

**37th Union World Conference on Lung Health:
Human Resource Management Issues in High-Burden
Countries
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LOVEMORE MBERGERANWA: Afternoon ladies and gentlemen. I think we can get started now. I would like to, first of all, thank you all for coming, and Jane and I are happy that you are able to come. It's been a long, hectic week, and a lot of people have given up. It is quite evident. My name is Mbengeranwa, I'm a consultant with the union. I would like to introduce to you the chairman of this session, Dr. Wilfred Nkhoma, who is a public health specialist with more than 20 years' experience in disease control. He has been a TB and HIV control program manager, as well as a director of prevention health services in Malawi. He is, currently, the TB regional advisor for Djibouti[misspelling?]in the Afro region. Wilfred, you can take over now, thank you.

WILFRED NKHOMA: Thank you coordinator. Good afternoon. I think as the coordinator and the coordinators are flanking me. I feel more secure. My task, I think is one of the simplest, this afternoon, which is to coordinate the discussion on the important subject that we are supposed to cover now. The subject of why we're, two hours, is as you know, human resource management issues in the high burden countries. I think this refers to TB, but I'm not sure as we go through the subject, we shall all appreciate that it

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actually goes beyond just TB but more the entire health service.

We have six presentations to listen to. The first two discussing the factors that pull and push the health workforce but also look at on a global level, how these can be addressed, the principals behind addressing them. And then we have some specific country examples of how this can be done, so that workforce can be attracted and retained. And finally, we also are aware, all of us, that human resource are also prayed on by other factors and HIV/AIDS for countries, where this is a problem, is another significant factors. And we shall also listen to a presentation and a discussion, a reflection on that particular subject.

And our next speaker is ROTIMI SAMKORE. I hope I'm pronouncing it the name well. He's an African public health rights campaigner, and a coordinator of the center for youth age education and development of rights in Africa, otherwise known as CREDO Africa, Mr. Samkore, please, you have 15 minutes.

ROTIMI SAMKORE: Well, thank you colleagues. Please let me apologize, first, I'm not very good with the technology, so if what I'm saying does not flow with the PowerPoint, please forgive me. Okay, I'll try my best. Colleagues, the first point that I would like to make is that, we must make no mistake about the scale of the crisis that is facing us. I

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always say to people that, what we have in Africa it's not an AIDS crisis, TB crisis or malaria crisis, it's a public health crisis and all these other things are manifestation of the bigger crisis of which we have to resolve. And I would go without to say that the future of Africa, in fact, hinges on whether or not the public health crisis on the continent is resolved. I have absolutely no doubt in my mind about it. And I try and make the point, Africa is the only continent on the planet on which an estimated six million people are lost every year to wide diversity of diseases. Not six thousand, sixty thousand or 600 thousand, six million. And HIV, TB, and malaria top what we call in CREDO, the premier league of death.

And we say that to put it in context, maybe we need to look at it another way. And we give the example, that, for instance, this is the equivalent of countries like Libya, which has 5.8 million people, or Eritrea with 4.4 million, or Sierra Leone with 5.5 million people, or Togo with 6.1 million people, disappearing off the face of the planet every year. Or if you want to put it another way, it could be a combination of either Botswana, Swaziland, Lesotho, Namibia, Gambia, Gabon, Mauritius, Mauritania or Namibia, all of which have populations less than two million. Any combination of 3 or 4 of them, disappearing off the planet, off the face of the planet, every year. This is the equivalent of the scale of the crisis that we face. And we choose to put it this way, so that our leaders

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can appreciate the context of what we are saying, because when some are forced obtain the African union summit and we talk about the public health crisis, it looks like the right companies have come to make a whole lot of noise again. And so we put it to them, that, what precisely would they do if in that one year their country vanished. What would they be presiding over? Absolutely nothing.

We go further to say that in another context, this kind of losses would be described as genocide. We all remember the figures, the Nazi's murdered an estimated six million Jews, in seven years. In Rwanda, one million Tutsies and other citizens were murdered in 100 days. Upwards of two million died at the hands of the Khmer Rouge in Cambodia in four years, and of course in Darfur, we are still counting, half a million. Yet, all these figures combined, do not even make up half of what we are loosing in Africa to disease. And yet there was outrage over all those genocides and there was none about this. So we said to our leaders, if we are talking of peacekeepers for Darfur, and these are peacekeeper with guns. Why are not talking now of enemies, not of soldiers but of healthcare workers to help resolve Africa's public health crisis.

Today as we speak here, the UN population researchers have concluded that unless the spread of HIV alone is halted or reversed, Africa will top the global AIDS death league with at least 100 million deaths by 2025. This is more than double the

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projections for India and China, of 31 million and 18 million, respectively, both of which have larger populations than Africa. And we are looking at the age group of between 16 and 24 years old. The most productive sector of any country, of any society. Now we are talking 2025, which would make a problem maybe for a 45 year time span. And if we remember that in Africa, over 400 years of the transatlantic slave trade. We lost about 100 million people to the slave trade and slavery related deaths. The continent has not yet recovered for losing it's most productive sector. And now we are talking about an equivalent loss in 45 years, not 400 years this time.

It is clear if this happens, Africa will sink without a trace, so we ask the question, here, why is this happening on a- what does the health worker crisis have to do with this? Or more importantly, is it possible in any way, to resolve Africa's public health crisis without resolving the human resource crisis? We saw, of course, the answer to this is no.

And speaking to the issue of the pull factors, colleagues here may have read the Djibouti 2006 report, which paints a sad picture of the global health worker crisis, not just Africa, the global world. But for Africa it reveals a fact that is little know outside healthcare circles. And that is that, Africa the total number of shortages exceeds the existing number of healthcare workers. The total number of shortages for Africa is 817,992 and what we have is just

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over a half of million, 590,000. This is the only continent in which the shortages exceed what we currently have. But it also hints at an even more horrendous fact.

And that is, that Africa is the only continent in which arguably we have more healthcare professionals, in many countries, working outside those countries than are working inside those countries. And this is where we come to the pull factors. Colleagues have spoken, already, of the push factors and I will not go much in to those now. Thank you. Sorry, just a minute to try and speed up. The main key pull factor, which is little realized, which is also very small to one of the push factors in Africa, is that in the 1980's the level of investment in education dropped in many western countries. Those of you that live in the west, will remember the region in Chachiara[missspelled?] in which public expenditure was slashed and literally a certainty in which student's grants, grants were abolished and loans were introduced in countries like United Kingdom.

