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Plenary: Human Capacity Development
PEPFAR The Global Fund to Fight AIDS, Tuberculosis and Malaria; UNAIDS; UNICEF; The World Bank and The World Health Organization
June 4, 2008

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MUBASHAR SHEIKH: Welcome back from, I hope that you had a good meeting and enjoyed the hospitality of the people here in Uganda in the hotel. I welcome you to the session, which deals with the theme of human capacity development and it is my privilege to moderate my session and I thank the organizers for giving me this opportunity.

In case you are wondering who I am and where do I come from, my name is Mubashar Sheikh, I am the Executive Director of Global Health Workforce Alliance. This alliance is actually a partnership of different stakeholders and constituencies, which basically works to address the issue of crisis of global health workforce, which is affecting all countries but most critically Africa and also in Sub Saharan Africa.

We have been lucky here that we were in Kambala a couple of months ago and many of you might have been with us when we were, in March we discussed these issues in detail and we came out with a Kambala Declaration and [inaudible] change and I think some of the issues, which we will discuss today – they were in direct relevance to that discussion in March.

I have been privileged to work in during my professional life with a number of community-based approaches and settings and this has given me the sort of experience and the knowledge of how much potential and wisdom, which lays with

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the community and how we can maximize this potential of community working with the health sector and I think this is the team of this particular session as well and hopefully, as we go along during the presentations and subsequent discussions, we will get a better understanding of the scope and the application of this approach.

The way this session is organized is that we will have two speakers who will share with us about their experiences among – in totally different working environments. Each speaker will have about 15 minutes. This will be followed by a group of panelists, which again, presents different constituencies, different stakeholders and the request on all of them to sort of share their part, their comments on the presenters and sort of thoughts and their presentations within a period of three to four minutes.

This will allow us to have another round of interaction between the panelists and the speakers. My apologies that it is a closed session, we will not have the opportunity to basically open up the discussion among the audience but you will have that opportunity during the breakout sessions, which I understand will follow immediately after the tea break at the end of this session. So my apologies for that although it is not my fault. If you have any problems or if you are not happy with it, please talk to the organizers.

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Before I invite the speaker, I think it is – I just share a few words about introductions – this team of this session. I just want to draw your attention again back to the issue, which I mentioned earlier about the crisis, which we are facing as far as far as the human resources for health workers – shortages of concern and just in context of only one category of worker, which is a doctor, and the availability in terms of population.

Just to share with you some figures, we have a representative from [inaudible] but we know that there is only one doctor, which is available for 30,000 population in Botswana and a few other countries like Tanzania and Mozambique.

Again, as far as Uganda, which is our host country and a couple of other countries, the situation is also as bad as others, where we have one doctor per 20,000 and South Africa, Kenya, and Botswana, we have one for 5,000 population. But the issues is not necessarily limited only to the numbers.

It is much more complex. When we sort of look at it in the context of our response, effective response to the treatment, care of HIV and that is why this issue of HCD, I think, provides us some answers because we need to have a broad, strategic approach, an approach which goes beyond the

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numbers and, which basically links the policy in situations and communities for a collective and effective response to HIV.

HCD is an approach, which primarily aims at sensing the help from the human capacity of health sector. It allows and encourages interplay between the partnerships, leadership, resource mobilization, and human resource management.

I think it is important for us to understand that human resource management, we are, HCD allows us to look at in the broader context, not only in terms of production or scaling up of training but in terms of scale development, in terms of performance, and similar other issues and that is why the human capacity development approach has shown its worth and its potential and positive impact in our effort and in our response to HIV/AIDS.

In the first plenary session in the morning as well as some of the breakout sessions, we have heard a number of examples about cost shifting and other issues, which has shown a positive impact on better health systems and the communities have come together, sort of some change of responsibilities, some task shifting and some similar initiatives, which has started to produce some of sort of positive impacts on our response but it is an issue, which is still wandering, which is still developing and I am sure our presenters will help us to understand this further.

