lack of focus and priorities.
9. Compartmentalization of various services not possible at implementation level since same midwife/CHW covers MNCH, HIV/AIDS services.

Recommendations

The discussions resulted in a number of recommendations to the effect that:

1. Efforts be made to integrate medical education to include result based management skills to improve performance of health workers.
2. Health plans should be produced locally (i.e. down – up approach) to create a sense of ownership among local leaders.
3. Countries should domesticate global health declarations at country level and provide leadership for their implementation
4. Governments should enhance working relationships and coordination with global and regional boards; such as WHO-AFRO, SADC, ECOWAS and ECSA HC.
5. All should promote South-to-South collaboration to build local capacity for enhanced quality health care delivery.
6. Community-based providers (CHWs) need to be owned by the districts even if non-state actors are supporting them, and all their activities should be within the broader district health programme
7. There should be greater and more formal FBO-Government partnerships, through MoUs and other arrangements through which government may support FBOs e.g. by meeting operational/salary costs for FBOs, supplies and commodities
8. Appropriated trained health workers from FBOs should be part of the national HRH pool that can be deployed by the govt.
9. Policy frameworks for Public Private Partnership need to be encouraged such as secondment of key staff to FBOs, PHC grants to FBOs, supplies of HIV commodities to private service providers.
10. Governments should consider having same policy guidelines for all service providers
11. There is need to involve all stakeholders working in the health service delivery for the implementation of these policies.

The Market Place

The day ended with a cocktail reception at the ‘*market place*’ where models of innovations were discussed informally as participants handled the various issues that had been discussed during the sessions. There were flipcharts where participants freely contributed in ‘Quality Cycles’. GHWA had a corner showcasing some of its knowledge products; Save the Children was on the opposite end challenging participants to review their perceptions against the realities on the ground Communiqué; while the FBOs held forte at one end of the “Market Place” pressing home their contribution to the well-being of the many communities they serve in the many countries. Another vibrant “corner” was on HRH Audits.



2.4 Day three: Acting on What We Know

The theme for the Day was ‘Acting on what we know’ and deliberations started with reflections on the previous day’s presentations by the Consultation Facilitator, Dr Percy Mahlathi, African Institute of Health and Leadership Development. That was then followed by presentations that tackled the need for increased production of health workers amidst resource constraints, the challenges of financing HRH for MNCH and PMTCT, and on the role of Parliamentary Committees on Health.

2.4.1 Presentations on responses to health worker issues

Chair: Dr N Squires, DfID

The first session was chaired by Dr Niel Squires (DFID) and had three presentations.

On the *Challenges of training Skilled Health professionals in resource constrained settings*, **Prof Mbambo-Kekana** (University of Limpopo) noted the consensus that there was need to increase production of health workers of all categories, and suggested that CHWs be regarded as Community Health professionals, after all:



Presentation session on Day 3

- “A professional is a person who is paid to undertake a specialized set of tasks and to complete them for a fee.
- A great deal of trust is placed on a professional and therefore should be subjected to strict code of conduct with ethical and moral obligations
- Professionalism means commitment to the client, community and one’s own profession through ethical practices.” And the CHWs fit the bill.

She then gave the context of health professional training in South Africa with many institutions concentrated in the rich commercial capital of Gauteng (Johannesburg and Pretoria area) and fewer in the poorer provinces. On the constraint of resources, Prof Mbambo-Kekana’s view was “We lack what we have”, in recognition of the fact that more could be done within the available resources.



Prof Mbambo-Kekana
University of Limpopo

The presenter reflected on the expenditure on health, and expenditure on higher education in South Africa, showing that substantial amounts were allocated to health and education, and yet even more was required. She appreciated the constraints in resources at home, in the schools and at university, noting that students from poorer homes were often poorly prepared for University education, and that few qualified for health science courses due to disadvantages such as lack of maths science teachers, lack of laboratories and libraries, poor medium of instruction, poor careers guidance and poor study methods. University level constraints included inadequate HR, difficulties in recruitment of lecturing staff due to lack of support structures such as good schools with resources, lack of or proper affordable

accommodation for staff, lack of or minimal social facilities, poor salary structures and heavy work overloads.

Prof Mbambo-Kekana also alluded to constraints imposed by professional bodies that often capped numbers at certain levels and the lack of facilitation of training of mid-level workers. She outlined some of the solutions SA had instituted, including the one-year Community Service and re-opening of nursing colleges, various examples of Private Public Partnerships through which the private sector was training a lot of the CHWs and mid-level workers, and the introduction of the national certificate for Community Health Workers (1 year) and the Diploma for Profession Specific Technician (2 year).

Mr Michael Sande (HSB Zimbabwe) gave an overview of the strategies employed by Zimbabwe in *Financing of HRH for MNCH and PMTCT- The case of Zimbabwe*. He dwelt at length on the Short Term Economic Recovery Plan (STERP) blueprint which the Inclusive Government put in place in order to identify those areas that could be resuscitated in the short term.

STERP, he said, had the endorsement and participation of all stakeholders in the health sector, based on a shared common understanding of the health problems and a jointly developed 90-Day recovery plan for health institutions. The recovery plan reportedly showed what government commitments were, and what business and technical partners would be responsible for; the mode of execution included PPPs.