And students that were going in for courses like medicine and dentistry faced the possibility of graduating with debts of at least 20 or 30,000 pounds. And of course that lead to a drop in enrollment. And what did the policymakers decide? They decided, if they are not investing in education in their countries, to turn to the developing countries. And, therefore, they actively encouraged

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recruitments from those countries. In addition to that, we had the IMF driven public expenditure ceilings in Africa which led to the contradictions that exists in countries like Kenya.

Where, while they are simultaneously thousands of nursing vacancies to be filled, at the same time there are thousands of unemployed nurses, because the government say they cannot employ due to budget costs. But alongside these there are even more dangerous trends, which we do not recognize. This countries, especially the UK and the US, have evolved very skillful ways of draining our health professionals and other professionals. We know of the green card visa lottery in the US and the highly skilled immigrant program in the UK. And I just give a quick example of statistics. In 2005, six Africa countries were in the top ten of the US green card diversity lottery, Nigeria with over 6,000, Kenya with over 6,000, Ethiopia with over 6,000, Morocco with over 5,000, Guyana with about 4,000 and Kenya with over 3,000. The total number from Africa in the top ten was 31,295 compared with none African figures for just about 23,000. And these figures are consistent for the 10 years before 2005.

And I admit the point because it's just not a lottery. If you win the lottery, you go for interviews, and then they becoming the kind of skills that you are bringing

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to their country, so it's health workers and other professionals. So, if we look at all this kind of pull factors, we will realize that, in fact, it is not accidental but even worse; and this is going to make it worse. We don't quite realize that because birth weights are dropping in the western world. It therefore means, they need increased levels of migration to make up of shortage of healthcare and other professionals; and I just quote quickly from the world migration statistics. If Europe's big 4: France, Germany, Italy and the UK wish to maintain their 1995 labor force populations at the same level by 2050, immigration will have to rise by 1.1 million a year, from the existing level 237,000 a year, so this will happen between now and 2050. Of course, all of them are going to be professionals and most of them will be healthcare professionals or healthcare workers. So we have been subsidizing the west and I quote research from the IDORC, which indicates, in the US alone, with it's 130,000 foreign physicians have saved an estimated \$26 billion in training costs. And that is in the US alone. It costs about \$184,000 to train each migrating professionals. There are more statistics, which I will skip.

So we have the absurdity in which the only G8 country that produces a surplus of physicians and nurses is Italy. All the other G8 countries are drawing from Africa to make up their shortages. Yet every year, we go to the G8's and we

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are told about all sorts of support to Africa where as in reality the subsidy is the other way around. So we ask what do we do? Some of us have long come to the conclusion, at least, those of us that have come to this campaign with the right point of view, that the most important right of all is the right to health and to healthcare.

And we are foresighted by saying that you have to be alive and well to be able to enjoy your exercise and your other rights in any meaningful way. Specifically, we propose that we engage the African union and the G8's in the coming year with a strong campaign to ensure that Africa's healthcare worker crisis is resolved in a sustainable way. This means that African governments have to put down the funds themselves and not continuously rely on grants.

In the first instance, it means that 15-percent promise by the African governments to dedicate 15-percent of their annual budgets to healthcare has to be enforced. It also means that in the west we have to seek support from colleagues in the west to ensure that expenditures ceilings imposed by organizations like the IMF, which make it impossible for such budgetary allocations to happen in Africa, are scrapped. There is a whole list of demands here, at which, I may explain here during the discussion. But colleagues, I just wish to end on the note that for many ordinary Africans, the question of resolving the healthcare

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crisis, it's not an academic issue, neither is it an issue for healthcare professionals like many of you in the audience here, or companies like myself. It's simply a question of life and death. It either we will resolve it in the next five to six years or many countries from Africa will simply vanish from the face of the planet. And I would not put it beyond the development that maybe in ten or twenty years, the issue of extinction of Africans living in Africa will force itself to the top of the world agenda, if the healthcare worker crisis is not resolved. Thank you. [applause]

WILFRED NKHOMA: Thank you Sankore for that presentation on the pull factors, as he mentioned, I think we'll have an opportunity to dissect this a little further during the discussion. If I can now ask Dr Wandwalo, Eliud Wandwalo, a public health specialist from Tanzania working with the mission TB controlled program there, focal point for TB/HIV within the program. But he has published on this subject, many times, and he's going to talk about the effect of HIV/AIDS on the money source, stock. So that after his presentation, we are going to have finished the factors that are effecting the numbers and countries. And then we are going to have a short discussion before going to solving them. Dr Wandwalo you have the floor, 15 minutes.

ELIUD WANDWALO: Thank you. I'm going to discuss with you this important topic on the effect of HIV on the

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workforce in developing countries. And my focus will be particularly in the countries with higher prevalence for HIV in Africa, specifically Sub-Saharan. I have developed my presentation to four parts. I'll first discuss the direct effect of HIV in the workforce in these countries, and then I'll discuss the social economic effect of HIV in the workforce in developing countries, and then I'll conclude by highlighting some of the challenges and also some of the proposed solutions.

HIV, as we know, has disproportionately effected developing countries, more in countries in Sub-Saharan. UN estimates that of the 40 million people living with HIV last year, about two thirds of them come from Africa, especially Sub-Saharan. Even prior to the HIV/AIDS epidemic, developing countries experienced human resource shortage and this was mainly due to the limited resource to train more professionals and the fact that many of them are moving to developed countries due to career and better payments. HIV epidemic has compounded the human resource crisis by effecting the over strained workforce in public and private sectors in these countries.

This skill of the human crisis and impact of HIV on the workforce in developing countries can globally be categorized in to many ways. First, through the baroque effect by the using supply of workforce, through the creation

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due to death, departure of service and reduced performance. And secondly, it is due to the social economy consequence resulting from reduction in labor supply and earnings, loss of valuable skills and experience, and also a decline in productivity. And both of these two effects have huge costs and social economic consequence. International labor organization estimates that an average of 0.2-percent of annual rate of growth of GDP of developing countries between 1982 and 2002 are lowest in developing countries because of HIV/AIDS. And slow GDP means slow job creation, employment and income growth.

