Meeting of the Africa Health Workforce Observatory

September 26-29, 2006
Arusha, Tanzania

Contents

EXECUTIVE SUMMARY

1.1 Background

Most African countries are challenged with weak and inadequate health systems as evidenced by unsatisfactory health status indicators. Most of the health infrastructure is in a dilapidated state; essential equipment, supplies and logistics are often lacking, and referral systems are rarely functional while HIV/AIDS, tuberculosis, malaria and other priority diseases are rampant. A critical obstacle to strengthening health systems is the health workforce crisis that is present in one form or another.

The World Health Report 2006 reports a shortage of 800,000 nurses, doctors and midwives in the African region; the current workforce would need to be doubled to eliminate this shortage. This is a key obstacle to achieving the Millennium Development Goals. The African region carries 24% of the global disease burden but has only 3% of the world's health workers and less than 1% of the world's financial resources for health. Exacerbating this shortfall is the increase in migration of health workers and the impact of emerging diseases.

Responding to this health workforce crisis, approximately 90 participants from 14 African countries and international organizations have joined forces to form the Africa Health Workforce Observatory. The East, Central and Southern Africa (ECSA) Health Community, the World Health Organization (WHO), the World Bank and the Capacity Project (funded by the United States Agency for International Development [USAID]) partnered to accelerate the establishment of the Observatory.

The Africa Health Workforce Observatory is proposed as a cooperative network initiative among the countries and partners of the region. It is intended to serve as a mechanism for promoting health and health workforce policy dialogue, sharing information and forming partnerships to strengthen health workforce systems and human resources for health (HRH) policy development in Africa. Members are collaborating at the national and regional levels to share information, form strategic partnerships and support informed human resources policy and planning decisions.

The Regional Consultation to move the HRH agenda forward, held in Brazzaville in July 2005, strongly supported the establishment of the Africa Health Workforce Observatory and asked WHO to facilitate the process of mobilizing the Observatory. Since then, significant progress has been made. Representatives of ECSA Health Community, WHO, World Bank and the Capacity Project came together in Arusha, Tanzania, on July 10, 2006, to plan for the joint meeting summarized in this report.

The European Commission provided input in order to build a link between the work on the Observatory and technical inputs into an Inter-Ministerial Meeting on HRH held in Brazzaville in November 2006.

1.2 Overview of meeting

The Africa Health Workforce Observatory meeting was co-hosted by the Capacity Project, ECSA Health Community, World Bank and WHO. Held September 26-29, 2006, at the ECSA headquarters in Arusha, Tanzania, the meeting focused on developing mechanisms to create up-to-date and reliable information that enables evidence-based decision making for HRH.

Participants from 14 African countries attended, including human resources directors, researchers, academicians, managers of human resources information systems (HRIS) and heads of professional regulatory bodies.

The objectives of the meeting were to:

- Introduce and mobilize support for the Observatory at the regional and national level

- Identify key health workforce policy issues
- Discuss health workforce information and monitoring systems, including key indicators and methods for sharing data
- Discuss methods for health workforce supply and demand analysis
- Identify issues to be submitted to the ministerial meeting.

The meeting also presented an opportunity for global donors to listen to countries' needs and engage in collaborative discussions about solutions. Attendees cited the highly participatory methodology, designed to emphasize knowledge sharing, as a highlight of the meeting. Participants made significant progress in building consensus and developing a sustainable center in the region for HRIS strengthening. Each participating country will maintain momentum through the country-level action plans.

1.3 Participants

Participants came from Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mauritius, Namibia, Rwanda, Seychelles, Swaziland, Tanzania (mainland and Zanzibar), Uganda, Zambia and Zimbabwe. Organizations and institutions that were represented included the World Bank, WHO, Capacity Project, ECSA Health Community, the European Commission, Oxford Policy Management, Norwegian Agency for Development Cooperation (NORAD), COMSEC-London, Georgetown University, CDC-Emory University Project, ACOSHED, GTZ and I-TECH.

1.4 Initial outcomes

The Africa Health Workforce Observatory meeting ended with a call to put in place a plan of action for the participating countries' respective national observatories.

Health and medical experts from Africa and development partners supporting the health sector in the continent stressed at the end of the meeting that the concept of the Africa Health Workforce Observatory should be further communicated to policy makers.

Participants planned to report back to their colleagues on the concept of the Africa Health Workforce Observatory and to share and finalize the initial draft of the "Plan of Action" for national observatories. Participants also planned to report back to the permanent secretaries in their respective ministries of health to build support, advocacy and awareness of the issues.

The WHO pledged support for countries based on specific requests and functions of the secretariat. The Africa Health Workforce Observatory was requested to follow up on the progress of the formation of national observatories and to make available the status report from the data on the African region. As part of its mandate as a global initiative to plan, develop and support the health workforce, the Capacity Project will provide software and other necessary support for countries willing to establish national observatories.

The Secretariat of the Africa Regional Observatory is initially based at the WHO African Regional Office in Brazzaville. It will be relocated elsewhere later if need arises.

AFRICA HEALTH WORKFORCE OBSERVATORY

On the first day, Dr. Steven Shongwe of ECSA Health Community made welcoming remarks and introductions.

The meeting's opening address was delivered by Dr. Gilbert R. Mliga, Acting Permanent Secretary, Ministry of Health and Social Welfare, Tanzania, and Director of Human Resources Development at the Ministry of Health. He stated that the African continent is heavily challenged by critical problems affecting delivery of quality health care services, which include the weak, inadequate and dilapidated health infrastructure, inadequate essential equipment, supplies and logistics, dependency on out-of-pocket health financing to the detriment of the poor and non-functioning referral systems. Exacerbating all these problems is the HRH shortage that has reached a crisis level.

A number of events in the last few years have highlighted the magnitude and seriousness of the health workforce problems—globally and especially in Africa. One of the issues that has been identified is the need for better information and knowledge-sharing about the health workforce. Thus a health workforce observatory was proposed as one of the mechanisms to address this challenge.

2.1 Africa Health Workforce Observatory

The Africa Health Workforce Observatory is envisaged as a cooperative network initiative among the countries and partners of the region as well as a forum for networking at the country level for national observatories (which bring together stakeholders at the country level) to produce information and knowledge necessary for improving human resources policy decisions. The Observatory is also expected to function as a strong vehicle for sharing information and building capacity in order to improve health workforce development.

The general objectives of the Observatory are: 1) to develop national capacity for monitoring and evaluation of the HRH situation and trends; 2) to provide information and evidence on the formulation of HRH development policies, strategies and plans; 3) to provide a forum for partnership, sharing of experience and advocacy in HRH development; and 4) to facilitate the use of HRH data for informed decision-making at all levels of the health system. The functions of the Observatory include country monitoring and information, research and analysis, sharing and dissemination and capacity-building for HRH.

2.2 National health workforce observatories in Africa

Participants emphasized that the formation of national workforce observatories would not be a duplication of existing HRH structures and systems in member countries. The possible functions, similar to those of the Africa Health Workforce Observatory, include monitoring HR trends, undertaking studies and research, sharing information, contributing to capacity building and engaging in policy dialogues.

Ethiopia and Ghana, two African countries that have started national observatories, shared their experiences. The example of the Brazil Observatory has also been presented as a well-established case in existence for almost a decade.

2.3 Progress of HRH work in Ethiopia

Yohannes Tadesse of the Ministry of Health (MOH), Ethiopia, made a presentation on Ethiopia's experiences in building a national HRH observatory. Tadesse explained that the MOH approved the idea immediately when it was floated to stakeholders in the sector. The HRH program was officially launched in April 2006. The first meeting of the National Observatory took place on July 13, 2006.