Mr M Sande HSB Zimbabwe

Mr Sande reported further that evidence from various studies led to the establishment of the Health Transition Fund (HTF), a multi-donor pooled fund which sought to reduce maternal and child mortality. The HTF enabled the abolition of user fees for services, improved access to comprehensive emergency obstetric care (EmOC) and newborn care; and was expected to save more than 30,000 lives among pregnant women and children under five up to 2014.

He then discussed the National Health Strategy 2009-2013: Equity and Quality in Health – A People’s Right, which provides a framework for immediate resuscitation of the health sector (Health System Strengthening), and aims to put Zimbabwe back on track towards achieving the MDGs. According to Mr Sande, HTF continued supporting improvements in quality of maternal, new born and child health and nutrition services, the provision of medicines and basic equipment, HRH for a large part of the sector, and health policy, planning and financing. Retention strategies put in place in Zimbabwe have been a combination of monetary and non-monetary incentives, as show in Table 1 below.

Table 1: HRH Retention Strategies in Zimbabwe

Monetary Incentives	Non-monetary incentives
<ul style="list-style-type: none"> • Regular review of salaries and allowances • Allowances e.g. Transport , housing (some tax free) • Rural allowances 	<ul style="list-style-type: none"> • Manpower Development leave on full pay • Private practice • Pension and Medical Aid • Housing Loans • Duty free vehicle import facility for HWs • The government granted an “amnesty” to encourage the return of striking/ resigned health workers who had left government service during the crisis. • Engagement of Local Authorities to prioritise HWs in the allocation of housing stands.

Additional support from partners was also received for salary top-ups from the Global Fund, and there was also programme specific support. In conclusion, Mr Sande stated that:

“Although Zimbabwe acknowledges that donor support is not a sustainable option in the long term, the support has played a very significant role in revitalising the health sector.”

Hon Blessing Chebundo, Chairperson of the Association of Southern and Eastern African Parliamentary Committees on Health (SEAPACOH), discussed the role and benefits of parliamentary portfolio committees, and emphasised the need to work together to overcome gaps. He described SEAPACOH as a network of Parliamentary Committees on Health from the Southern and Eastern Africa regions, who have come together to pursue equity issues on Health and HIV/AIDS. The networking is driven by inequity in resource allocations for the health sector and the devastating impact of the HIV and AIDS epidemic on the populations of countries especially in Sub-Saharan Africa, and the need to create collaborative synergies to enhance the effectiveness of the portfolio committees.

Hon Chebundo outlined the functions, working arrangements and the work of portfolio committees, and presented them as a good link between the health sector and policy since the committees were accessible and always welcomed inputs from the technical people. For instance, he illustrated, portfolio committees monitor, investigate, enquire into and make recommendations relating to any aspect of the legislative programme, budget, rationalization, policy formulation or any other matter it may consider relevant to health. In the process, there are many opportunities for collaboration with many stakeholders including CSOs, health professionals and the media in furtherance of the health agenda.

The Hon MP emphasised that over time it had been realized that there are many health issues and decisions common to the regions, such complex issues as the issues and agreements at Multi Country Free Trade Agreements (WTO), that are beyond individual domestic parliament committee control and oversight and would need collective parliamentary position and recommendations, hence the need for SEAPACOH. He pointed out that while it is not parliament’s job to prepare or present the case on global/regional issues it is its oversight role to make sure that the government has prepared the best possible case.



Hon B Chebundo, SEAPACOH

Hon Chebundo emphasised the benefit of collaboration with portfolio committees as including access to researched and technical information; that evidence generated by civil society and independent researchers can be provided from a perspective not influenced by conventional analysis; and networking and collaboration with civil society groups on health also serve as an advocacy strategy for raising awareness on issues of public health services. He stated that engaging civil society helps to foster a sense of collective ownership of parliamentary and government processes, and helps to improve relationships between these institutions; and that civil society organizations may act as bridges between government on one side, and the public and development partners on the other side in addressing health issues. He

however cautioned against the many mushrooming CSOs, such as those dealing with gender (women rights) and HIV and AIDS in almost all the countries in the region. He said these CSOs tended to rival and duplicate each other’s efforts, and make it difficult for the Parliamentary Committee to coordinate for dialogue and their inputs.

The MP highlighted some of the challenges faced by their network, including changes in committee membership with elections (which makes continuity difficult as a whole), resource constraints and inaccessibility of some areas which make it difficult for the MPs to follow through on agreed actions, the focus on specific health issues alone without equal attention to ‘social determinants of health issues’ such as safe adequate drinking water; shelter provision; food security all of which fall under different portfolio committees.

Finally, Hon Chebundo declared that “SEAPACOH believes that the key hallmark of every modern parliamentary democracy and society is the development and sustenance of its public health system as a basis for social and economic development and therefore political viability and stability. Without doubt, the entire future of African regions, and their social and economic development and political viability and stability rests on the resolution of their public health crisis.”



Discussion

After the three presentations, discussion focussed on points for clarification. For instance, the Consultation was told that the training of community health workers was the mandate of a different level of institution, not university. Clarification on the STERP in Zimbabwe was also provided. Some of the numbers given by the presentation from Zimbabwe – of almost 100% full staffing for nursing cadres also attracted some attention. The success was applauded, but caution was also advised – 100% of established posts may not be 100% what is actually needed. The SEAPACOH presentation was seen as an eye opener, for many of the participants did not know the workings of parliament through its committees, and did not know the potential that existed for collaboration. Dr Niel Squires, the session chair, summed up the salient points and closed the session on a very optimistic note: that the energy and commitment evident in the room meant that the health gains were within sight.