The direct effect of HIV on workforce in this country is due to the fact that the epidemic is concentrated in the working age group of 15-49 years. And half of all people, who become infected with HIV, do so before they reach the age of 25 and the most will die before the age of 35, which is core working force of this country. In no more employment cycle, it's tough to continue to contribute to the nation or to further future 20-30 years. And the country is so in developing countries because the effect of HIV/AIDS.

As you can see in this graph, most of the people who are effected by HIV are in working age group of 15-45 years. And this trend is most of the developing countries which are highly effected with HIV/AIDS. The risks of HIV/AIDS among workforce is similar to various HIV among the general

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population. But reports in many developing countries show that people with higher education, higher income, have high prevalence of HIV and this are core working force in these countries. I now estimate that global work force has lost about 28 million people due to HIV and this trend will continue to rise if urgent action is not taken.

About two thirds of this lost is in Africa and key sectors such as health education, agriculture, business sectors has been effected. AIDS related illness is submitted in some countries in southern Africa has reduced the work force as much as 20-percent. And projection in this country, is that between 1.6 to 3.3-percent of the workforce in the countries with stable HIV prevalence of 15 and above will die from HIV/AIDS each year. That on the effect of HIV on workforce in developing countries is very limited and success but one of the comprehensive review which was done in Malawi by the Malawi Institute of Management shows that the public sector, the attrition of public sector has risen by six times between 1990 and 2000. And this review it also found that the Malawi team public safety increased by a factor of ten. And this data attributed to HIV/AIDS. The report also showed that higher morality rates among professional staff than among junior staff. For example, death among research scientist and [inaudible] officer was twice of that of mortality in general population in Malawi.

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In this report, also, they found that the vacancy left behind by people who are ill or they die from HIV, were left unfilled for a longer period of time. For example, more than half of established post in [inaudible] sector were unfilled and also in agriculture sector more than 67-percent of the vacancy were vacant. Higher vacancy rate we have found in rural area than in urban areas and this trend is the same in similar in other developing countries. For example, see here recent study which was conducted to the near sure to demonstrate in [inaudible] is about 55-percent. The other direct effect of HIV in the workforce is due to reduced performance due to absenteeism and low moral. Low moral could be due to the fact that sick workforce can not perform ultimately, or it could be due to the fact that other health workers are asked to cover for the sick colleague. But the most important effect of the HIV on the workforce is due to drop in absenteeism and this could be due to the direct illness of the person or it could directly due to the fact that people are attending funeral or caring for sick relative.

A report from Botswana shows that a person with HIV can be absent from the work for about 50-percent of the time in the final year of life. This is a table which shows the percentage of job absenteeism due to HIV related reasons. And this study was conducted last year in two regions in Tanzania

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and it showed about 43-percent of absenteeism in the wake, health worker of two regions was due to HIV related reasons. The other effect of HIV is on social economic area on the workforce. The economic effect would be direct due to the loss of labor, disability and death of bread winner and also due to the rising medical costs. From direct costs it could be due to the absenteeism, reduced productivity, the moral rights staff, staff recruitment and retraining.

When HIV/AIDS comes a significant work place problem, most of the public, private sector and business responded to this epidemic as a social kind of undertaking. But upon realizing that HIV is effecting most of the workforce most of the private sector and business started to respond to this epidemic due to the economic reasons. And most of the private sector and business have put a variable bust intervention programs in the work place. And this is an area where I think the public sector needs to learn from the private sector.

The effect of HIV in the business and private sectors are enormous. A study which was done in Kenya in commercial farms in Kenya showed that death and illness have replaced old age retirement as the reason for the employee to leave the work place. The retirement accounted for 2-percent of the work force to leave the work place, while a quarter of work force of this company, the special sugar company, were

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due to HIV/AIDS. AIDS related illness and death increases expenditure and reduce revenue and a similar study found the most significant factor in increased labor costs was absenteeism accounting to 52-percent of ill AIDS related costs.

The impact of HIV/AIDS on the informal sector is devastating in the developing countries, because informal sector contribute to about half of the work force in this countries and in countries like India and formal sector contributes to about 70-percent of the work force. So in summary the effect of HIV in the work force, mainly due to illness and death and also reduced performance, and direct effect of HIV could be due to social economic impact. And with consequence of reduced labor supply and earnings, loss of valuable skills and experience which is very difficult to replace, decline of productivity and growth and increase medical costs and costs of retraining and recoachment for organizations.

So what can we do with this? I think this is an area where we need to put robust response to the problem of HIV in the workplace. Developing clear work place policy and programs is important. Studies have shown that villages and [inaudible] are more likely to support an employee with HIV and to comply with work place laws if there is a specific policy against discrimination. And this is an area where the

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public sector, including TB programs, need to learn a lot from private sector. The intervention is undertake an extensive prevention care and support service in the work place. Studies have shown that the cost saving due to investment in prevention care and support are higher, as much 3.5 to 7.5 times the cost of intervention, and the most benefit of work place intervention is increase in moral among the work force.

The issue of management of which a system is very critical and is lacking in many countries. Doctor on staffing at [inaudible]absenteeism, recruitment and chronic impact of HIV in public sector are not routinely collected. And I think that this is an area where the public sector is lacking. We don't have a doctor which quantified the economic impact of losing work force through HIV. It's obvious that without seeking effect effort of HIV in the work place, very few of the global targets including the millennium goals be met. Human resource management is integrated issue that we've seen in many countries including to be a problem that needs to address this issue gently. Thank you.

WILFRED NKHOMA: Thank Dr. Wandwalo, if I could now ask the three speakers, Professor Tevera, Dr Wandwalo and Samkore to join us here, for the next 10 minutes, we're going

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to have a discussion on the papers that have just been presented. If you could please come to the front.

So I'm sure you had some questions. I think we'll take the questions and then you can come and stand in front of one of the mics in the room. And you can direct your questions to either of these speakers. So Dr. Tevera spoke about the push factors that effect human resources, stressing the issue of whether it's long or short time and the issue of the special and sectoral nature of movement, that these are factors acting at the point of origin. And the Samkore talked about the pull factors and he did cite some examples, and Dr. Wandwalo had just outlined some of the effects of HIV/AIDS on the human resource stock in health, in general. So the floor is open for the next ten minutes. You can come to either, and I can already see one there, you have the floor.