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So I will invite my first speaker here for – to comment within 15 minutes to make his presentation. Ian Campbell, who is a physician, an international health program consultant who facilitates participatory design and evaluation of home and community-based approaches to a range of health issues often resourced by hospitals or clinic systems and by faith leaders and structures. He currently coordinates AFFIRM Facilitation Associates, which is a global community of practice connecting local faith-linked to responses to HIV and other critical issues, which change in health systems and organizations.

HIV has been a key entry point to broader health and development reflection and action. The initial experience of integrated home and community response with district health systems was developed in 1986 at the Salvation Army Chikankata Hospital in Zambia where Ian was the Chief Medical Officer from 1983 to '89.

From 1990, he was engaged worldwide through the Salvation Army with many other partners and often with UN collaboration to transfer concepts and practices relating to human capacity development for health and life competence. Ian, please come.

IAN CAMPBELL, M.B.B.S., M.R.C.P. (UK), D.R.C.O.G.: Thank you very much. It is a privilege to be here this afternoon and to thank the organizers but also to thank some in

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this audience who have been inside this conversation, I think, for about a quarter of a century.

I think of Eric Von Pragg [misspelled?] you might see there with whom we have had this conversation back in 1986-87, McMatthews in the early 90s in terms of reflecting closely on the response globally of people living with HIV and what a driving that it has been around illustrating what human capacity for response actually is. Lou Baria [misspelled?] who used to run the local response unit at UNA [misspelled?] is now in Tanzania helping to shape the essence of human strength as the base of the definition of local response.

And yet there are other partners with whom I have been working - the Constellation for AIDS Competence, Interhealth Worldwide, the AIDS education program, University of Chiang Mai and the Salvation Army worldwide and I have been working with them for many years, which I am most grateful.

The message today for me is that local communities can and do respond from their human strengths. Organizations can learn from that by getting in with them and learning together with them and they can become relevant, competent, and motivated as they do it.

Here in the human resource development issue, crucial as it is, may find some form of a home. I intend to illustrate and discuss some facets of HCD, propose some additionally in

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connecting value of an HCD framework and propose some practical steps that can be explored to more authentically understand and embed HCD into policy and practice.

At a satellite meeting at the Barcelona International AIDS Conference in 2002, a working group convened by the technical network, developed a unit of UN AIDS, concluded that HCD refers to the will, skills, abilities, and systems to respond to HIV. For me, the will is the subject.

It involves people coming together face-to-face in local situations of home, neighborhood, and other community settings to acknowledge challenges, conflicts, and human strengths, and interweave care, treatment, support, prevention, and transfer.

A great example for me comes from Kitatani in Kenya, halfway between Nairobi and Mombasa. In 2001, I was privileged to visit a friend there who is one of the pastors in charge of the local Salvation Army church. She understood that HIV was for everyone. She formed a team from the neighborhoods with support that it is from an Africa-based facilitation team, a group of experienced field-based people who could nevertheless facilitate and bring out the best in local people and with no external funds.

Seven years later, there are 72 local responses directly stimulated by the original team and there are 15 other

local responses stimulated by one of the other initial responses.

In other words, there are some primary responses and there are some secondary responses and it is sustained and it is 70 years on and furthermore, at a cost of $2,200 per year, this stimulation and expansion and connectivity for transfer is happening. The money is internally generated. About 700 community members are actively involved as local facilitators and about 53,000 people are engaged in care and prevention as a result.

The Center of Human Capacity Development's response affirms local community capacity to respond and organizational capacity to adjust to that competence for response found locally and that organizational environment consists certainly of at least service providers and policy makers.

There are at least four dimensions of human capacity development and I want to speak of them each in turn, the local community, the transfer dimension, organizational, and the policy dimensions. I want to look at the interconnection between the more mediated through learning from local action and experience.