2.4.2 Panel Discussion on the role of different partners

Moderator Dr Sigrun Møgedal

The panel discussion on the role of different partners at the various levels gave emphasis on how to get the various role players to act towards a common goal. Panelists were Dr Ken Sagoe (Ghana), Bjarne Garden (GHWA), Patrick Kadama (African Platform on HRH), Meshack Ndolo (Intrahealth), Hyppolite Kalambay (IHP+), Thom Yungana (SANNAM), PMNCH (Angela Mutunga).

The Presenters shared what they do and what priorities they have envisaged towards improving access to health workers at the frontline for better Maternal and Child Survival. Country experiences from Ghana and from DRC illustrated how it was often difficult to manage the competing interests of many partners. The message was that the approach through strategic planning afforded the chance to harmonise.

Partner organisations – represented by Intrahealth International – showed how they could, through engagement with country processes, help improve the situation in-country by scaling up frontline health worker deployment to hard to reach areas. Another example given was

that of Intrahealth working with government (in Kenya) to reduce the hiring time for health workers in Kenya, and also in establishing electronic HRIS.

Dr Kalambay emphasised the IHP+ processes, which may greatly reduce fragmentation, promote integration. With the example of the DRC where at some point health professionals had to report on up to 800 indicators, for many different partners/funders; and HRH professionals spent more on reports than on service delivery. What the DRC had done was to work towards:

1. One health sector strategy to reduce fragmentation
2. One National Health Sector Strategic Plan to align partner interventions
3. One M&E framework to reduce the number of indicators to be reported on
4. One National Development HRH Plan
5. Integrated training programmes instead of fragmented ones, and more efficiency in HRH training

The above strategies created more time for service delivery. Dr Kalambay concludes that it was important to improve human resources capacity, but it was equally important to put in place an integrated training programme, that strong leadership was necessary improving HRH effectiveness ; and that there was need to improve policy dialogue between all the stakeholders in the Health sector – and those were some areas where IHP+ could be helpful.

Professional groups, represented by SANNAM, were concerned that efforts to increase access to health workers at the frontline should not be at the expense of quality of service and patient safety. Hence, theirs was a call for proper regulatory frameworks and role definition to ensure that where task shifting occurred, it was done within the competencies and skills of the cadres to which tasks were delegated.

For GHWA, Bjarne Garden lauded the consultation and hoped it would provide an opportunity to reflect on inputs from previous meetings and help visualise the kind of coordinated response needed. It was his hope too that the Consultation would explore ways of how a common response could be operationalized in support of scaling up the CHWs and health workers at the frontline. GHWA appreciated the interest and participation of all stakeholders and partners on issues of HRH, and informed the participants of upcoming changes in direction GHWA was due to take through a new strategy that was informed by an independent external evaluation.

2.4.3 Final Group Work Session and Feedback: Moderated by Louise Holly Save the Children

Participants were put into groups consisting of country delegates and partner organisations to reflect on action areas from country perspectives, but also with a focus on how partner organisations could be involved in ensuring a coordinated response at the country level. The groups were invited to reflect on the questions so far raised and the recommendations so far made with a view to agreeing on which ones ought to be taken forward. It was one of the tasks for the groups to identify next steps for countries and global actors, and what the responses from the partners ought to be.



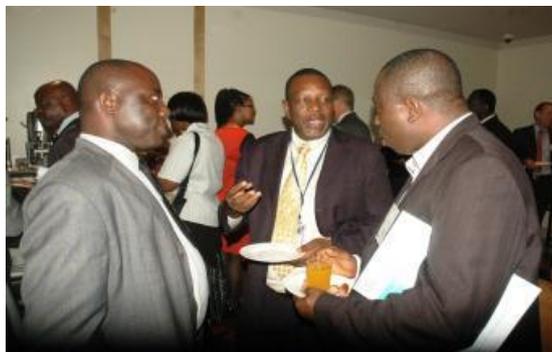
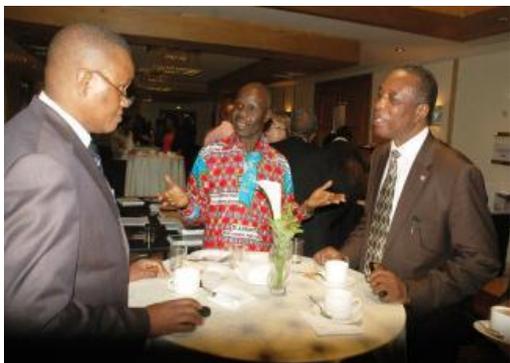
L Holly, SCF UK

In the plenary feedback session, a final set of recommendations, with contributions from the various groups, and as derived over the three days, were deliberated upon. A comprehensive list was drawn up, and it was agreed that in the final wording some would be consolidated to avoid appearing repetitive. The Consultation Facilitator presented the

consolidated list of recommendations, which was unanimously accepted, subject to editorial revision for accuracy and to avoid redundancy.