MALE SPEAKER 1: Hello, thank you for this wonderful presentation, I think we've got a good sense of how multi-factorial a lot of these issues are, but what I was wondering of each of you or at least on specific in the Zimbabwe case and also from the advocacy standpoint could comment on, is what happen when the government, itself, is a push factor? And in your research have you noticed that at times during political crisis, especially, that you've seen an uptake in immigration out and that whether there is a movement back in

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after that resolves. Or whether you see people who after they leave the country settle down, get reacquainted in that new area that they are and thereby they stay there and never come back and if that is a plausible factor that would be a contributor to this, especially in a post colonial era, I mean Zimbabwe is only 26 years old so, thank you.

WILFRED NKHOMA: Okay, maybe there is another question somebody can also pose it, Dr Tevera, please take note of that.

KAY WILHELM: My name is Kay Wilhelm, I'm part of the New South Wales medical board in Australia and we have physicians for area of need, doctors who come in to Australia from countries like Africa, for several years, and that's not without it's own difficulties because they are working usually in rural areas in Australia. But you're not so easy to work in, there is quite a bit of change in workplace for them. But I'm wondering what you would like to say to medical boards such as us, I mean, what would be helpful if doctors do want to come out for a few years and work in Australia? What would you like to say about that experience and how they could possibly go back?

WILFRED NKHOMA: Okay, you have the floor and then we can have responses-

JOSEPH KALULMA: [misspelled?] Okay Joseph Kalulma from Uganda. There is a question for Dr Wandwaldo. That

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have, it is true that human resource management issues are a neglected area, agreed. But in your comments would you, perhaps, be more specific regarding the tuberculosis control program. What would you like to see done about human resource management issues with using your own country, as an example.

WILFRED NKHOMA: Okay, shall we have the answers to these three questions and then we're going to have one other round. So Dr Tevera, Samkore and Dr Wandwalo, maybe you wish to address the three questions.

S. DANIEL TEVERA: I think I'll go first. What happens when government is a push factor. In the interviews like there is some interviews which were down in Zimbabwe, and incidentally this same question was administered in six other countries in southern Africa. We simply asked what-why are considering to leave or have you considered to leave? And you know for Zimbabwe, many people including the very sectors, we thought well okay it's going to be like the political factors coming upfront, but what is really interesting is that they would coming, it was like the economic factors which were mostly highlighted. But obviously this begs another question.

Okay what's wrong with the economy? Is there inflation which is high, the unemployment and so on. And obviously the government is ultimately accountable. So at

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the level of the individual, yes of course, they could do better if the economy changed. There were a number of people who were saying, well, all of these things that systemic constraints but what needs to be done is fix the economy, which ever way you can do to fix the economy. So, in other words, it kept getting to the economic issues. Maybe people are just didn't want to talk about high core politics but they wanted to focus on things that which would effect them directly.

WILFRED NKHOMA: Samkore, I'm sure you might want to make a comment on the- when government is the push factor.

ROTIMI SAMKORE: Yes, please. Although my presentation was mainly on the pull factors. I think that this is an absolutely crucial push factor. But I think it is important that we realize that it's not just a question of economic and political instability due to bad governance. These are strong factors and we must not play them down. But we must not forget that a lot of countries, themselves, are not viable. If we look at the number of African countries that in and on themselves, have populations of one million, one and half million, two million, four million and so forth. And we look at the kind of infrastructure that has existed in those countries, historically, you know then we will realize that really, as I always say to some of my friends, with the

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best wheel on the planet, the countries are just simply unviable.

So we will need to look at the development of those countries in a much bigger development context. What kind of investment is needed in those countries. And it's not just a question of budgetary location in country, it's the question also of globalization now, how do trade imbalances, all sort of political policy measures from the IMF, and so how do all those things effect those countries? So I think that those things need to be looked at, alongside the issues of just PR, political bankruptcy or dictatorship.

WILFRED NKHOMA: Okay, Dr Wandwalo, you have a specific question but I also like to remind you, there is another question from somebody from the medical boards. And she is asking so what is the message we are saying to the medical boards with regards to the recruitment?

ELIUD WANDWALO: Yes. The question was how, what do we do with human resource management in developing countries and specifically from TB control stand point. But if our experience in Tanzania, I think the issue of human resource is much a total issue and it's not only the TB program or health sector issue. Recently in Tanzania, we have been meeting between the health sector and also the president. [Inaudible] in that meeting and he was really surprised by the fact that there is a limitation of not employing people

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with low education. The permit is for people with higher education from secondary education and higher. And giving our experience in TB at the peripheral centers, we normally use microscopist and these other people with very low education and they can perform microscopy very well. So I think we should continue to use people of that caliber and, especially, for microscopy which they could be trained easily and they could perform microscopy very well.

Another issue in TB control, what we've been doing in Tanzania is to involve community more in TB control. And this could help also albeit the issue of human resource in these countries. The president in that meeting also proposed what don't you use retired people who go to the villages and they don't have any thing to do? Why don't you use them to cover for the shortage of human resource in this areas? But I think that we know we need also good retention skills, especially of the skilled labor, especially in TB control where you need to train people for a longer time you know that to be able to perform very well. Thank you.

WILFRED NKHOMA: All right, Professor Tevera, to say something about what we are saying to the health board and maybe Samkora can also touch on that.

S. DANIEL TEVERA: Well, I mean, the health board don't exist in the vacuum, that's certainly my opinion. The health board are department of the government. And again, I

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think that the health boards really are unable to absolutely anything about any of the issues without one, of the prerequisites amount of budget allocation and expenditure and, also, if you look at the issue of the pull factors. We are speaking with some of the government officials at one of the AU summits, and we're asking them, for instance, the question of pay for doctors. Would you consider, not just doctors and nurses, would you consider providing special skills of pay for them in order to ensure that they don't leave for economic reasons, but also increase budgetary allocation to the health sector to ensure that we have our own working conditions are there. They have the equipment. They have the infrastructure and even basic equipment, things like gloves and so forth, exist.

We told them stories of mid wives, who have spoken to, who are leaving because blood was splashing on them during delivery, you know, getting into their eyes and so forth. And they were panicking. Have they been infected by HIV, and, so on and so forth. I wonder what they are saying to us. Well, you know, if one that you do to this the IMF expenditure ceiling make it impossible for us to do that and so on and so forth. So you know it goes back to the whole issue of that it's not just one side that we need to look at. We need to look at the external factors but we also need to look at the internal factors.