Regarding the local response refers to the capacity of the people in the living environments of home and neighborhood as well as the workplace and local community-based

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organizations. It is in these settings that it is possible to acknowledge fragility and utilize existing human strengths and develop a sense of hope for the future.

From 25 years of responding to HIV through building on community strength for response in over 41 countries, the Salvation Army has learned many lessons. It was in Zambia at Chikankata Hospital in 1987 that I, with some colleagues, noticed at least three strategic foundations to expansion of local response.

One is what we called transferable concepts reflecting the human strengths of local people to respond. Care characterized by presence, community as belonging, change originating within people's hearts and minds and hope with an energy passed on to others.

The second foundation is the dynamic link between home care and neighborhood-driven change and the spheres as well that are linked of service provision and policy operating from a center somewhere ideally close by.

A third foundation for local response is what has been called now, for at least two decades, shared confidentiality. Secrecy harms by stigmatizing. In all cultures, local families and neighbors can choose to share knowledge on issues of common concern and can do so safely and confidentially.

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This discovery is a liberating experience for communities and also for the organizational people, facilitation team members who watch.

I want to go to the transfer dimension of human capacity development. Community-to-community transfer refers to the horizontal shift of vision and action for change and for care and other things that can go on from one community setting to another. Now in all areas of the world, this has been observed to happen without external organizational presence but it happens better when there is some encouragement.

Then action research process conducted in Zambia, Malawi, Uganda, and Kenya in 2001 by the Salvation Army, 12 reference or primary communities, each showed competence for deciding on change and for measuring change. Now each of those 12 was asked to map their influence on surrounding communities for HIV response.

An expansion from 12 to 36 responses happened within a two-month period at virtually no cost. Kitatani community is one of those primary or reference communities based on this work and many other examples. It can be confidently asserted now that most communities, if functional, can transfer vision and optimism for change and tools and methodologies and ways of working to at least two other communities in less than 12 months.

This is a transfer map, an example of one of those communities. Many forms of mapping are happening these days as part of qualitative measurements. Transfer mapping is not often seen. This is one example.

A recent example is from Rwanda where, in a two-year period – November 2005 to December 2007, six community responses has expanded to 24 and the number of team members, HIV if you like, has increased from 14 to 154. The common factors for success are facilitation of response by way of visits by a team that learns and mentors at the same time an involvement of local people as self-measurers of change.

When communities in our experience or my experience transfer vision and action to other communities, the result is increased capacity for personal, family, and neighborhood responsibility for care, support, and change and in the hospital in accessing resources from many other sources. Sometimes that capacity can engender fear in people within organizations and politics.

The third dimension that I want to talk about is organizational response in the preamble to the NGO code of conduct for health systems strengthening released on April 23rd of this year, a rewrite of the one done in 2005, it is stated that NGOs and not just NGOs can undermine the public sector and even the health system as a whole by diverting health workers

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into privatized operations that tend to worsen the isolation of communities from formal health systems.

This is a challenge for all of us as we try to relieve the tension between stimulating human capacity for response in local settings and in organizations and filling gaps through human resource development.

The contrast between an interventionist expertise-based approach and an experience-based facilitation approach is illustrated here. Perhaps one of the more subtle is the first regarding institutional beliefs. We may believe in our expertise. However, we often do not believe in people's strengths to respond. Of course we know that expertise is needed but without an invitation from the recipients or the beneficiaries for support from the outside often based on being genuinely respected as owners and actors. The well-intended intervention often has no home. It has no natural resting place, the partnerships falter.

There are two recent examples of a shift in perspective, if you like, I think from some major institutions. One is the Global Fund in terms of its emphasis on community system strengthening in around eight and hopefully now nine and the other is a WHO initiative just coming out now through the partnership unit, which is intending to do action research and stimulate involvement in nine district settings over three

years that can help inform an approach to the renewal of primary healthcare but from a human capacity development perspective.

Regarding organizational dimension of HCV, I think there are two indicators of competence and relevance for an organization. One is a facilitation working culture. A recent expression of this has been in Zambia in the Gambian Mandi districts and in March of this year and all over across district team formed of about 25 people from faith based and government from community and institutional, from all sectors actually.