One of the Consultation organisers, Prof Dambisya, then presented the draft outcome statement that had been developed by a committee drawn from a cross-section of participants. The Communique of the Nairobi Consultation included take-home messages for improvement on country, regional and global plans and actions, which participants adopted as the Nairobi Consensus. The final communique as adopted is attached as appendix 2 to this report.

On immediate next steps, participants requested that the Communique be presented in the forthcoming meeting in Tunis and at other national, regional and international platforms. Participants hoped the Communique would be used as a basis for further action in improving access to health workers at the frontline for better maternal and child survival within the countries, and country delegates made a commitment to disseminate the Communique and other outputs from the Consultation to all stakeholders.



Discussions amongst delegates during the meeting and into the evenings

2.5 Closing Session

There were remarks from Dr Patrick Kadama for the African Platform, Dr Karusa Kiragu for the UN H4+ partners, and from Mr Thom Yungana from Zambia on behalf of the countries. Each of them appreciated the efforts put into organising and holding the Consultation, and all shared the hope that the outcomes of the Consultation would help drive the agenda of improved maternal and child survival.

Prof Miriam Were on behalf of Kenya, was impressed by the passion and dedication shown by the participants, and echoed her dream for healthy African populations through increasing access to health workers at the frontline. She emphasised that most cadres had clearly defined roles and responsibilities within the health system, it was only the community health worker whose status and role were not so clear. Hence, as participants prepared to act on the outcomes of the Consultation she challenged them to think of how to clarify the role of, and improve the working environments for the CHWs who remain critical to service delivery at the frontline.

Mr Bjarne Garden, on behalf of Norad and the other organisers gave a vote of thanks recognising the hospitality of Kenya and the Intercontinental Hotel, Dr Sigrun Møgedal who was the force behind the idea, to Prof Yoswa Dambisya, the University of Limpopo and EQUINET for having taken on the coordination role for the Consultation, other sponsors, and to all the participants for the enthusiasm, interest and engagement throughout the Consultation.

Norad was specially thanked for initiating, supporting and executing the idea of the Consultation.

3. Recommendations of the Consultation

A number of recommendations were made, with emphasis on “**Recommendations for Action.**” That was in recognition of the fact that many of the actions required for improving access to health workers at the frontline were well documented; the challenge was often closing the gap between evidence and action. The consultation therefore underscored the need for national governments, continental and regional organisations, development partners, funding agencies, academic and research institutions and civil society to all improve collaboration and give greater priority to increasing access to health workers at the frontline for better maternal and child survival.

Recommendations were made for action at the national level and also to regional and global actors, and all stakeholders were called upon to contribute to the agenda for improvement in maternal and child survival through coordinated responses, within existing country plans, processes and mechanism. Specifically the recommended were targeted to the various levels and role players as outlined below:

At National Level:

- Countries should accelerate efforts to improve the supply and equitable distribution of health workers;
- Improved supply and equitable distribution of health workers at the frontline should be complemented by efforts to increase community awareness and build demand for quality health services available at the frontline;

- Optimum service integration at the frontline and strong teams should be promoted, guided by identified competence needs and context-appropriate skill mix;
- Regulatory frameworks should be developed for all cadres of health workers and standardised training and guidelines on supervision and task-shifting produced for health workers at the frontline, including community health workers (CHWs);
- CHWs should have established career pathways with opportunities to develop professional qualifications and become part of the formal health workforce;
- Sustainable incentive structures should be developed for health workers at the frontline, including CHWs, that are commensurate with their skill set and responsibilities;
- New technology and other innovations should be embraced to build training capacity and support health workers in their work at all levels;
- MoUs should be developed between governments and NGOs/FBOs to formalise and regulate the role that these organisations play in improving access to health workers at the frontline;
- Ministries of Health should engage other sectors including Ministries of Education, Finance and the Public Service in efforts to strengthen the health workforce;
- Where they do not already exist, inter-agency coordinating committees on HRH, such as the Country Coordination and Facilitation (CCF) mechanism, chaired by Ministries of health, should be established;
- National HRH conferences should be organised to share best practices and facilitate closer coordination between partners;
- Health workers, communities, civil society and sub-national level health services should be involved in the development, monitoring and accountability of national health plans in order to increase national ownership;
- More parliamentarians should be encouraged to engage in HRH issues and hold governments to account for their commitments;
- Governments should disseminate information about progress towards HRH commitments/policies (including commitments to Every Woman, Every Child, the Global Plan and WHO Code of Conduct on International Recruitment of Health personnel) through the media, national coordination mechanisms, civil society networks, and other relevant channels;
- Governments should increase overall investment in healthcare, in line with the Abuja target of 15%, and allocate a sufficient proportion to HRH and to services at the frontline;

Regionally:

- Continental and regional bodies should create and facilitate platforms for countries to share learning and best practices for improving access to health workers at the frontline;
- Regional organisations should also facilitate efforts to standardise CHW practice, harmonise training curricula and task-shifting guidelines across the region;

At the Global Level

- All stakeholders should recognise the vital work of health workers at the frontline and their value in ensuring equitable access to key health services;
- All stakeholders should work together to develop mechanisms for the translation and adaptation/adoption of global and continental HRH initiatives into specific country contexts and needs, including clear monitoring and evaluation processes;
- Development partners, technical agencies and research institutions should work with countries to build a stronger evidence base on the most effective ways of improving access to health workers at the frontline and maximising the impact of different cadres of health workers;

- Development partners and donor agencies should increase financial and technical assistance to support countries to develop evidence-based policies and implementation of HRH commitments and plans.