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And I dare say that in terms of resolving the political and economic instability in the countries, human resources has a strong role to play because if you are the other country that has lost maybe one million professionals, management's indicated, in all sectors of the economy. Who is going to run the country? There is no one left to run the country. It's hard to support some of the healthcare professionals. So I plead that we don't isolate boards and say we want them to do A,B,C,D, even if the chair of the board wanted to he may find him or herself in very great difficulty.

WILFRED NKHOMA: Is this a very short one?

S. DANIEL TEVERA: Yes, I do concur with what has been said. As a good development when in Zimbabwe the health services board was established, not so long ago. Okay, the impact could be limited but what is important is that it might provide better dialogue with government. This dialog between government and healthcare professionals and also it will highlight some of the problems, some of the needs in the healthcare sector. So on those grounds, I think it's quite important to have such a board.

WILFRED NKHOMA: Okay, I think that maybe at some point, eventually, we will also ask the person who asked the question, maybe, they also have some insights that they can share with us. But I think, it is also, I think aging on

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what should medical boards outside what we are recruiting consider. And I think we will probably have some time to discuss this a little further at the end.

If I can ask the lady here to wait, a little, the other three presentations. But I will prioritize you when the mic time comes. In fact at this point I can frankly speak to and ask them to go and sit where they came from. Meanwhile, if I can now ask us to move to the next stage, we have seen the pull and push factors that are depleting the healthcare worker stock, now how do we deal with it, faced on a globally rule.

I will ask Dr. Jose Figueroa, with the public health doctor. He has worked in the department of public health in London, right now, he is a director there. He was also focal point for TB control for the Americas under the Britain headquarters in Geneva and he has worked on human resource issues both in the Americas and globally. And he will talk to us about global issues in addressing the human resource crisis. You have 15 minutes.

JOSE FIGUEROA: Thank you, Mister chair. I will include first of all situating human resources within the current landscape. And there will be a bit of repetition when I try to go faster I will as previous three speakers identified which one was our key challenges facing us. What are the possible opportunities of any new thing that has

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arisen, some of strategic direction, some of the barriers to move for noting examples and finally on the side of conclusions. So within the current landscape that is now a deficit of 4.3 million of health workers. This is mainly to be able to reach the millennium development goals and there are critical shortages of human resources in 57 countries, 36 in Sub-Saharan Africa.

At the same time we have shortages, there is a lot of unrealized talent out there so there is an imbalance and some barriers to be able to actually move forward. Because of training health workers to eliminating the shortfall by 2015, it is approximately been estimated at 136 million US dollars per year per country. But that's a lot more than the budget of the whole country in many African and many South American developing countries. And the initial cost of pay of health workers, if we could find them and train them to be around 311 million US dollars per country. So where is that money gong to come from?

Briefly about Africa, although it's been already mentioned, with Africa the share of the world's population is 13.8 of the world's population, the share of the world's disease burden is 25-percent, so quite disproportionate and the share of the human resources is 1.3-percent, so you can see that complete different proportions and the inequalities in this. These are some of the main human resources

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challenges that we have to find solutions to. We have insufficient quantity of healthcare staff sometimes equality is also deficient. There is uneven distribution, not only between developing and developed countries but also between rural areas and urban areas. And also within urban areas between the deprived and not deprived areas, so the envers care low is present here.

Poor salaries, the conditions of working are often almost inhumane, HIV and AIDS, which some of the implications have already been mentioned. But also the fact that HIV and AIDS have made the belief that healthcare professions are more dangerous than other profession. So recruitment or getting people to go into studying for healthcare professions is now a problem. The support capacity of supervision and therefore maintaining the human resource, at a good level. Low motivation, absenteeism, attrition rates, poor enrollment, brain drain, poor training, developing human resources, developing healthcare staff takes along time, it's expensive.

Health sector reform was another problem for human resources, and human resources key factor in the health sector have no being conceived under reforms the problem of technical programs. And that's what I'm not necessarily talking solving the problem for tuberculosis but trying to address it in a global manner. Inadequate human resource

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intelligence, that was mentioned by one of the previous speakers, low human resources planning capacity and management capacity, again mentioned before. This is just to point out the [inaudible] problems.

So what happened when we have the [inaudible] programs that are working quite well. At the level in the presentation is the same people who implement many different programs. If only one of them received additional resources, then they would start poaching people to that program to make it stronger. And if this continues, the people in the forefront implemented will decrease every time or so. At the end we would have fat [inaudible] programs but who would be there to actually implement the task? And also they would be bringing in people from rural areas to work in urban areas in management of the program, in other parts of the program that aren't necessarily to do with delivery of services. So who is going to deliver services?

If you are to that the private sectors, the NGOs, the international organizations moving into labor markets. Because the salaries are so bad so I better to go to the city and drive a taxi rather than being a doctor in rural area. The rural to urban migration and the brain drain we are going to completely deplete healthcare staff on the front level. There is only one healthcare workforce; it is a limited healthcare workforce and therefore we have to manage it as

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one single asset. Person of the opportunities, well, it seems to finally some recognition, some awareness of the not completely the whole dimension of the problem but at least some of the areas. There have been addressed the need to build adequate space and now you can see more papers when you are doing a little research on human resources. Ten years ago it was almost impossible to find the old paper on human resources. Today, you find on particularly operational research and evaluation of small incentives in different parts of the world.

Decision in our [inaudible] certain to move capacity building in some areas and dollars are looking more hard to improve capacity for human resource development of human resource management development. The global fund [inaudible] donors have finally identified that it's not just so much of providing economic resources but also for finding the way that money can be implemented. And that the key factor for implemented that money is an adequate healthcare work force. The millennium development goals are a perfect excuse to underline how important it is and how we will be able to develop them to deliver them, if we don't have enough resources. The world has reported in 2006 the address in human resources issues again from an importancy matter.

And okay I agree G8 hasn't done enough, but some the initial steps that G8 have been taken are already producing

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good fruits and could probably serve us a good advocacy example for the future year. And to advocate for conciliation of that for way dealing with human resources on a global level.