And the proposal that is coming up is that for a unit cost of $1 per person per year across the population of 100,000 people, it is expected that no neighborhood need be left behind. It is expected that there would be a massive turnaround in local ownership for scaling out response and to assure thereby that going to sell [misspelled?] consistent scaling out locally and scaling up organizationally.

The second indicator of organizational competence for human capacity development is the systematic learning from local action and experience. SALT, as illustrated in this diagram, is a pneumonic for stimulate, appreciate, learn, and transfer. It is a disposition to be practiced in the locality of home and neighborhood.

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Whatever the origin of the SALT team members and for hundreds of organizations worldwide mediated through the organizations that I listed in the beginning and others. SALT visits are now a regular part of the daily, or shall I say, a regular part of the working culture and are systematically timetabled to enable people of organizations who would otherwise would be very dispirited to be renewed in their comprehension and the meeting points they have with the genesis of human capacity development for response to HIV.

For example, from the districts in Gambia and Zambia, Matthew, a district health planning manager says I have come to appreciate these SALT visits. They have really helped me to understand certain things about communities during my day-to-day work and he speaks for thousands and thousands of workers in districts and governments and nongoverment settings who, otherwise, are actually left out of the jigsaw puzzle they were having to work with.

At the very least, we can say that a facilitation team approach establishes a learning culture. One result for those involved is a revitalization of personal and organizational vision and commitment.

Regarding policy, that fourth dimension, I will just give an illustration to show how policy can be an integral element and a stimulator for human capacity development. In

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March 2003, the local community of Kitatani hosted an international partnership from UN AIDS and UNITAR in Geneva. Together with the partner organization, they developed this self-assessment tool for HIV competence that measures levels of response. This tool is now being shared internationally and is influencing the policy makers who have become involved.

Now I have got two points to make by way of a conclusion that of course says is the case. The first point is simply six short comments as follows.

HCD is a connector in various areas and the first area that I want to say – just a sentence – is a connector for rights, ethics, and health. This is meant to be if you like a proposition that might be [inaudible] to a panelist saying something about it. I would say that the right to shared response is at the heart of human dignity and respect. I would also want to say that there is a second connector area for HCD and it is between local health movements and health systems.

I have mentioned something this already and I would simply reaffirm the fact that scaling out local responses is happening but it could happen much better if there is a scaled out interaction or systems and organizations and interventions that embraces learning from the local action and experience and find that connecting point between the local and the organizational as a normal part of the daily work routine.

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The third dimension for connection is in human resource development. Simon Efuca [misspelled?] from the Church of Self Association of Zambia says HCD was the ideal context and framework for HID. There is a contrast and yet a complementarity between HID and HCD. I will give you three examples as highlighted in the slide and just mention the first because of lack of time in saying that whereas HCD, quite rightly, looks at organization systems' repair and maintenance, HCD has a broader dimension, quite rightly, which is about country and community response.

I could go on but I would not. It is simply the comments that I need to make. The fourth dimension for connection is that of partnership. This is what this whole meeting, the implementing meeting is about and the only comment I want to make there is that as partners, we have an obligation to all ask the right questions together that are strength based particularly around the strengths of the common humanity for responding to the epidemic from the shared human strength that we have been observing in the last quarter century.

The fifth comment is around measurements. The graphic relates to community-led anti-retroviral treatment, management, and measurements. The proposition is this. Everyone can measure. Usually most people are, no matter how simple is the living circumstance and no matter whether it is visible or

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invisible to people like us, there are at least three key indicators that show competence for a shared measurement approach and can be applied to all the dimensions of HCD – local, organizational, policy, and transfer. Is there action for care on change? Is there measurement for self-progress? And is there transfer of vision in ways of working?