A call to action

It was agreed that business as usual would not be enough to achieve the breakthroughs required in maternal and child health and HIV. At the conclusion of the consultation, participants made a call to all stakeholders to use these recommendations as a basis for further action in improving access to health workers at the frontline for better maternal and child survival, and build on them as appropriate, tailored to specific policy and implementation contexts. Participants committed to inform decision makers, colleagues and partners about the outcomes of the consultation and to feed these recommendations into maternal and child health policy and accountability processes at regional and global level.

3.1 Communique of the Consultation

At the conclusion of the Consultation, the participants adopted a communique that, among others called upon countries, development partners, NGOs, FBOs and academia, to act together in furtherance of better maternal and child survival. The full text appears at the beginning of this report (Pp 2-3).



List of Acronyms

<5MR:	Under-five mortality rate
ACHEST:	African Centre for Global Health and Social Transformation
AIDS:	Acquired immune deficiency syndrome
AIHLD:	African Institute of Health and Leadership Development
AMREF:	African Medical and Research Foundation
ANC:	Antenatal care
APHRH:	African Platform on Human Resources for Health
ART:	Anti-retroviral therapy
AUC:	African Union Commission
CARMMA:	Campaign for the Accelerated Reduction of Maternal Mortality in Africa
CBP:	Community based provider
CCF:	Country coordination facilitation
CHAK:	Christian Health Association of Kenya
CHAM:	Christian Health Association of Malawi
CHWs:	Community health workers
COPECSA:	College of Pathologists of East, Central and Southern Africa
COSECSA:	College of Surgeons of East, Central and Southern Africa
CPR:	Contraceptive prevalence rate
CSOs:	Civil Society Organizations
DFID:	Department for International Development (UK)
DHS:	Demographic and household survey
DNA PCR:	Deoxyribonucleic acid polymerase chain reaction
DRC:	Democratic Republic of Congo
ECSA HC:	East, Central and Southern African Health Community
ECSACOGS:	East, Central and Southern African College of Obstetricians and Obstetricians
ECSACON:	East, Central, and Southern African College of Nurses
EGPAF:	Elizabeth Glaser Pediatric AIDS Foundation
EmOC:	Emergency Obstetric Care
eMTCT:	Elimination of mother to child transmission
EQUINET:	Regional Network for Equity in Health in East and Southern Africa
EWEC:	<i>UN Global Strategy for Women's and Children's Health (Every Woman Every Child)</i>
FBOs:	Faith based organisation
FP:	Family planning
GFATM:	Global Fund to Fight AIDS, TB and Malaria
GHWA:	Global Health Workforce Alliance
HIV:	Human immunodeficiency virus
HMC:	Health Ministers' Conference
HRAA:	Human Resources Alliance for Africa
HRH:	Human resources for health
HRIS:	Human Resources Information System
HSAs:	Health surveillance assistants
HTF:	Health Transition Fund
ICT:	Information and communication technology
IHP+:	International Health Partnership
IMR:	Infant mortality rate
IYCF:	Infant and young child feeding
KIT:	Royal Tropical Institute (Amsterdam)
LMICs:	Low and middle income countries
m2m:	Mother-to-Mother
MDGs:	Millennium Development Goals

MLHWs: Mid-level health workers
 MMR: Maternal mortality rate
 MNCH: Maternal, new born and child health
 MoH: Ministry of Health
 MOHCW: Ministry of Health and Child Welfare (Zimbabwe)
 MOU: Memorandum of understanding
 MTCT: Mother to child transmission
 NCHS: National Catholic Health Services (Ghana)
 NGOs: Non-government organisations
 Norad: Norwegian Agency for Development Cooperation
 OCEAC: Coordination Organisation for the Fight against Endemic Diseases in Central Africa

 PHC: Primary Health Care
 PMNCH: Partnership on Maternal, Newborn and Child Health
 PMTCT: prevention of mother to child transmission
 PPP: Public-Private Partnerships
 RECs: Regional economic communities/blocks
 RH: reproductive health
 RMNCH: Reproductive, maternal, new born and child health
 SADC: Southern African Development Cooperation
 SANNAM: Southern African Network of Nurses and Midwives
 SEAPACOH: Southern and Eastern African Parliamentary Committees on Health
 SSA: sub-Saharan Africa(n)
 STERP: Short Term Economic Recovery Plan
 UNAIDS: Joint United Nations Programme on HIV/AIDS
 UNFPA: United Nations Population Fund,
 UNH4+: UN Health Agencies (WHO, UNAIDS, UNICEF, UNFPA; plus others)
 UNICEF: United Nations Children's Fund
 UPMB: Uganda Protestant Medical Bureau
 VHW: Village health worker
 WAHO: West African Health Organization
 WHO: World Health Organization
 WHO-AFRO: World Health Organization Africa Region
 WOFAK: Women Fighting AIDS in Kenya
 WTO: World Trade Organization