Now how do we tackle human resources to increase delivery? While there are different components of human resources. The one issue would be the recruitment, looking at pre-service training clinically versus managerial training, specialist training or [inaudible] training and for professionals of volunteers or other relevant groups of people that you could recruit into that human resource. Once you've recruit, then you have retain them. And you have to look at different incentives. And some of the previous speakers show, it's not necessarily economic incentive that are the priority. They can be other kind of allowances or they can be incentives to improve the quality of life, housing, dealing with the family of people, communication, electricity, having access to a computer, having access to continuous professional development.

And also this is all part of adequate human resource management. Adequate supervision, adequate monetary evaluation of programs and support. The other thing that you have to manage is distribution. And there are different types of distribution here, geographical, urban, rural - it is a key one. But also the type of staff, key staff, there

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is other staff, people who are specialized, people who actually test the level, center versus service delivery areas and also public service and private service. And finally, how do you stop depleting the human resources to death, is an important issue, brain drain, loss to other sectors and retirement. So what are some of the possible mechanisms to deal with these different problems?

Okay, we need to increase the healthcare workforce. We said the quantities is insufficient. We need to increase the performance of the existent workforce with quality was also deficient. We can improve or we need to improve the distribution. We have to find ways of working differently and we have to innovate. So what about increasing the workforce, increasing the numbers? The map that I'm signaling here show the higher education roaming across Africa and the dark green areas show the areas of the country were the higher education enrollment is less than three percent. This one is under five mortality rates and it's amazing how they match. So the areas that we got lower education are the areas that we have high mortality. Okay, lower education, will it impact on the way that you deal with babies, the way you deal with infants, but it will also impact in the care, the services available to be able to deal with infants. So how do we increase the healthcare work force?

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Well, increasing the numbers, we need to increase recruitment, we need to improve retention, we need to reduce attrition, so that will make bigger the pool of human resources available. We need to aspire and regulate the private sector. How do we involve them PPM, or other ways of involving the private sector has been working better with them to actually to make the impact greater. And we need to manage migration and that further need to mention here. However it's not that easy. Increasing numbers of the staff have the problem that we need to, if we are looking at preservice training, we are looking at education. So which you can look at quality of education, [inaudible] and the change of the skills. Are we going to produce more of the same kind of professionals that have already been produced or are we going to look for another key way that we can train somebody in a shorter period of time, saving some resources to do unspecific tasks.

WILFRED NKHOMA: Five minutes.

JOSE FIGUEROA: Building training capacity, okay, you need to look at the schools. What is the capacity of the country to actually increase the numbers of people that are used? Improve in-service training, that's part of retention, but also in keeping good quality of the service. Community engagement and social marketing, utilizing the community, using the community to actually provide some of the care.

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That means that the task of human resource and healthcare work force is highly difference is supporting communities to do so.

Increasing recruitment, while you have to improve management of human resources, personal amount of assistance and also planning. And planning has to be done at least six to seven years ahead because producing a healthcare worker, producing a doctor and nurse takes three, four, five, six years. And as recruitment problem, capacity, rehire retirees, using vouchers or exemption fee exceptions, ensuring an adequate mix of skills and reorganization of outreach workers, how you can make them part of the system. For retention, financial and nonfinancial incentives and working conditions has already been mentioned, so I will skip it.

Italy was mentioned as a country that didn't poach staff from many African countries; however, this is a note in one hospital in Romania, and what it's saying is that if you are nurse and you want to go and immigrate to Italy and have a visa, you just find a number and they will get you a job and an immigration. So there is a lot of issues about poaching and not necessarily the ordinary suspects, the ones that are doing it all the time. The worldwide and international telephonic instructor Jose Pollock has been mentioned and this is something needs to be addressed on a

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global level. Salaries, hard working conditions, these also need to be looked at, at national but also on a global level. Some of the novelty different approaches, these are to find new kettles of staff health essential in Ethiopia and Mozambique, an example, task specific training. Training professionals to do a specific task and TB microscopy was already mentioned.

You have not had non healthcare staff, Peru, Aymara have really interesting examples in tuberculosis control. Peru has trained porters at health facilities to identify TB suspects and they are really good at doing that. And also to those who support treatment support at healthcare staff. Community involvement in Uganda, in Mexico, has also taken a lot of[inaudible]. Modern education is another other way that you can train staff modern so that way they could continuing developing professionally and they are used for different programs. Task transfers is something that has been more and more evidence based building in the efficiency and safety of task transfer methods. This is just an example of Mexico and how the communities involved and they do some of the test laborating DNT for those test. Public increased efficiency, if you have the adequate a skill makes, but a lot the adequate team of people so you know what you do and you know who is going to be ones you cannot continue to doing the work. If you create a spirit of sharing and the whole team

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will move forward and they will all enjoy the successes of the team.

You also have to have adequate resources so you are more effective if you have the wait of the work. But if you didn't have the material you won't be able to move head. And flexible employment arrangement could also facilitate the efficiency of the team and this is an example of me and my team work quite, they know their tasks and the disease center actually in the way TB control is excellent.

How do you increase motivation? Human resources management is key we call it the training supervision support. But also all the other, money, recognition, working conditions and center of development, career development. And this is an example of Pakistan. The issue of distribution is an equity issue so you have contractual arraignment in 70s, improve working conditions, regular consulting supervision and support, adequate communication within family provision. Rural workers need not to be forgotten they need to be part of the system. Center controls often non effective and there is a need to the centralize services, produce additional resources for rural areas. From developing for rural areas to rural pipeline and the rural workforce responsibility are examples of the literature of how you can actively train people from rural communities in rural communities to do work in their own

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communities. And that way you don't take them away from the families and they have developed for the specific for rural communities they live in.

And finally this is an example of south Africa and [inaudible] and there is some evidence already published in these things. They ask some of the rural areas that has care staff, a different aspect that will actually improve their retention and will likely improve their efficiency of what direction in their job. And as you can see it's not all to do with economic or bigger salary. The things like improving rural hospital accommodations, which ensures progression in your career, continuing medical education, support from specialists, consultants to make sure what you are doing is right, physical hospital infrastructure in rural refer systems.

And then something about management hospitals and involving doctors within the management of the hospitals in the area. So there is a lot to be recognized as part of the community that you work in and being able to perform better in the community you work in. Migration is what needs to be addressed on the global level. But you have to remember that there is a human right of people to move from one country to another. I am an example of somebody who had to leave Columbia because my life was in danger and when I was there, if I hadn't been allowed to move because I was a medic it

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would have been quite unfair. This is what we want human resources that are happy to do and perform well. And unless governments and dollars make strong political international commitment to implement double strategies in the short term and long term the crisis is likely to not be resolve. Thank you.