What matters is that for every intervention – there should be an expanded pattern of response. Measuring according to patterns of response requires that commitment, the qualitative and semi-quantitative methodologies that must be integrated into quantitative research. This is no longer a soft option in my view. It is an absolute necessity if we are to see this scaling up that is required and the interface between local response and systems intervention to actually become coherent.

I want to finish by proposing that there are some steps that we can take forward together. One is that we can encourage community conversation and as part of community conversation, a community counseling approach in all programs that involve response of people in all facets of HIV.

The second step that we need to take in terms of budgets and planning is to create space for learning from local response and budget for the necessary participatory action

research that is needed to compliment other forms of research in virtually all programs that we do it.

The third is that we need to really focus on what we mean by developing facilitation team methodology. It is happening in districts. It is happening in nations. Lets share about that.

Fourthly, can we foster human capacity development partnerships that embrace the broad dimension of response but also integrate human resource development and human resources for health.

Finally, I want to – have to finish by saying simply that the dimensions of HCD form a connected framework for action, learning, and measurement that engages a shared response and includes people from the village to the World Health Assembly and beyond. Thank you [applause].

MUBASHAR SHEIKH: Thanks Ian. My apologies for pushing you but compared to – with Ian actually I mean he was initially informed that he would be allocated 20 minutes. So he had to sort of adjust within that period but Ian thanks for the presentation, which clearly helps us understand the concepts, the processes, the dimensions, and the outcomes of the impact of this very important approach and also help us understand that it just goes beyond the classical sort of our normal understanding of human resource development versus a broader

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work where we looked at the community mobilization empowerment and engaging them in the entire process.

As we are running short of time, I think I would move straight to the next presenter because I think this will also help us in focusing on one other component within the broader approach, which is the human resource development and he will share with us experience of Ethiopia in developing human resources to overcome the crisis that country is facing.

I request Mr. Adhanom Ghebreyesus who is the Deputy Director General, Federal HIV/AIDS Prevention and Control Office in Ethiopia. He primarily coordinates and leads the National HIV/AIDS Prevention and Control Program particularly in the area of health sector response, advocacy, and social mobilization, monitoring and evaluation, and capacity building.

From 2000 to 2006, he was the head of the Disease Prevention and Control Department of the Regional Heath Bureau for the National Nationalities and People's Regional State of Ethiopia. He has an MPH in international health and development from Tulane University School of Public Health and Tropical Medicine. You have 13 minutes.

TEDROS ADHANOM GHEBREYESUS, PH.D.: First I would like to thank the organizers for giving [inaudible] opportunity to express this experience in this big meeting. My presentation is on behalf of his Excellency, Dr. Tewodros Adhanom, the Minister

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of Health of Ethiopia and basically my presentation will highlight areas of the country level, areas of the need level, of service, and as well as also at higher levels.

Well [inaudible] in general, as we have seen, where currently doing business systems [inaudible] the human force is one of the major areas that [inaudible] and this is one of the major obstacles that will be focused. We have also designed a helper in any other country who drive the policy, which is focusing on prevention with provision of essential [inaudible] services and developed health [inaudible] programs who [inaudible] for the next 20 years, I think now currently [inaudible] for five years response and all of that was done in partnership.

When we see achievements in the last three or four years and its intention through the universal access, we could imagine that we had very significant progress on one hand but on the other I think we do need to have to make more vigorous to achieve universal access.

Just for instance, the number of [inaudible] were only 658 influenced [inaudible] raised to over 1,200 in 2007 but we have to reach to 3,400 over in 2010 and coming through [inaudibl], you could imagine that we will only had three sites and the government together with partners have launched pre-ART

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[misspelled?] programs in March 2005 and currently we have [inaudible] sites but [inaudible] for universal access.

When we come to stabilization, you could see that for HIV counseling and testing, it is 11.5 million in 2005 and for '07, it has raised to $2.3 million, which is five-fold increment. Likewise on treatment, you could see that it has raised from a little over $8,000 to over 100,000 ever [inaudible] on ARTs.