Appendix 1. Participant List

Name	Country	Organisation
1. Mr Ngumbu Mbabaza Epiphane	DRC	Ministry of Health, Kinshasa
2. Dr Bernard Bossiky Ngoy Belly		
3. Dr Hyppolite Kalambay		
4. Dr Warren Namaara	Ethiopia	UNAIDS, Addis Ababa
5. Ms Zeleke Azeb Admassu		Federal Ministry of Health, Addis Ababa,
6. Mr Tamiru Michael Mesfin		
7. Mr George Adjei	Ghana	National Catholic Health Services, Accra
8. Dr Ken Sagoe		Ministry of Health, Accra
9. Mr James Antwi		
10. Mr Francis Victor Ekey		
11. Mrs Kate Badoe Sagoe		
12. Ms Rose Kumwenda N'goma	Malawi	Christian Health Association of Malawi; Lilongwe
13. Mr Michel Eliya		Ministry of Health, Lilongwe
14. Dr Thita Moses Dzowela		
15. Mr J Kalilangwe	Netherlands	KIT, Amsterdam.
16. Kathy Herschderfer		
17. Mr Aniefiok Moses	Nigeria	Federal Ministry of Health, Abuja, Nigeria
18. Mr Araoye Segilola	Norway	Norwegian Knowledge Center/Norad; Oslo
19. Dr Sigrun Mogedal		
20. Ms Ragnhild Seip		
21. Mr Bjarne Garden	South Africa	Norad, Oslo
22. Prof Yoswa M Dambisya		Regional Network for Equity in Health in East and Southern Africa (EQUINET)/University of Limpopo, Polokwane
23. Mr DA Sello		
24. Ms Barbara Makama		
25. Ms Thokozani Mohlahla		University of Limpopo, Polokwane
26. Prof NP Mbambo-Kekana		African Institute of Health and Leadership Development, Pretoria
27. Dr Percy Mahlathi		Save the Children, Pretoria
28. Karen Waltensperger	Switzerland	UNAIDS, , Geneva
29. Dr Karusa Kiragu		GHWA, Geneva, Switzerland
30. Dr Muhammed M Afzal	Swaziland	Human Resources Alliance for Africa, Mbabane
31. Dr Cosmas Musumali		
32. Ernest Manyawu	Tanzania	East, Central and Southern Africa Health Community, Arusha
33. Dr Rogers Ayiko		
34. Dr Ahmad M Makuwani		Ministry of Health and Social Welfare, Dar es Salaam
35. Elizabeth Sallu		
36. Dr Patrick Kadama		
37. Dr Vincent Ojome	Uganda	African Center for Global Health and Social Transformation, Kampala
38. Dr Lorna Muhirwe		Uganda Protestant Medical Bureau, Kampala
39. Prof Celestino Obua		Makerere University College of Health Sciences, Kampala
40. Dr Musa Bungudu		UNAIDS, Kampala
41. Mr Francis Ntalazi		Ministry of Health, Kampala
42. Dr Miriam Sentongo		
43. Dr Shaban Mugerwa		
44. Ms Louise Holly	UK	Save the Children, London
45. Dr Niel Squires	UK	DFID, London
46. Dr Barbara Stilwell	USA	IntraHealth International, Chapel Hill
47. Mr Thom Dauti Yungana		SANNAM/ZUNO, Lusaka
48. Dr. Lisulo Walubita		Ministry of Health, Lusaka
49. Dr. Chikama Mukwangule		
50. Mr. Lazarous Mulenda		

Name	Country	Organisation
51. Mrs Mercy Ulaya	Zambia	National AIDS Council, Lusaka
52. Ms Musuluma Nachilima		
53. Hon Blessing Chebundo		
54. Dr Angela Mushavi	Zimbabwe	SEAPACOH/Parliament of Zimbabwe, Harare
55. Ms Slyvia Kudakwashe		Ministry of Health and Child Welfare, Harare
56. Mr Michael Sande		Health Services Board, Harare
57. Dr Peter Ngatia		AMREF, AMREF International Training Center, Langata Road, Nairobi
58. Ms Victoria Kimotho	Kenya	EQUINET/Kenya Health Equity Network, Nairobi
59. Mr Charles Dulo		
60. Dr Mollent Okech		CapacityPlus, Nairobi
61. Ms Brenda Rao		Columbia Global Centers-Africa, Nairobi
62. Ms Catherine Kahare		EGPAF, Nairobi
63. Doris Mwarey		
64. Dr James Wariero		
65. Ms Rhoda Igweta		m2m, Nairobi
66. Dr Judith Kose-Otieno		
67. Dr Samuel Mwenda		Save the Children, Kenya; Nairobi
68. Ms Nicole Sijenyi Fulton		
69. Mr Duncan Ngari		
70. Ms Brenda Kariuki		
71. Mr Jack Onyando		
72. Mr Meshack Ndolo		
73. Dr James Mwanzia		
74. Mr Daniel Kapoot		
75. Mr Lawrence Kimoti		
76. Ms Terry Achieng	Kenya Nursing Association, Nairobi	
77. Mr Hassan Ihuto		
78. Mrs Ruth Ngechu	Kenya	Ministry of Public Health and Sanitation, Nairobi
79. David Njoroge		
80. Dr Lucy Musyoka		Ministry of Medical Services, Afya House, Nairobi
81. Mr William Okoyo		
82. Ms Judy Sirima		NASCOP, 19361-00202, Nairobi.
83. Mr Chris Rakoum		WOFAK, Nairobi
84. Dr Agatha Olago		UNICEF; UN Complex, Nairobi
85. Ms Carole Odada		International Medical Corps, Rhapta Road, Westland, Nairobi
86. Dr Nande Putta		UZIMA Foundation, Nairobi
87. Mrs Rose Muthoni Njiraini		Global Plan Secretariat, Nairobi
88. Prof Miriam Were		
89. Dr Nicholas Muraguri		
90. Ms Catherine Bilger		
91. Mr Luke Kodambo		
92. Dr T Monique James		
93. Mr Gilbert Wamalwa		
94. Ms Jackline Aridi		
95. Ms Angela Mutunga		
96. Mr Martin Osok		
97. Hon Prof P Anyang' Nyong'o	Freelance Photographer	
	CGC Africa; Nairobi	
	FCI Kenya, Nairobi	
	World Vision Kenya, Nairobi	
	Ministry of Medical Services, Nairobi	