WILRED NKHOMA: Thank you very much Jose, and think to supplement, compliment what Jose has said on a global level. We shall hear from two speakers who will speak on a specific examples starting with Dr. Mohamed Amir Khan, public health professional from Pakistan, who is working with the non governmental organization there, working in health in development and research. But he's also currently the chair of TB section and TB education working group of the union. He will be followed by Dr. Sahotra, chief medical scientist TB problem in India. Extensive [inaudible] and TB problem implementation. And they will all talk about similar thing of attracting and retaining staff for TB control in developing countries. Dr. you have the floor, 15 minutes.

MOHAMED AMIR KHAN: Thanks very much, Mister chair and my colleagues. So, the purpose of my presentation, first of all I would like to move on that after such elaborate and strong presentations that you might feel that I would be able to much to what has been discussed, shared in a much more elaborate way. So for give me if you find that already things

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have been discussed in more detail. And I'm just repeating whatever has already been said. So the purpose of my presentation is to share experiences and views on few selected dimensions of recruiting and sustaining staff in developing countries context. And to encourage discussion on the way forward to discuss some of these gaps challenges.

Purpose of my presentation is not to give a comprehensive review of the topic of discussion or is not to developed a set of concrete recommendations or plans for addressing this issues. So as discussed in more details by my colleagues, some of the challenges are the first challenges, the first challenge I have focused is money dimensions. Is the low pay government is generally unable and donors are generally reluctant to pay more to the staff. So this is the challenge. So what NGOs and bilaterals can do?

The one possible intervention is advocacy and support for rationalized pay. Tanzania has shown a positive experience of rationalizing the pay scales of their government staff and have shown some good results. There is a need to review the innovations which have been done so far for increasing the payment, overall payment, to the current staff. In Pakistan there has been an experiment of change of management of the government facilities. Some of the districts, government facilities have been handed over to a

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NGO and who they have reorganized the staff [inaudible] and staff set up at the facility level. So reduce the number the staff but increase the payment for various set of services. And this experience has been reviewed, analyzed with the World Bank's support and right now is being expanded to more districts. So there has been some positive results not only in terms of staff performance but in terms of utilization of services and satisfaction of individuals' rights.

In Zambia there has been a experience of establishing anonymous health votes. People have found it a bit complex exercise, which need to be studied more carefully and we might be able to get some useful hints. In Guyana there has been an experience of [inaudible] with new pay scales but the, my understanding is the, there has been some progress but the progress seems to be a bit slow. That takes more time in the government to put things in place, especially the changes. In Cambodia there have been experience of output related budgeting which has been different support. We need to look at this experience it will be able to learn from that. In Philippines there has been a piloting of special allowances to help staff but the there has been management issues related with managing these special allowances to staff.

In Pakistan there has been a small scale experience of adding mobility arraignments and per diem for district

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level to provider of the liberty network. And that has shown the government staff, with a regular government staff, has been provided some additional mobility support and some additional per diem for his fee work. And that has given encouraging results. Another approach which can be considered basically investment in economic development and Malaysia in last couple of decades, to the over all development, have been able, probably, to offer better arraignments to the staff.

Looking at another challenge which is specifically incentives for the healthcare staff, especially in reference to TB control program, the potential role of NGOs and bilectroids is the taken play an important role in developing and scaling of the incentives. The incentives can be in the form of special allowances such as a [inaudible]loans, property loans, or it can be in form privity success to professional opportunities, people schedule trainings, conferences. We has a very small NGO are trying some of these things out and we feel that have been some useful experiences. Another possibility is access to loan, basically, there is a experience in Pakistan, where they have established a health foundation, which is like a window to offer loans to healthcare worker who are interested to enhance their income and all that in addition to being the

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government or to be totally in private sector by providing loans at very, very easy conditions.

There have been some experiences of running the recognition programs. National people control program in Pakistan, in fact, has introduced some arraignment of recognizing the staff performance at national, regional, and district levels on regular basis. Cash incentives for TB care providers, China has shown some positive experiences with cash incentives for TB care providers, of course, as well less patients also. True for [inaudible] support and we need to look at this experiences more carefully and might be able to learn. And then another area is identify and manage disincentives, basically, when while looking at the incentives we need to pay equal attention to disincentives and try to remove these disincentives. A good example of disincentives is in Pakistan the laboratory staff gets a share of the fees that is collected on laboratory test. And with all the good intentions we declared if TB testing as free of charge then test, so now there is no fee charged for AFB testing. But the implication is now the staff, the lab staff is not getting any share on the AFB tests. So the very natural challenge is that they are more interested to work on or do the test where they get some share out of the fees. So while being ambitious about the welfare of the patients we need to be careful that sometimes it.

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The other area which [inaudible] and can play some role is access to further training. Of course in country to enhancement we have a good experiences as Pakistan and GTZ and other bilateral agency have supported health services academy in Pakistan and a couple of other institutes for training the post graduate public health professionals. Linkages, establishing the linkages with the overseas institutions, we have a very useful experience that needs to be reviewed. Of establishing linkage between the national TB control program and NGOs and overseas teaching institution.

Access to working opportunities, this is another area that NGOs can play some role, basically by disseminating the information about national and international opportunities and encouraging involvement of in country expertise in donor funded project assignments. And, again, I will be referring Pakistan experiences. Darfur has established a technical assistance management agency where the preference is to recruit the in country consultants where possible. And the overseas consultants are recruited only where in there is no national expertise available. So it is very positive experience.

Then there comes an issue of pull factors in developed countries which has been discussed by my colleagues in much more details. So we all agree there needs to be some code of practice on international recruitments. With some

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arrangements to ensure after certain period of time, the person will go back to his home country. And of course the other approach is to encourage the private sector growth so that comparable opportunities can be created within the country.

Working environment, poor physical environment, of course, NGOs can play some role instructional enhancement in both in terms of premises and equipment. Social changes, NGOs can play some role by doing advocacy for staff, security and support and enhanced in direction with staff and communities. We, technical support is another challenge and NGOs can contribute by developing and implementing operational guidelines for delivery and managing TB care. And Pakistan is again a very good example of NGOs contributing to this respect for TB control program.