2.4 Ghana Health Workforce Observatory

After the initial discussions and plans at the West African Health Organization (WAHO) meeting, which was held in Ouagadougou on August 14-16, 2006, the MOH began advocacy to obtain government commitment through the Minister of Health. The following actions have taken place or were planned:

- The MOH has accepted the proposal to become a coordinating body and will appoint a focal person
- The Ministry has identified stakeholders and the human resources task team can provide a good base for the Observatory
- The Ministry has identified a source of funding
- Stakeholders need to be oriented and sensitized
- The observatory group will be inaugurated
- A steering committee will be set up to monitor (an independent group with just a few members of the observatory group)
- The Observatory group will develop work plans and budgets.

2.5 Working cooperatively: the Brazilian HRH observatory network

The Brazilian HRH Observatory network was officially established by Ministerial Directive in 1999 and is co-chaired by the MOH and PAHO/Brazil. The Brazil HRH Observatory is considered the more successful initiative within the HRH Observatory network in the Americas. It has 21 working stations in different areas related to the health workforce such as demographics, training, employment, professional regulation and management information systems. It has initiated horizontal cooperation with other working stations, including shared projects and a website.

2.6 Working groups

Six working groups formed to discuss the presentations and the Africa Health Workforce Observatory as a whole. The working groups considered the following questions:

What are your expectations from the Africa Health Workforce Observatory? How do you see countries benefiting from the establishment of the Observatory?

- Condense information on HR
- Champion HR
- Build capacity in HR
- Harmonize standards and definitions
- Promote evidence-based policy making
- Form working groups
- Help with health sector reform
- Engage in joint planning
- Conduct studies and have a network of researchers
- Compare indicators
- Link information systems
- Develop approaches from various experiences
- Analyze data and flow of data, upgrade systems

    Benefits
- Member states will get to know common problems and come up with strategies to overcome the HR crisis
- After understanding each others' strengths and weaknesses, countries can help each other
- Member states can discuss with development partners that aid not accompanied by capacity building will not have impact

- Information that leverages development will influence how donors invest in the continent, ensuring wider-based and longer-term investment in health sector

Who are the different stakeholders and partners you would involve/include in relation to the Observatory? What do you see as their role?

- Ministry of Health
- Ministry of Finance
- Ministry of Education
- Ministry of Social Welfare
- Ministry of Public Service
- Research institutions
- Non-governmental organizations
- Private sector
- Faith-based organizations
- Regulatory bodies
- Development partners
- Health professional associations
- Parliamentarians
- Unions
- Bilaterals

Roles
- Employers: Generate and use the information
- Producers: Provide information on training
- Researchers: Generate information
- Partners: Resources mobilization/technical assistance/skills transfer
- Donors/partners: Contribute to policies in place at MOH for HRH
- Non-health providers: Use advocacy to help get policies approved
- Research organizations/institutions: Provide evidence base to guide the policies in each country

How should the regional secretariat (currently based in WHO regional office) function in facilitating and coordinating the activities of national observatories?

- Harmonize and standardize data to enable comparative studies
- Mobilize resources
- Organize meetings and workshops
- Disseminate best practices
- Facilitate networking
- Help to facilitate capacity building
- Develop analytical tools and guidelines
- Conduct data analysis
- Share experiences
- Conduct research and documentation
- Identify information gaps
- Make website and updates available
- Supervise ongoing activities
- Provide guidelines and keep overall database for Africa region

What suggestions do you have to make observatories work at the country level?

- Identify partners
- Identify stakeholders

- Identify focal point within Ministry of Health
- Identify focal point for data linkage due to existence of many systems
- Have common guidelines
- Strengthen political will
- Create a mechanism in which to trace the available infomation for public use
- Establish mandate/legitimacy of the Observatory
- Identify champions
- Develop online sessions and work through the challenges being faced
- Have clear terms of reference and tasks
- Have a legal framework and commitment from highest level in the government

INFORMATION SYSTEMS

Many developing countries are facing daunting obstacles to meeting the health care needs of their people. A critical challenge to training, deploying and retaining the health workforce is the lack of current, accurate data about health professionals working in the countries. Even where data are collected, usually on paper forms, that data often cannot be used effectively.

Decision makers may not know, for example, how many doctors and nurses are being trained and in what specialties, how health workers are distributed across urban and rural areas, why health professionals are leaving the health workforce and other critical pieces of information necessary to assemble an effective HRH strategy. Understanding the answers to these and other key policy questions will help decision makers effectively plan to ensure a steady supply of trained health professionals, deploy human resources in the correct positions and locations to meet health care needs and retain health worker skills and experience in the country.

A mature and complete HRIS links all human resources data from the time health professionals enter pre-service training to when they leave the health workforce. Using the system, decision makers can quickly find the answers they need to assess HRH problems, plan effective interventions and evaluate those interventions.

3.1 Current status of health workforce data and information

WHO presented on the current status of health workforce data and information. Below is a summary of the presentation and discussions that followed.

The World Health Report 2006 reported a shortage of 800,000 nurses, doctors and midwives in the African region. Responding to this need would require doubling the current workforce, and is thus a key obstacle in achieving the Millennium Development Goals. The African region carries 24% of the global disease burden, yet has only 3% of the world's health workers and less than 1% of the world's financial resources for health. Exacerbating this shortfall is the increase in migration of health workers and the devastating impact HIV/AIDS and other emerging diseases have had on the health community. African countries encounter serious constraints to maintaining accurate health workforce data and information, such as:

- Lack of well-functioning national HRH databases
- Few, if any, electronic versions of health workforce records readily available
- Inadequate financial, technical and human resources in HRD departments
- Numerous health care cadres (up to 70 per country) , many of which are country-specific and therefore difficult to compare
- Additional technical challenges for statistics, like dual employment, ghost workers and registration methods.

In 2005 WHO conducted a survey of African countries, covering health workforce profiles and training institutions, in order to have a better understanding of the health workforce availability and distribution in the continent. The results of the survey contributed to the World Health Report and are made available in the global health workforce atlas. A more detailed analysis can be found at the Africa Health Workforce Observatory website.

A number of challenges are faced in improving information. There is a need to:

- Institutionalize the process for regular data collection
- Improve capacity to analyze various data sources

- Improve coordination and collaboration among public/private, academic and professional associations
- Ensure financial support for improving and updating health workforce information and maintenance of databases
- Improve sharing and feedback mechanisms through the internet, regional reports, etc.

3.2 Potential data sources: strengths, weaknesses and data quality

From the presentation and ensuing discussion, the following three types of data sources for health workforce information were identified:

- Socioeconomic and demographic
    - o Demographic censuses and household surveys and polls
- Institutional
    - o Economic censuses or establishment (or facilities) surveys
- Administrative registers and other data sources
    - o Public and private health provider statistics and social security database: productivity and outcomes; mechanisms of payment; demographic data of employed people, etc.
    - o Labor registration databases: professional skills; salaries; turnover; assessment to social benefits and unemployment (e.g., registered workers, certification, etc.)
    - o National health accounts: flows of sources to finance HWF in public and private sectors; share of HWF in the global costs of health sector
    - o Colleges and vocational schools databases: statistics about graduation by type of professions in post secondary and university levels
    - o Unions databases: statistics about affiliation to unions.

Each data source has its opportunities and limitations. For example, household surveys and censuses contain useful statistics such as gender, age, sex and employment, but the regularity of data is restrictive (most are available only at ten-year intervals).

Labor surveys are a good source of HRH information because they contain the hours of work, remuneration and contract types, but they are limited because the data is not necessarily representative of the health sector. There needs to be collaboration between the MOH, Labor, National Planning and the various employers.