Appendix 2: Programme of the Consultation.

Consultation of Frontline Health Workers: Acting on What We Know

Nairobi, Kenya; 25-27 June 2012

Sunday June 24 2012	
14:00 – 20:00	Arrival and Registration
Monday June 25 2012: Day 1: Consolidating Country Actions and Plans	
08.00 – 09.00	<i>Registration</i>
09.00 – 10.00 Chair: Patrick Kadama Rapporteur: Tanzania	Session 1: Setting the Scene <ul style="list-style-type: none"> Welcome Remarks and Introductions - Chair Administrative issues – Charles Dulo, EQUINET Overview – The consultation at a glance – Yoswa Dambisya - EQUINET Objectives, expected outcomes and methods of work – Sigrun Mogadel (Norad/UNAIDS) Feedback on the USAID CHW Summit – Peter Ngatia – AMREF
10.00 – 10:30	TEA BREAK
11.00 – 13:00 <i>5-7 min interventions supported by briefs in folder</i> Rapporteur: Uganda	Session 2: Opportunities for global and regional cooperation/synergies Panel 1: Chair: Ken Sagoe (Ghana) <ul style="list-style-type: none"> Regional perspective – ECSA HC –Ernest Manyawu The African Response – African Platform for HRH/ACHEST – Patrick Kadama Community Health Workers, new inputs on evidence – Intrahealth – Barbara Stilwell Community Health Workers – Issues from the KIT Conference - Kathy Herschderfer (KIT) Panel 2: Chair: Angela Mushavi (Zimbabwe) <ul style="list-style-type: none"> Global and Country Collaboration on HRH - Muhammad Afzal (GHWA) The Global Plan – implications for HRH – Karusa Kiragu (UNAIDS) <i>Questions and discussion of synergies</i>
13:00 – 14:00	LUNCH
14:00-15:30 <i>Sharing based on country issue notes prepared before the consultation</i> Each group to appoint a rapporteur	Session 3: Small groups - Country Realities - Chair – Samuel Mwenda Group 1: Ethiopia, Nigeria, Zambia and Uganda- Moderator – Dr MM Afzal (GHWA) Group 2: Malawi, Tanzania, Zimbabwe– Moderator – Prof Mbambo-Kekana (Univ Limpopo) Group 3: Kenya, Ghana and DRC – Moderator – Warren Namaara (UNAIDS) Exploring country experience with action on HRH for EWEC and the Global Plan in the context of broader HRH and system responses, with respect to: <ul style="list-style-type: none"> - HRH planning, links between health facility based and community based workforce - RH/MNCH services and PMTCT, - Experiences from non-state sector - Organizational and regulatory issues, demand and continuity in services, retention, skill mix and incentives. - What works, success factors, what could be improved, and links between HRH planning, RH/MNCH, the Global Plan, EWEC); Barriers/challenges.
15:30 – 16:00	BREAK
16:00 – 17:00 <i>Group moderators & Consultation Facilitator</i> Rapporteur: Kenya	Session 4: Feedback session – Chair – Yoswa Dambisya Discussions <ul style="list-style-type: none"> Consensus on what to present to the bigger meeting. Summary with emphasis on successful practices, challenges, lessons, cross-cutting issues and next steps. Promising areas where recommendations can be pursued in the consultation
17:00 -17:30	Facilitators' meeting; Country team meetings
18:00-19:00	GHWA – African Platform on HRH Side Session (By invitation)