Well we have the challenges and we have huge gaps, [inaudible] universal access. These challenges are very common and a shortage of the human forces as well high attrition of skilled staff in Africa professional mix at various levels as well as competency gaps in professionals; poor motivation and weak work environment are some of the major challenges.

When we look into the human force density for health, [inaudible] stand among a list in Africa. You could imagine that for every 33,000 population, we have one physician and for every 5,000 population, we have one nurse but it concerns all categories of nurses. So that indicates we do need to have a vigorous move to really reach universal access.

Some of the experience that we have gained, at various levels as mentioned earlier on, we are addressing the level of the community, the level of which is the mid-level at health

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centers and then at the hospitals and, of course, at the system level on HMIs of the last [inaudible] to make attention.

Coming to the community, there is a response, the health extension program is one of the innovative approaches that actually links positive [inaudible] healthcare with the community. It is has got four major packages.

These are the [inaudible] including HIVs, malaria, and tuberculosis, and the family health package, mother and child health, nutrition, as well the hygiene environmental health and, of course, a tool that could be used is health integration, [inaudible].

And these extension workers, they do provide service from house to house, which makes the households have much better access. The implementation was done in partnership, that is the regions, [inaudible] in developing the care plans of the trained [inaudible] materials of the last [inaudible] in the field.

Of course, the communities will take part in selecting the trainees and these many well-trained extension workers – this is simply, it has got too many reasons. One, it is culturally acceptable for women to go to another woman's home or man's home and to talk frankly with I think a woman but for a man to be difficult. Second, because of the comparative

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advantage that women in our society have for caring for children, for caring for family.

Well I have been saying this for just one year and quarter of the time is spent on theory and three-quarters of our time is spent on practice. In a deployment, when you look at deployment, who we have deployed, 24,600 essential workers and we are glady reaching the universal access target for every community of 2,000 to 5,000 Ugandan having two extension workers, which is covering and reaching the universal access target at a country level.

These are government salaried that are followed by the government and have deployed at health force level. When it comes in to what do they do, mainly they do a social transformation. They make social change by conducting community conversation currently while able to reach 80-percent of all communities by community conversation and they do promote HIV prevention, treatment, care, and support and of course, they produce more of the households, they have around 91 house contacts to households.

And then when they practice those practices, they become model households. These model households become promoters. They promote the neighborhood households by disseminating the key HIV [inaudible] messages over the last [inaudible] action.

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While this is the plan indicating how the health [inaudible] workers and the community health promoters are working with households and communities for the primary purposes of health. Well the health extension work, which is at the country level, does require additional support and at the midlevel where also [inaudible] response by training in main areas.

One for health centers, training health officers, which do have a Bachelor's of Medicine and of course, the medical training as well. This health officer's training basically aims for others the human force needs of scaling up for universal access and abating service of the rural areas, rural health centers who come to deploy around 3,200 health centers will be deployed with health officers along with 700 district health offices and 800 district hospitals by 2010. That is a massive move.

And it will help us to decentralize managed of service delivery and to better promote public health and to help us reach universal access for health prevention, treatment, care, and support.

Well the plan was to train around 5,000 health officers who have Bachelor's of Medicine degree until 2010 and the training is both generic and post-visit [inaudible] nurses in to health training and the training is undertaken in the

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universities otherwise in teaching with the hospitals who have this provision Uganda hospitals with better staff are used to make practical trainings.

It was three trainings and most of one-third of time is for theory, then two-thirds of the time will be spent at the practice sites. With the universities in which you are training, this is the role of the universities mainly as well now, they do have academic role, clinical role to facilitate the trainings and the regions do have the role of mentoring and, of course, facilitating the training at the hospital level and deployment and, of course, playing leadership role.

Well the achievements so far, we have the first 1,000 health officers and 4,200 are in school now and by 2010, we are going to be deploying what is required to reach universal access and it is running as planned.