Economic censuses focus on job positions, not on people. Many variables including categories, skills, time of employment, and contract types are needed. In many cases major differences exist in the classification of health professionals.

Data quality is another major concern. The data need to be *complete, consistent, correct, timely, accessible and relevant (useful)*. Some strategies to improve data quality include the use of paper forms, data entry strategies, continuous review and improvement feedback and the systematic cross-check between systems.

3.3 Use of administrative data

The Capacity Project has developed a process for strengthening HRIS within a country and providing decision-makers with the knowledge of how to analyze and make decisions based on human resources data. The principles underlying this process are:

- A participatory approach that involves all stakeholders from the outset and gives them ownership of the system
- An iterative development methodology that incorporates existing systems, tools and processes as much as possible to lower costs and speed up implementation

- Mature software designed for the country context and to answer the key HR policy questions for that country
- Building capacity, ensuring sustainability and continuously improving the system through training and technical support
- Teaching decision-makers how to analyze and use the data that the HRIS provides to make sound HR decisions.

The critical features of successfully strengthening HRIS are:

- Key HRH stakeholders' support of and participation in the project
- Responsiveness to HR policy and management questions, as determined by these stakeholders
- Capacity building through training, strengthening infrastructure and improving technical support
- Progression in planned, iterative steps toward a complete and mature solution
- Fostering use of the data for informed, effective decision-making
- Building sustainability and continuous improvement of the system into the process from the outset.

For more information visit http://www.capacityproject.org/hris or email hris@capacityproject.org.

3.4 Experience of the Nursing Council of Kenya

The Nursing Council of Kenya gave a presentation on the case of Kenyan nurses. The presentation suggested that it was unfortunate that workforce information has been in paper form for a long time in different agencies. This has made it impossible to assess current workforce needs to facilitate the development of plans to meet the country's growing health care requirements. However, with the support of the Lillian Carter Center for International Nursing, the nursing workforce data in Kenya have been computerized and analyzed. A comprehensive nursing workforce database is based upon both supply and demand data. The database can be used to assess the supply of nurses (and their characteristics) and the demand for nurse employees (and their characteristics) over time.

3.5 The need for HRIS strengthening in Swaziland

Swaziland has had missing or incomplete data for decision making, as the systems that existed for a long time were not complementing each other. Information flow was very slow and not received by all who needed it. Pieces of data were stored separately in unlinked systems. Managers lacked timely information about staff movements. Other problems included a delay in updating records and lack of effective procedures for updating data at the Ministry of Health and Social Welfare.

3.6 Initiative to commence and institutionalize the collection of data on Availability, Profiles, and Distribution (APD) of HRH: Malawi

A presentation by Christopher H. Herbst of the World Bank provided an overview of potential World Bank assistance for Malawi to commence and institutionalize the collection of data on availability, distribution and profiles (ADP) of health workers. Data on availability should include data on the number of different health cadres, data on distribution should include data on geographical and institutional distribution of cadres (across districts, sectors, urban-rural divides, facility types) and data on profiles should include data on sex, age, educational attainment, etc. The Government had requested technical assistance in conducting a facility level survey to obtain such data, crucial to guide, accelerate, improve and target HRH program and policy development at the national level. At the same time, World Bank assistance was requested to help create appropriate mechanisms to facilitate regular updating of ADP health worker data. This was deemed necessary not only to keep data up to date, but to track ADP data over time and determine whether HRH benchmarks are being achieved and whether policies and programs related to HRH are actually working. Furthermore, the institutionalization of routine HRH data collection and analysis can also reduce the number of ghost workers that strain budgets and facilitate the timely identification and filling of empty posts.

Herbst stressed that collection, institutionalization, analysis and interpretation of health worker ADP data in Malawi would be fully country-led. To ensure sustainability of data collection efforts, the planned facility level survey would have to be conducted in close collaboration with health authorities at the district level. This would facilitate a country-led process to promote ownership for collection and analysis of data. World Bank assistance to Malawi would involve working closely with the MOH and district health authorities and focus on building capacity in such areas as designing data collection tools, building district level capacity to regularly collect, enter, store and maintain data as well as capacity to analyze and interpret data. Weak capacity in these areas frequently explain low quality, out of date and insufficient health worker ADP data in many countries. The World Bank would also assist in computing required indicators and help translate these into policy and program recommendations once the facility level census was complete. To conclude, Herbst stressed that the proposed initiative in Malawi was still at a very early stage, and he invited suggestions from the audience to help secure its success.

3.7 Role and development of stakeholder leadership groups to guide national HRH Observatories: Ugandan experience

Representing the Capacity Project, Pam McQuide, Edward Mukooyo and Paul Kiwanuka-Mukiibi explained that the Project has found the Stakeholder Leadership Group (SLG) to be a promising practice for engaging different stakeholders and partners to rally together to address HRH issues. The SLG is a participatory approach to ensure ownership, empower stakeholders, build capacity, communicate needs and share with other ministries, sectors, countries and regions. The SLG can include representatives or managers from various ministries (Health, Finance, Public Service), human resources departments, HRIS units, training organizations and registrars from Health Councils.

The role of the SLG is to lead, coordinate, harmonize and provide oversight functions for HRIS-related activities in the country. To ensure a well-functioning team, it is critical to establish a framework for the SLG, including obtaining consensus on the mission and purpose, agreeing on principles of operation (e.g., transparency), establishing an organizational structure (e.g., nominating chairperson, establishing meeting location) and developing a timeline for activities and meetings.

The experience from the SLG in Uganda was shared. The SLG in Uganda has undertaken activities such as participating in World Health Day, looking at supportive supervision and safety in the workplace and centralizing the HRH database. The SLG places emphasis on country ownership and wishes to expand the role of other stakeholders. The Ugandan experience illustrates that it is worthwhile to bring stakeholders together to ensure a country-led process, ownership and a participatory approach.

One of the main challenges in Uganda arose through the art of the process—bringing together stakeholders with different priorities. These challenges were overcome through agreement on principles of work, understanding the different points of view and interests, emphasizing the project's objectives, focusing on outputs, being as transparent as possible (in terms of members' different objectives and resources) and having regular meetings.

3.8 Need for current, reliable HRIS: Ugandan example

Pam McQuide and Rita Matte drew from their experiences in Uganda to discuss the importance of current and accurate HR information systems. In the developing world, the demand for medical professionals is increasing while the supply is decreasing. To address this challenge, reliable HR data are required. Good HRIS data are needed for training (quantity and cadre), registration (qualified supply), deployment (needs by site and cadre), management (personnel and payroll) and planning (future needs). To strengthen the HRIS, the process involves forming a Stakeholder Leadership Group, defining HR policy questions, assessing and strengthening infrastructure, adapting and implementing software, integrating existing systems and ensuring sustainability and continuous improvement.

3.9 Data quality issues in practice: Ugandan experience

Samwel Wakibi discussed the data quality challenges in his work with the Uganda Nursing Council. Searches by index and registration number were impossible. A method was found to solve the linking problem but is dependent on excellent data quality. Sophisticated dual data entry ensures accuracy, pull-down menus ensure consistency and increased speed of data entry and training and continuous monitoring of data entry clerks keeps performance high. There is a data entry audit trail; analysis of this log may result in improved training of entry clerks, changes in operating procedure, modification of software or user interface and redesign of data collection forms.