Tuesday June 26 2012: Day 2: What We Know	
08.00 – 08.30	Registration
08.30 – 09.30 <i>Chair: Dr Peter Ngatia, AMREF Rapporteur - Zimbabwe</i>	Session 1: Formal opening <ul style="list-style-type: none"> • Welcome Remarks : EQUINET – Yoswa Dambisya • Remarks by CSOs – Caroline Odada, Women Fighting AIDS in Kenya (WOFAK) • Remarks by Norad – Bjarne Garden • Reamarks by IntraHealth – Barbara Stilwell • Reflections on Implications of Health Workers at the Frontline for Better Maternal and Child Survival – Prof Miriam Were • Official Opening: Chief Guest: Minister of Medical Services, Hon Prof P Anyang' Nyong'o <p>Overview of program for the day – Percy Mahlathi - Consultation Facilitator</p>
09:30 – 10:30 <i>Moderator: Dr James Mwanzia (Intrahealth); Rapporteur – Nigeria</i>	Session 2: The HRH response in Context: issues and opportunities <ul style="list-style-type: none"> • “Every Women Every Child” – scale up and accountability – Karusa Kiragu • The “Global Plan” – bottleneck analysis; Global Plan Secretariat (N.Muraguri) • Achieving a coordinated response – Nande Putta, UNICEF • Role of the non-government sector – Rose Kumwenda N’goma – CHAM, Malawi <p>Discussion and consolidation of identified issues and opportunities</p>
10.30 – 11.00	TEA BREAK
11:00 – 13:00 <i>Moderator: Karusa Kiragu UNAIDS Rapporteur - Ghana</i>	Session 3: Country responses, overview of progress and challenges <ul style="list-style-type: none"> • Summary from previous day’s country deliberations; what works? Where are we “stuck” and why? – Nigeria <i>20 Minute Interventions/Discussion</i> • Models and innovations, and what makes it work <ul style="list-style-type: none"> ○ Decentralization in Malawi and Implications for HRH - Michael Eliya Phiri ○ Education is a service that needs to be shifted - Nicole Sijenyi Fulton – m2m ○ Government collaboration with non-government players – Angela Mushavi, Zimbabwe <p>Discussion: Identification of key issues and opportunities that require in-depth discussion in groups</p>
13:00 – 14:00	LUNCH
14:00-15:30 <i>Each group will choose Chair and rapporteur; There will be a resource person allocated to each group Facilitator: Percy Mahlathi</i>	Session 4: Group work – 90 minutes Mixed country delegations, NGOs, H4+ partners : Discussions based on identified promising practices, synergies, gaps and bottlenecks from Day 1; Reflect on, e.g.: <ul style="list-style-type: none"> • EWEC/Global Plan HRH needs and opportunities for synergies. Examine country plans and responses for achieving synergies and dissonance; relationship to broader HRH plans and investments; identify resources/solutions • What do we know about the gaps in access to skilled HRH for MNCH and PMTCT • Issues related to global-national-local interaction and how to converge efforts to strengthen African leadership for action and results. • Public/NGO/private interactions and how to scale up in a way that is aligned and build on best practices
15:30 – 16:00	BREAK
16:00 – 17:00 <i>Moderator: Ernest Manyawu Rapporteur - Malawi</i>	Session 4: Feedback session <ul style="list-style-type: none"> • Key issues from the group work • Discussion
17:00 -17:30	Facilitators’ meeting; Country team meetings
18:00 –19.30	Reception with “market place” on models and innovation – Hosted by Norad

Wednesday 27 June 2012 Day 3: Acting on What We Know

<p>08.30 – 10.00 <i>Moderator Neil Squires</i> <i>UK aid</i> Rapporteur: Zambia</p>	<p>Session 1: Working together to overcome the gaps</p> <ul style="list-style-type: none"> • Reflections on Day 2 proceedings – Percy Mahlathi • The need for increased production of health workers – challenges of training skilled health professionals in resource constrained settings – Prof NP Mbambo-Kekana, Univ of Limpopo • Financing of HRH for MNCH and PMTCT – Michael Sande , Health Service Board, Zimbabwe • Parliamentary Committees on Health– Hon Blessing Chebundo SEAPACOH. <p>Discussion – Common Issues going forward</p>
<p>10.00 – 10:30</p>	<p>TEA BREAK</p>
<p>10.30 – 11:30 <i>Each panelist presents for max 5 min.</i> <i>Moderator: Sigrun Mogedal</i> Rapporteur: Zimbabwe</p>	<p>Session 2: Panel Discussion: The role of different partners at global, national & local levels Panelists: Ken Sagoe (Ghana), Bjarne Garden (GHWA), Patrick Kadama (African Platform on HRH), Meshack Ndolo (Intrahealth), Hyppolite Kalambay (IHP+), Thom Yungana (SANNAM), PMNCH (Angela Mutunga) General discussions/comments</p>
<p>11:30-13:00 <i>Consolidating the message</i> <i>Facilitator: Musa Bungudu</i></p>	<p>Session 3: Group work – Acting on what we know within country plans</p> <ul style="list-style-type: none"> • Mixed groups reflecting on action areas identified <ul style="list-style-type: none"> ○ Recommendations on next steps for countries and for global actors ○ Responses from partners <p>Each group to choose Chair and Rapporteur</p> <ul style="list-style-type: none"> • Drafting Committee: Statement on the Consultation
<p>13:00 – 14:00</p>	<p>LUNCH</p>
<p>14:00-15:30 <i>Moderator – Louise Holly SCF</i> <i>Rapporteur – Ethiopia</i></p>	<p>Session 4: Plenary</p> <ul style="list-style-type: none"> • Feedback from the groups - recommendations • Final set of recommendations – Percy Mahlathi • Presentation and Discussion of the Statement – Yoswa Dambisya
<p>15:30 – 16:00</p>	<p>BREAK</p>
<p><i>16:00 – 17:00</i> <i>Moderator: Bjarne Garden Norad</i> <i>Rapporteur: Mollent Okech</i></p>	<p>Session 5: Closing</p> <ul style="list-style-type: none"> • African leadership responses – African Platform • Global partner responses – H4+ • Country stakeholder responses - Zambia • Adoption of the Communique of the Consultation • Official Closure of Meeting – Prof Miriam Were
<p>17:00 -17:30</p>	<p>Facilitators and Organizers Exit Meeting</p>