The medical doctor's training is one of the bigger areas that we have suffered a lot and now we are also using the flooding strategy as well as these issues.

As you know, before 2008, the average annual [inaudible] of medical rose only 200 and now we are have increased that into 1,000 and in 2009, we are planning to update as many as 8,000 index by September by using 24 universities and 40 hospitals. And I think that will help us

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reach and deploy in 2013 these [inaudible] others to the hospitals.

Well we also adopt a mentoring model as we scale up the service, we have to maintain quality and, because of this the clinical mentoring has been initiated and taft [misspelled?] shifting is used to track better access using the [inaudible] has been provided by the health officers and the nurse. Of course, we have to address the legal issues. We are currently working on making policies that will enable but disable [inaudible] emergency, I think more of addressing the challenge.

[Inaudible] by community counselors is underway as well as by the head of counseling by [inaudible] and follow-up these patients on ART by the care managers who are also these [inaudible]. The technology meetings and centers do help to really discuss on clinical cares so that the clinicians do provide some support for the health [inaudible] from the hospitals to the health [inaudible] staff from the health centers other to households from the health stations as well.

Well one of the bigger areas of [inaudible] is also a system area. In this regard, we have undertaken a special training on and made the offer of the last HMIs, which is health migration information technicians' training of the [inaudible] health systems [inaudible].

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The main purpose of this is to improve performance by making instant information for decision-making. It is a joint program of [inaudible] universities together with Tulane CDC, paper supported and the first 28 were graduated. Now we are almost on topic with the second batch, which is 43 and the third batch I think will be commencing soon.

The third batch will use a different approach. Previously we have used a sandwich approach – two months at the school, two months at work. Now on the third batch we will be having full-time schooling in which they will, international applicants could be taken in and that will help, I think, bring these things into a better level.

The service technicians, the information management analysis was a huge gap and now we are planning to enroll 8,000 HMS admissions, some of them who are having ten plus two [misspelled?] graduates will be given a one-year training and those who are to complete will be staying for three years and then deployed at health centers, facilities as well as on the health system organization level including district and regions.

Well planning is not enough. We have to have an [inaudible] that could retain and motivate the systems. And because of that, we have designed a [inaudible] structure and in this kind of structure, which also includes minimum years

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require for service to get an opportunity for training or promotion as well as improve work environment who have been reforming and hospital reform is underway, which really makes hospitals to be made by a board and achieve its officer giving the physicians more time to [inaudible] the system.

And it was underway to provide housing at remote areas and of course, some remuneration, of course 70-percent increment was done, but that was not, may not be very high as the scale you see living costs.

Well these are the challenges. Anyhow, we are addressing them, again we have to readdress them and telling them coming back again. One of the major challenges in planning the training is the teaching staff. We have a shortage of teaching staff and to whether our partners, who hope we can [inaudible] those issues. And we also have to address the facility gaps at [inaudible] sites and we also have this [inaudible] issue as well as coordination at various levels.

Well basically this is to indicate that, we cannot do it alone as a government. We believe in partnership as [inaudible] and we would like to thank and many of the partners have been involved in actually making this thing reality like PEPFAR, Global Fund, the World Bank, [inaudible] systems, the centers, the Ministry of education, health, and of course, the HIV offices at various levels, the universities, training

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hospitals, health professionals, private sector, and universities as well as people living with HIV who are contributing much and the communities and leadership at various levels.

Well what we expect next we do need to create better capacity at the training facilities and at the practice sites and that is where our partners could lend their hands as usual to make these things happen.

Secondly, we have to really focus on strengthening the health network model so that we mentor and task, shift and also back that with policy and with capacity and many of the universities and partners are working on that line.

The financial and non-financial entities are very important. We have to really make these things happen and get improved. [Inaudible] the government and performance improvement and leadership capacity development at various levels is key so that people get motivated and get a shared vision and shared goals so that we move a system to really make a difference and we have started making a difference and we hope that I think we can make a difference through partnership. Thank you very much [applause].

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