3.10 Open source HRIS software: Capacity Project tools

Dykki Settle of the Capacity Project introduced possible software solutions for HRIS. The discussion focused on the possibility of connecting open source software with existing software and the flexibility to adapt to country-specific circumstances. Settle assured that open source software can be connected with existing systems and is flexible; for example, for the use of other languages. There will be a need to harmonize with data collected for the NIHS. The first practical experiences from country applications come from health service providers in Bangladesh. The Capacity Project is available to support the start-up of the use of open source software; a first version to be used for HRIS will be available in early 2007.

HEALTH LABOR MARKETS

Many past attempts to address the health workforce crisis in Africa have focused mainly on increasing the production of nurses and doctors. However, the shortage and maldistribution of health workers occurs within the broader context of national and international labor and health labor markets in which workers act to maximize their compensation (financial and nonfinancial) and their job satisfaction. In order to effectively address the crisis, governments and their partners will need to gain an understanding of these markets and which interventions will result in the poor receiving better access to health services. For example, merely producing more nurses and doctors will not resolve the crisis because they will continue to emigrate for better salaries and job conditions. Raising salaries in isolation will also not work unless job conditions such as HIV/AIDS risk and overwork are addressed at the same time. Non-salary factors play such an important role in health worker migration that there is no evidence that increasing salaries has resulted in decreased emigration.

In order to help participating countries address this complexity in the diagnosis and resolution of the health workforce crisis, health labor market concepts and analytical tools were introduced and discussed by the World Bank's Africa Health Workforce Team[1]. The highlights of the World Bank presentations are summarized below.

4.1 Understanding labor markets in sub-Saharan Africa

Labor, like other economic goods, can be allocated to different tasks (public or private sector, health or non-health sectors). When individuals choose where and how to allocate their labor, they will tend to seek out the highest returns (financial and nonfinancial, job satisfaction, job growth opportunities, etc.). Governments that wish to allocate labor differently than the market will either have to:

1. Restrict the movement of labor (via training workers for which there is not an international market, bonding, managed immigration or training people less likely to migrate internally or internationally)
2. Offer labor more than the market currently will for those positions the government seeks to fill
3. Create more paid positions or create incentives for the private sector to serve underserved areas. (This strategy is necessary in countries like Kenya that have large numbers of unemployed nurses who would accept government postings if any were available.)

When left to themselves, free markets will maximize the efficiency of the market; however they will not maximize the equity. For example, the brain drain of doctors and nurses represents a market efficiency (it is cheaper to train health care workers in Africa than in the U.S.) but creates inequities (lack of access to health care amongst the rural poor in Africa). If a government is interested in health care equity (that all citizens should have access to a basic level of health care), then the government will need to provide incentives for the market to supply all people. For example, the government will need to look into more affordable and effective ways of supplying health care to the underserved. Two aspects of labor supply are sectoral shortages (absolute shortage of health workers in the country) and geographical maldistribution (more health workers in wealthy, urban areas and fewer in poor, rural, or high-morbidity areas). Each type of shortage must be addressed with different types of interventions.

Health labor markets have aspects that make them different from other labor markets and different from other goods considered to be essential. Health care requires skilled labor to be present at the point of delivery. Unlike food, water, housing and clothing, which are material commodities that can be produced or gathered elsewhere by skilled labor and delivered to the point of use by unskilled labor, health care is a *service* that must be continuously supplied by skilled labor at the point of use.

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[1] The World Bank's Africa Health Workforce Program is financed via grants from the Gates Foundation and the Government of Norway.

The Africa health labor market itself has unique characteristics that need to be addressed in solving the Africa health workforce crisis. General income levels are very low in Africa, which means that most patients cannot afford to pay much out of pocket for health care. The governments either are not able or not willing to pay internationally competitive wages for health cadres for which there is an international market (doctors and nurses) and are not training and hiring enough skilled workers for which there is not an international market (medical officers, midwives, auxiliary nurses and other paraprofessionals). Restricting the international migration of doctors and nurses has economic costs including the cost of administering and enforcing the restrictions and the cost of forgone remittances that emigrated workers would have sent home.

4.2 Dynamics of the health labor market

The framework in Figure 1 describes the main elements of the labor market and possible interventions through health workforce policies. With regard to the microeconomics of health worker behavior, the supply of health workers is based on individual decisions of health workers following incentive differentials (financial and non-financial). Financial incentives are not the only ones that matter to attract and keep health workers in their positions. Job descriptions, management styles and job satisfaction can also be very important. In fact, no evidence has been provided yet that an increase in wages for health workers does slow down migration.

Rather than addressing the market forces, most governments have planned their health workforce based on staffing norms (per capita or per facility) and have assumed that all workers that are trained will work for the government health system rather than working in the private sector, working in a non-health sector, not working at all or leaving the country.
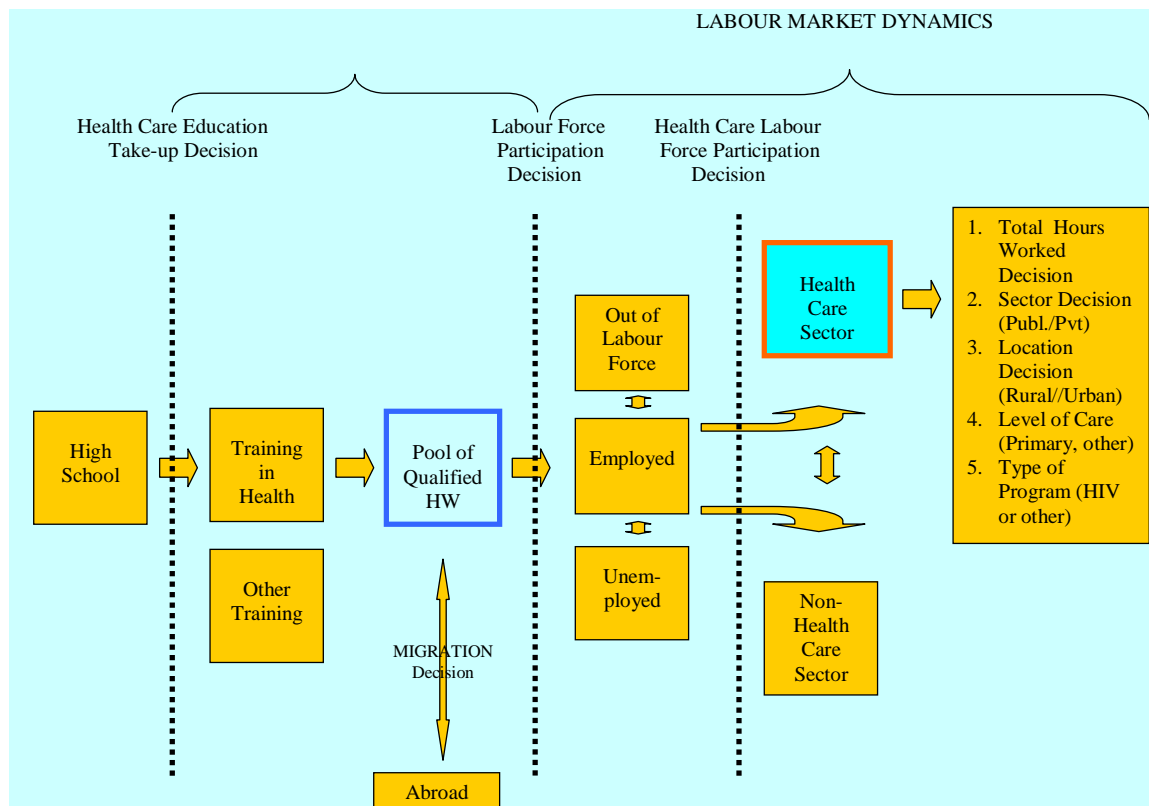

Fig. 1

4.3 Health workforce productivity: Ghana's experiences

A country study from Ghana was introduced, demonstrating how mapping workforce productivity can be used as an HRH decision-making tool. As an indicator for measuring productivity, equivalent patient days per health worker were used (number of patients seen per health care worker). This was mapped against service delivery outcomes (number of patients seen in a district per population of the district). In this way, four different types of districts were defined: high productivity with high coverage, low productivity with high coverage, high productivity with low coverage and low productivity with low coverage. High productivity and high coverage indicates great cost-effectiveness. In those areas with low productivity and high coverage, there might be an oversupply of health workers whereas districts with high productivity and low coverage most likely need to have more health workers. This initial comparison of districts provides a rough estimate of where extra supervision or health workers are needed; however, in depth studies are needed to provide the necessary evidence for policy decisions. For example, the high productivity districts should be further studied to understand why they are so productive and these lessons learned should be transferred to less productive districts.

In the discussion following this presentation, GTZ remarked that non-wage factors seemed to be emphasized to the point of discouraging countries from increasing salaries. Clearly, wages in developing countries will never be able to bridge the gap with rich country wages; however, salaries should at least meet basic needs within the country contexts. As a possible solution, the definition of minimum threshold for wages and salaries was discussed. For example, a nurse working full time should not be living below the poverty line.

4.4 Qualitative health worker study in Rwanda

This study took a closer look at the microeconomics of health worker behavior. Health workers actively make choices to maximize well-being and act on different individual tastes and preferences. They have choices in sector (public vs. private), locality (rural/urban) and performance (to be highly productive, to be present but unproductive, or to be absent from the health facility).

This qualitative study in Rwanda used a focus group discussion approach to obtain a better understanding of health workers' behavior. For the analysis of the recorded interviews all quotations of participants were coded with non-pre-defined codes. Several issues such as urban versus rural employment and absenteeism were discussed in detail.

The conclusions of the study revealed that health workers actively assess labor market choices and opportunities and there is considerable heterogeneity in health workers' preferences. Many factors, such as job stability, training opportunities and access to health care for their family, influence health workers' motivation and behavior. Systems for performance evaluation and career development offer another opportunity to retain workers and reach staffing goals. Performance-based pay seems promising because it combines monetary incentives with monitoring and supportive supervision. However, erosion of intrinsic motivation and quality of care should be avoided.

Discussions clarified that improved performance through incentives has not been measured yet in Africa and more research is needed in this area before it can be fed into policy reforms. Clearly, definitions of objective measurements of health workers' performance are needed in the future.

4.5 Deprived area incentive scheme

The presentation by James Antwi of Ghana outlined the first steps of a deprived area incentive scheme in Ghana whose goal was to retain health workers in rural areas. As a prerequisite, the criteria for the definition of a "deprived area" had to be clarified. Various criteria for the infrastructure were included to identify "deprived areas" as differentiated from "most deprived areas." Secondly, the staff categories that were to

benefit from the scheme were identified. While a limited number of cadres was chosen first, it became soon evident that a comprehensive approach to include all health care cadres would be more acceptable.

While it is too early yet to analyze the effects of the scheme, some first experiences with the process of the distribution were reported. Different proceedings in the various districts were observed. The numbers of cadres varied, some eligible workers did not receive their additional pay consistently, in a timely manner, or at all and in one district, for example, the mission hospitals were not included in the scheme. Clearly, a priority for future improvements of the implementation process is a more comprehensive inclusion of cadres, facilities and districts.

A challenge is the financial sustainability of the scheme and the evaluation of the impact on the distribution and performance of health workers across the country. When asked if the financial resources needed for the scheme lead to compromises with other investments in health care, Mr. Antwi answered with the advice that human resources are clearly the key priority and are the limiting input in health at the national level at this time.

There was also great awareness that implementation of selective incentives may not only possess operational challenges but also be de-motivating for those that are left out of the scheme.

4.6 Working groups

Following the presentations, working groups formed to discuss the following questions:

Given the problems or challenges in your country, what are the critical HRH policy questions you need to have answered?

- How do we make the case to stakeholders such as the MOF about public sector reform, unions, labor groups… that these reforms are in their best interest?
- How do we demonstrate that investing in human resources results in better health outcomes?
- Do we need a code of practice among health workers?
- How do we fill HRH gaps with informal health workers?
- How do we maintain quality curricula, skills and knowledge of our health workers in this world of corrupted institutions and officials who offer certificates, diplomas and even degrees to the non-qualified?
- How can we improve data usage and sharing to inform policy decisions?
- How do we ensure sharing of best practices between and amongst countries?
- How do we set norms for community health nurses?
- How do we finance and sustain health workers salaries?
- Should development partners contribute to salaries of health workers?
- What categories of staff do we need to train to improve health indicators?
- Do we have a framework for health workforce development and to ensure implementation and M&E at the country level?
- How do we cost HRH plans? Do we have sufficient capacity to cost HRH needs?
- Are the country's health policy and HR policy linked?
- What is the optimum skill mix to ensure quality of care for the burden of disease in a particular country?
- What steps or guidelines are needed to relate to the norms or ratios for health care to meet the health needs?

What kind of workforce-related questions would you like to have answered at the inter-country level?

- How do we scale up training for health workers to ensure that health care providers have the quality and quantity to meet their needs?

- How do we ensure pre-service training is relevant to health needs in terms of quantity and quality?
- What kind of contractual arrangement do governments need to put in place to get return on investment in health workers they train?
- How effectively and efficiently can we use training as a way to motivate health care workers that is linked to career motivation and job needs.
- How do we retain staff in the health sector?
- How do we know how many health workers we currently have?
- What type of incentives do we need to encourage health workers to work in hard to reach areas?
- How do we develop and better manage human resources information systems?
- What strategies could be employed to increase productivity in performance of the health workforce, including performance management and motivation?
- What strategies can be put in place to recruit workers and effectively deploy the existing health workforce?
- How do we address the impact of HIV/AIDS on the health workforce?
- How do we better coordinate partner activities?
- How do we ensure consistency in the quality of care?
- What experiences can be drawn from other sectors in retaining health workers?

TOOLKITS AND FRAMEWORK

5.1 HRH Action Framework

It was explained that the HRH Action Framework is designed to assist governments and health managers to develop and implement strategies to achieve an effective and sustainable health workforce. By using a comprehensive approach, the Framework helps to address staff shortages, uneven distribution of staff, gaps in skills and competencies, low retention and poor motivation, among other challenges.

The HRH Action Framework was developed at a technical consultation in Washington, DC, on December 14-15, 2005. Sponsored by WHO and USAID, the consultation consisted of multilateral and bilateral agencies, donors, partner countries, NGOs and members of the academic community. Work has continued through an inclusive process to refine the Framework and Critical Success Factors and build a rich base of tools, guidelines and other resources that influence HRH solutions. More tools and resource materials—including useful country experiences—will be added as they become available. The Framework is available at http://www.capacityproject.org/framework. However, the idea is that the Framework is a life instrument that is adaptable to change and must be updated regularly.

The Framework has six Action Fields (HR Management Systems, Leadership, Partnership, Finance, Education and Policy) and four phases (Situation Analysis, Planning, Implementation and Monitoring & Evaluation) that make up an Action Cycle (see Figure 2).

Fig. 2

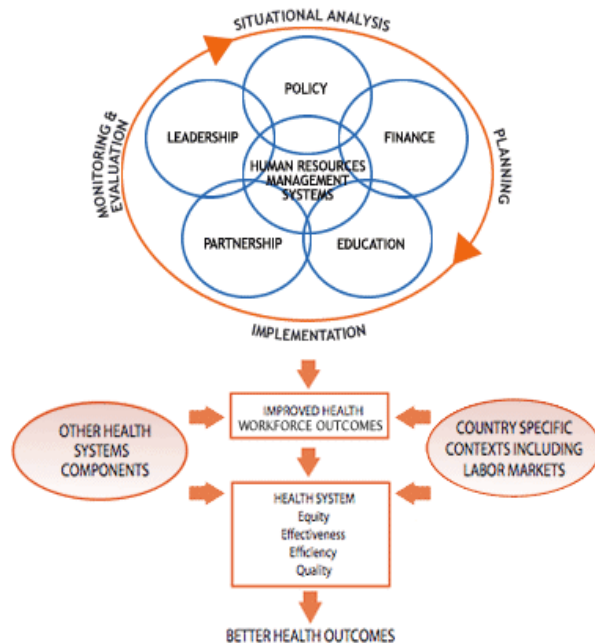The success of health workforce strengthening efforts depends not only on the *what* (the precise nature of the interventions) but equally on the *how* (the way in which interventions are planned and implemented). Twelve *Critical Success Factors* have been identified specifying how action in health workforce strengthening can best be undertaken. *(See Appendix for a summary of participants' comments and questions.)*

5.2 Guide to monitoring and evaluating the health workforce

A comprehensive reference on health workforce measurement strategies and analytical tools is being developed by the partnership of WHO, World Bank and the Capacity Project, to help countries improve the collection and analysis of health workforce data. Likewise, this reference tool will contribute to building the knowledge base needed to guide, accelerate and improve country action. The rationale for this tool stems from the need to have reliable and up-to-date data and commonly agreed upon analytical tools, to build technical capacity for health workforce information and policy development and to respond to the requirement for monitoring the health workforce from the global to the national and sub-national levels.

The reference tool is expected to be useful for staff responsible for health workforce statistics and planning at national and sub-national levels, and should be of interest to the research community, professional associations and bilateral and multilateral institutions active in health workforce information systems and planning. The measurement strategies will encompass such areas as tracking entry, transition, and exit from the workforce, tracking the active workforce and workforce expenditures, as well as the role of qualitative data. Case studies will provide tangible examples and lessons learned from use of the different measurement strategies in different countries.

5.3 Africa Health Labor Market Toolkit

The outline of the Africa Health Labor Market Toolkit was presented. The toolkit is being developed by the partnership of WHO, World Bank and the Capacity Project. The goal of the toolkit is to offer a new perspective for understanding and solving HRH crises in Africa, to improve understanding of the most effective ways to produce desired HRH outcomes and to go beyond the data to understand the policy "levers" used to improve the number and distribution of health workers. This toolkit will be a useful resource for staff responsible for health workforce statistics as well as HRH planning and management at national and sub-national levels. The toolkit will describe the main issues and policy questions in African health labor markets, provide a framework for the health labor market and discuss linking market data and analysis to policy. The toolkit will compile a number of quantitative and qualitative tools and methodologies for measuring various aspects of the health labor market. The quantitative tools will be helpful in describing existing conditions within the health labor markets and the quantitative tools will provide formative and explanatory data especially to help design effective retention incentives for health workers.

Tools and methodologies to be presented include:

- Health worker production indicators (including training and financing)
- Health worker training institution surveys
- Labor market demand analysis methodologies (employment demand and service demand)
- Productivity analysis tools
- Motivation research
- Incentive testing (contingent valuation).

Small group discussions with delegates revealed that most participating countries have not used health labor market methodologies and that most delegates did not have a resource to learn about such methodologies. Based on the health labor market training sessions and case studies, they appreciated the potential of the labor market approach to help solve their countries' HRH crises.

Once the toolkit is finalized, it will be formally launched in Africa. Training on how to use the tools and methodologies will be provided, and technical assistance and ongoing support will be available.

5.4 Policy issues for AU inter-ministerial meeting

Stephen Shongwe of ECSA Health Community led a session on input for the AU and ECSA Health Community's ministers' meetings (scheduled for February 2007). Policy issues for the AU inter-ministerial meeting were discussed (*see Appendix for a summary of issues and comments*).

5.5 Work group report: partners

The donor group gave an output report on its key issues. The group produced a chart summarizing the makeup of the donor group and emphasized that there are different roles, with all areas covered by one or more organizations, in the areas of advocacy; country support; capacity building; health systems linkages; financing; policy actions; research; and tools. Emerging issues were identified and discussed (*see Appendix for a summary of issues and comments*).

5.6 Working groups

Five groups were identified to consider three main questions:

What tools and toolkits are you using or planning to use (in part or whole) in your country?

- Human Resources for Health tools developed by countries supported by GTZ
- Census survey questionnaire for the Public Service Analysis
- Computer database on HR
- Computerized staff profiles at provincial and district level
- Tool for collecting data on retention of staff
- Integrated Finance Management System
- Public Finance Management System
- Therapy EDGE
- Health Management Information System
- Tools for budgeting, disease programs, financial management
- Computerized payroll system
- Health facility survey
- HRH census data (facility survey)
- Staff return template
- HMIS using open-source software

What has been your experience in using them?

- Manual returns require a lot of time to consolidate
- Good infrastructure enables intra-linkages
- Reports can be produced whenever required
- Consolidation of different types of workers at regional level difficult, especially at the lower level
- Unreliable
- Labor intensive
- Difficult to use
- Not used at point of collection
- Time-lag in reporting
- Payroll data had to be complemented with other kinds of information in order to become more useful for HR management
- Different templates are not harmonized
- Systems are not integrated

What bottlenecks or challenges have you encountered?

- Availability of data does not lead to automatic skills in planning
- Different organizations have different manual systems that are not easy to consolidate
- Current tool incomplete to answer all policy questions
- Capacity of HR staff to analyze data
- Incompatibility of systems
- Inaccuracy of manual systems
- Failure to extract information from the HR department
- Vertical programs not integrated with other national info systems
- Lack of ownership and sustainability
- Not comprehensive
- Lack of training for data collectors
- Lack of awareness of the importance of providing accurate and updated data
- Lack of standardization of templates

COUNTRY ACTION PLANS

6.1 Working groups

Country-level working groups were identified and asked to discuss the objectives of the Observatory in their countries, along with the Observatory's composition, risks and challenges, critical success factors, technical activities, partners and benefits to stakeholders. Each working group developed a country action plan based on a series of questions. A sampling of the working groups' responses to the questions is as follows:

What are the objectives for the Observatory in your country?

- Develop HRH policies to address issues of training, recruitment and deployment
- Strengthen HRIS
- Facilitate sharing of information on HRH
- Establish a common data bank on HRH information for HR planning and management and networking at the regional level
- Facilitate use of HRH data and provide evidence-based information for policy and planning, management and development for HRH
- Undertake research and conduct studies
- Help in evidence-based planning
- Pool and utilize HRH technical expertise
- Provide a forum for partnership, sharing of information, experiences and advocacy for HRH agenda
- Monitor HRH trends and provide evidence for HRH policy decisions and strategic planning
- Help build capacity in the health sector
- Identify gaps and make future projections on health workforce demand

Who would you include as active partners and stakeholders for your country's observatory and how can each partner/stakeholder benefit?

- Ministry of Health
- Ministry of Finance
- Ministry of Education
- Ministry of Public Service
- Ministry of Labor
- Public Service Commission
- FBOs
- Private Health Service Providers
- NGOs
- Health Professional Councils/Associations
- Partners/donors
- Regulatory/professional bodies

  Benefits
- Share information
- Access current, comprehensive and accurate information on HRH
- Improve decision making and policy development
- Avoid duplication of efforts
- Channel assistance to specific areas
- Keep track of trained personnel

What are the organizational arrangements for the National Observatory in your country?

Focal point
- Ministry of Health
- Ministry of Health HR Department
- Permanent Secretary for Health
- Human Resources Director

Secretariat
- Ministry of Health HR Department
- Human Resources Officer
- Health Information Officer
- Donor Representative
- Nursing Representative
- Medical Representative
- Sub-division HR Policy and Planning
- Ministry of Finance
- Public and Information Service
- Enterprise and Employment
- Nursing and medical cadres

Steering/Technical Committee
- Ministry of Health
- Ministry of Public Service
- Ministry of Finance
- Representative of private practitioners
- Labor Union/Association
- Partner Representative

What can be the initial technical activities considering the needs and priorities in your country?

- Undertake detailed labor market survey
- Do comprehensive technical needs assessments, i.e., baseline study
- Upgrade infrastructure
- Undertake inaugural comprehensive HRH workforce survey
- Standardize formats
- Convene stakeholders and explain idea of HRH observatory
- Conduct situation analysis
- Define key indicators
- Improve existing data collection tools and when necessary develop new ones
- Assemble and share existing HRH research, surveys and studies' findings
- Carry out training needs assessment at various levels to forecast HR requirements
- Define HR policy questions
- Integrate existing systems

What process will you follow in starting the national observatory in terms of advocacy, involving stakeholders and initiating activities in the context of your country?

- Debrief the HRH TWG and obtain consensus
- Convene a meeting of key stakeholders
- Appoint a steering committee to drive the process and direct the secretariat
- Develop a plan with timelines and budgets
- Use the already in place SLG, just reenergize and expand it

- Send formal invitation letters from the Permanent Secretary's office
- Provide background on the establishment of the HRH Observatory
- Schedule an official launch by the Minister of Health
- Draft the terms of reference for the Observatory
- Submit the proposal and TOR to management

Given the process that you have identified in establishing a national observatory, what kind of collaboration and support do you envision from the regional, international and bilateral partners?

- Technical support on appropriate software and hardware
- Financial support
- Monitoring and evaluation
- Capacity building
- Acquisition of resource material on HRH (e.g., toolkits, guidelines, software)
- Infrastructure support
- Seed money to support secretariat

What are the potential risks and challenges to implement this observatory? How do you think these can be overcome?

- Maintaining momentum
- Resistance from key stakeholders
- Resources constraints
- Role conflicts between existing structures and the group
- Stakeholders' reluctance to adapt to new ideas
- Difficulties in linking systems of different stakeholders
- Technical support to maintain and sustain systems
- Medium to long-term sustainability of the systems
- Lack of support from within the Ministry and outside
- Difficulty in assigning leadership

    How to overcome
- Advocacy
- Exchange visits/presentations of country experiences
- Training
- Integrated planning based on consensus/transparency, clear definition of roles, commitment, ownership, consistency in funding to sustain activities
- Identify champions and support them
- Ensure transparency in the whole process
- Build capacity, involving technical people
- Ensure sufficient budgetary allocation

Country-level working groups then made presentations on their discussions and resulting action plans, and considered follow-up steps to be taken.

It was observed that all the countries presented common structures, stakeholder mapping and institutional arrangements for the formation of the Observatory. Countries anticipated common risk factors like resistance to change, political commitment, financial sustainability and role conflicts between existing structures. However, countries indicated that with proper planning based on consensus and transparency, total commitment and proper advocacy and full financial support, the formation of the Observatory would be possible.

WAY FORWARD AND NEXT STEPS

Jennifer Nyoni of WHO summarized next steps and the way forward on behalf of all organizing partners.

Countries represented at the meeting can advance progress by:

- Reporting back to colleagues in the country on the concept of the Africa Health Workforce Observatory
- Sharing and finalizing the initial draft national plan of action for national observatories and further elaboration
- Providing feedback on national consultation concerning the concept of regional and national observatories
- Providing feedback on the way forward by each country and areas requiring collaboration.

Partners can advance progress by:

- Reviewing country needs after the meeting for coordinated feedback to countries
- Providing coordinated feedback to the other partners, giving room for flexibility
- Providing individual partner support for ongoing activities
- Continuing joint efforts in follow-up activities.

Comments from the meeting organizers included the following:

- *World Bank:* Make country health specialists aware that the countries will be forming national observatories and further integrate HRH into Bank lending
- *Capacity Project:* Work is ongoing; new countries that have interest will be consulted with very shortly; software presented will be available within weeks
- *ECSA Health Community:* Report back to Permanent Secretaries in countries involved, support advocacy, raise awareness for action plans possibly emerging from the meeting
- *WHO:* Support for countries based on specific requests, functions of secretariat; report back on AU meeting and link with GHWA.

The Regional Secretariat can advance progress by:

- Following up on each action point mentioned above
- Linking all resources on the website, which will be available soon
- Finalizing the report and posting it on the Observatory website, and informing everybody about the launch of the website
- Making available the status report from the data on the African Region, and updating the data as an ongoing process.

The meeting was brought to a close.

APPENDIX

Partners' Contact Information

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HRH Action Framework

In response to Neil Squires' call for feedback on the HRH Action Framework to make it more useful at the country level, participants had the following comments and questions for clarification:

- Where does productivity fit in the framework?
- Need consideration of private providers. We should consider other financing mechanisms (like insurance and reimbursements) that involve private providers.

- Define essential service package/quality and tie into the private sector
- Country specific context, including labor market circle on the framework: have to include the market for health services. Also, it's not just country specific, what about global effects?
- The framework should take into account issues of governance of health services, stewardship, accountability to communities for services provided
- How do policy objectives at the level of health outcomes (e.g., decreasing MMR) relate to the framework? With improved outcomes what are the human resource implications?
- Comprehensive framework is not touching on health workers themselves. Is there a set of HRH competencies that we could include in the training of health workers before they get certified so they consider HRH issues?
- The box in the diagram with "Improved health workforce outcomes": what are we looking at there? Numbers, cadres, etc? Can we be more specific on this?
- Action fields – where is research in this? Is it under M&E?
- Issue of organizational structure is important. If the organizational structure is weak, there will be a problem in implementing HRH actions.
- What about the related contextual issues, including political instabilities, war and famine?

This feedback will be shared with the steering group to better ensure that the Framework is a useful resource at the country level.

Policy issues for AU inter-ministerial meeting

The following is a summary of issues and comments related to Stephen Shongwe's presentation.

Financing: How do we ensure HRH is prioritized in international efforts to scale up financing for health?

- Investment in health is essential for MDG and economic productivity. In this respect HRH is a critical issue and needs to be addressed.
- Low budget for health sector. Lobby to increase health sector allocations.
- Request for increased donor budget support with timely release
- Strengthen governance and accountability to avoid misuse of funds
- Funds for health professionals so that donor spending is well spent for staff
- Tap into existing sources of funding, e.g., HIV/malaria to assist with health funding
- Tap into new sources of funding such as private sector for health education
- Tax reform and tax policy.

Education: What policies or next steps are needed to maximize training capacity at the country level and within the region?

- There is a need to address bottlenecks in training capacity to improve infrastructure, mentors/tutors, maintenance in clinical areas, retention strategies
- Regional harmonization of training and recognize equivalencies
- Continuing education programs should be emphasized to improve quality and motivation
- Teachers getting old, old teaching methods – need for new methods and realigning curriculum to the country needs
- Career opportunities for tutors – sabbaticals, teacher leave, exchanges
- Allow people from private practice to teach at the same time – don't tie them down to one area in order to increase teachers
- Give incentives for some areas that are hard to recruit, to encourage people to enter
- Standardization/harmonization and guidance for teachers.

Partnership: How can we maximize effective utilization of available funding for health through better harmonization and alignment of partner funding behind national plans?

- Lack of integration and numerous vertical programs are recognized and the request is made for new initiatives through horizontal mechanisms
- Better coordination among multiple departments working in relation to the health workforce in an uncoordinated manner – formalize inter-ministerial interaction at country level
- Strengthen national capacity and request donors to coordinate activities and to align with national strategies
- Bring partners in private sector behind national strategies.

Leadership: How can we strengthen government stewardship to improve governance and accountability in the management of human resources for health through country and regional actions?

- Good leaders through commitment, integrity but need to motivate them and it will improve output
- MOH should take leadership role to coordinate all stakeholders for HRH
- MOH leadership role in knowledge management
- Minister or someone in ministry take champion role in bring together different levels in ministries – demonstrate what you will get
- Responsibility to government to improve regulatory function and to establish better regulatory mechanisms and set standards and strengthen management and accountability
- Address the need to improve management skills – training in management
- Minister's commitment to use increasing evidence that increased skills will improve outcomes.

Regional Observatory functions: What regional observatory actions are necessary to add value to country HRH coordination?

- Regional observatory can advise ministers to endorse institutionalization of observatory at regional level
- Ministers can play role that observatory functions are institutionalized
- Stakeholder and partner coordination can bring partners together at country level, avoid duplication of resources
- The Regional observatory can also add value to the following areas:
    - Form forum for inter-country sharing with sub-regional nodes (e.g., ECSA), to become part of observatory
    - Harmonization – standardization of M&E for all member states
    - Clarification of concepts and definitions – who is the health worker (observatory), standard codes for data entry with best evidence for coding so can be shared
    - Capacity building – have technical support at country level – inter-country sharing and technical cooperation
    - Bring partners and technical assistance and link with country resources
    - Benchmarking function for M&E
    - Regional pool for technical cooperation.

Work group report: partners

The following is a summary of issues and comments related to the donor group's presentation.

Nomenclature and classification

- Discomfort with the nomenclature of the Observatory
- Observatory functions: Observatory, HRIS or nested within the HMIS. The important function is the collection of evidence-based decision making for surveillance, evaluation, health system.

- Standard classification or nomenclature of the health workforce will also assist in this benchmarking process at all levels; is required.
- Those who work in priority programs are not often included in the HWF but are a part of the Public Sector.

Leadership and ownership

- Regional Observatory does the linkages and provides the networking and information sharing platform. Regional Observatory provisionally housed in WHO-AFRO in Brazzaville, but this is temporary and can change if the countries wish it to be so
- Location of the observatory and the issues of ownership and buy in
- Process of the national health accounts is a good program to learn from.
- Look at the on-going structures in the country – e.g., the Poverty Reduction Framework in Tanzania

Relevance and application

- Whatever you create at the country level does not have to be called Observatory at the country level. It is the function of whatever the group is called that is important.
- Using information for planning and programming – should the Observatory team be responsible for data collection and analysis or should it also be the team using it for planning?
- What are the specific roles the Observatory should play? Tools and the duplication of effort at the country level.

Coordination

- Avoiding parallel structures
    o Relating this to existing information systems
    o Working with other multi-sectoral groups in or related to the health sector
    o Making sure that the information that is collected in the HR process effectively fits into a broader health systems strengthening system, which is the ultimate outcome
- Capacity building for the inter-sectoral approach
- How do we coordinate with the national observatory so that the national groups are not overwhelmed by different steering?

Linkages and engagement

- Financing the HWF rests with the Ministry of Finance, not health. They also need to be closely engaged in the work of the Observatory
- We need to identify platforms that bring these together in neutral, collaborative ways
- This needs to be an agenda within the strengthening of health systems. This is what the health ministers want and is critical in the pathway to improve health outcomes
- Building up civil society organizations so that they can contribute to this initiative

Capacity building and empowerment

- Empower national and regional groups to be able to share with others – will the observatory provide a platform for this?
- Empower the HR directors in Ministry of Health in relation to their counterparts in the priority control programs. They also need to be empowered to function at the level of Public Health Services Administration and with the Ministry of Finance, which also has powerful HR levers at the country level

Financing and sustainability

- How are the services and labor in the health sector funded? – supporting health care financing and solidarity systems
- Reinforcement and health financing mechanisms
- Expanding resource allocations within the HRM dialogue may rest with the LGA, we need to also identify mechanisms to engage them
- Knowledge sharing and advocacy so that this can continue. This meeting is inadequate to make this sustain itself for as long as is required to make the difference.

Benchmarking

- Standard mechanism for inter-country comparisons could be useful to inform national planning.
- Should this also be promoted as priority in this regard?

Agenda: Meeting of the Africa Health Workforce Observatory

	Tuesday, 26 September	Wednesday, 27 September	Thursday, 28 September	Friday, 29 September
8:30 - 10:30	Welcoming remarks and introductions, S. Shongwe, ECSA Opening address, G. Mliga, MOH Tanzania Introduction to the workshop, H. Lugina, ECSA Africa Health Workforce Observatory (J. Nyoni) Country experiences in starting up National Observatories (Y. Tadesse and M. Dal Poz) Discussion	Plenary: Health labor markets Monitoring health labor market dynamics (M. Vujicic) (10 min.) *Discussion* Methodologies to understand motivation (T. Lievens) (10 min.) Evaluating the impact of hardship incentives in Ghana (J. Antwi,) (10 min.) Use of health workers census data and educational institutions survey in Rwanda (C. Herbst) (10 min.) *Discussion* Introduction to group work (K. Tulenko) (10 min.)	Group discussion: sharing experiences on tools and feedback on the tools in process Presentation of group discussions (20 min.)	Group six report – output from the donor group (40 min.) Provide input for AU and ECSA ministers' meetings a. Framework (15 minutes) b. Discussion (30 minutes) c. Feedback (30 minutes)
10:30-11:00	*Break*	*Break*	*Break*	*Break*
11:00–13:00	Group discussion: Africa Health Workforce Observatory: perceptions, expectations, challenges Report out by groups (30 min.)	Group discussion: Health workforce policy questions and data requirements in addressing policy questions Presentation of group work (10 min./group)	Country working groups: Starting up and developing national health workforce observatories Introduction to working groups (G. Gedik)	Next steps (1 hour 30 min.)
13:00–14:00	*Lunch*	*Lunch*	*Lunch*	*Lunch*
14:00-16:00	Plenary: Current status of health workforce data and information (J. Nyoni) How to better understand health labor markets in SSA (B. Jack) Potential data sources, strengths and weakness and data quality (M. Dal Poz, D. Settle) Data quality of registry data in Uganda (S. Wakibi)	Role and development of stakeholder leadership groups at country level to guide national observatory groups (P. McQuide, E. Mukooyo) Health workforce framework (M. Dal Poz) *Discussion*	Country working groups (Continued)	Conclusions Way forward
16:00-16:30	*Break*	*Break*	*Break*	*Break*
16:30-18:00	Use of administrative data for planning, management, and policy formulation (P. McQuide, D. Settle) Country examples of health workforce information system development E. Oywer, A. Waudo, Kenya S. Wakibi, T. Khumalo, Swaziland	Guidelines for health workforce M&E (M. Dal Poz) Africa Health Labor Market Toolkit (K. Tulenko) Software solutions in data collecting and analyzing (D. Settle)	Presentation and follow up on country action plans	
19:00	Reception			