And then development and operational, supervision and monitoring arrangements, and already you guys have rationalized regulation. NGOs and bilateral can encourage and participate in the developing the regulation systems, of course, it has to be done by the government. What is the way forward? NGOs and bilateral to help understanding the situation and reasons. Because many of these things need to be further reviewed, in more details, and then develop and test approaches to the [inaudible] and sustain stock. For more sharing experiences and evidences, within the country,

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within the regions, and at global level and provide technical assistance for identifying developing and scaling up interventions, to promote retaining of stock within the countries. So this is what it is. Thank you very much for your time. [applause]

WILFRED NKHOMA: Thank you so much, Doctor. This was about NGOs and bilaterals, how they can help to attract and retain staff in developing countries. Now how about governments. Dr Sahotra from India. You have 15 minutes.

V.S. SAHOTRA: I'm sorry about a little confusion. This presentation was to be made by Dr. Sahotra, who had to leave today. And in place of him I'm making this presentation and I'll be covering the attracting and retaining staff for TB work the role that governments can play. That all that Indian government has played to a improve the performance of the program. I'll be covering with in four points, the basic and which are required for implementing growth strategy, the current challenges that are delivered to human resources that all the governments are addressing the challenges that our government has played, and the lessons learned, and what are the future challenges. The basic elements that are required from the human resource point of angle part that we need a workforce for quality assured level ability with trained level of technicians for diagnosis. We need trained medical manpower for treatment categorization. We also need trained

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accessible, acceptable and accountable DOTS providers for making the treatment accessible to the patients. We need trained supervisory staff at various levels to ensure systematic monitoring and accountability. We also need manpower for health management information systems, which are really essential for monitoring the performance of the program. And we also need effective drugs and [inaudible] with adequate and skilled manpower so that there is no treatment interruptions for the patients.

For the DOTS delivery we need to have a good functional public health system in place. We need to have an effective collaboration between the public and private sector and to improve the reach and access and strategic care for all patients since public health systems have their own deficiencies and most of the services, in arguably, most of the countries concentrated in the private sector. We need to enroll the community by increasing the awareness and participation, to seek [inaudible], to improved treatment adherence and reduce stigma.

So seeing all these imports required for TB control activities, we can say that TB control activities are human resources incentive. There are not many technical skills required for having an effective program and it is primarily a problematic and managerial challenge. What are the challenges in attracting and retaining staff for TB work? We

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don't have any good long term strategic planning for infrastructure in human resource development. And the needs which common straits to the demands of the health sector. There are usually a manpower resource crunch and even if there are attempts being made, there is brain drain and in spite of the development of the manpower, the countries are not able to retain the manpower.

There are issues regarding managerial capacity of program officers because program officers mostly are clinicians. We have shortage of public health professionals for program management. There is no specific managerial and financial training. The authority is not commiserate to responsibility. The program managers have a high responsibility but that hardly lies with some of the other people. And they have to report to the medical alliance.

Other challenges are there is very capacity of states, in terms of, infrastructure, human resources and finances some states have lack of finances, some have lack of infrastructure, and some places there is a lack of human resources. There are human resource gaps regarding limited availability of qualified personal. There is acute human resource distribution. Urban versus rural areas and economically overlooked versus underdeveloped areas. There is improper implementation of human resource policies with that have reference to salaries, transfers, postings,

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promotions, leading to lower commitment and moral personal who are working in regional health systems. There is brain drain, which is geographical and also across the programs. The supervision and monitoring usually gets a low priority. All health programs are at the grass root level being delivered by a single health worker. There are intersectoral challenges, because the health services are being provided by different sector and other healthcare being public health sectors, private health sectors{inaudible} sector, corporate sector or in need of assistance. There is no single forum for intersector dialogue, although, the services are being delivered by many. But there is no single forum where they can sit together and work out a effective program implementation.

There is no participation of private sector in national programs. We know that large proportion of TB patients seeing the healthcare in private sector. Until and unless we are able to access the private and volunteer sector, the programs will not have a desiring effect. The standardized TB management is essential for TB control and [prevention MD and TB. If we are not able to address and the other sectors, then will not able to mange TB. By addressing these challenges, which I have listed. The government can attract manpower boost morals, after the workforce and thus retain them, especially in TB work. The national TB control

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program of India, they adopted a few strategies which have helped to plug the gap in human resources.

First of all we redefined our organization structure within the public health system. There is a streamlining additional program management through formation of state and district societies. By mentioning of these societies we were able to create some kind of managerial and financial economic to the program implementers. We established a very good infrastructure and respond at the district TB center we provided a district TB officer and also of some contractual staff was provided at the district level, in terms of, [inaudible] technicians that ended up wherever there were shortages.

Then we have a TB unit at some district level which is there at a population of 500,000 and in difficult areas it is established at 250,000 population and at the sub-district level we have provided supervisory staff which is contractual. And these are senior supervisor, senior TB level supervisors, medical office of TB control. This person is on route from the existing healthcare services. At the level of microscopy center, where there were shortages of laboratory technicians we have provided lab technicians from the program. And at the lowest levels [inaudible] centers where there are Nibia where we have provided TB health service. And the doctors is also provided through the

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medical provider workers and the community healthcare volunteers in different forms.

Then to improve the political and administrative commitment from states. We have been continuing the advocacy with state authorities to provide full time TB program managers at state and district levels. We also advocate for insuring the minimum of two to three years, so that skill manpower is always available. And we also advocate with them to ensure that key staffs are in place. The national election that has been taken for HRD, we have HRD unit at the center level, which is supported by three national institutes, to monitor we can see training retraining, salary and financial incentives. We have defined specific rules and responsibilities for each level of health staff, ensuring clarity of purpose and accountability. The [inaudible] plans have developed with training, induction training, object training, and additional need based training. We have developed standardized model of training for each level staff, supporting supervision, we have tried to ensure increased commitment and enhancement of quality of work and morale. There is recognition of efforts of national and state level program managers through various means.

Further strategies developed for capacity building of program managers. Since most of them were clinicians, we trained them specifically on program management, financial

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and logistics management, leadership and communication issues. We also addressed administer and parliament to guide program activities at state and district levels and the recognition and documentation was done in the form of publication of success stories in annual reports, recognizing good performance. Awards were instituted for the workers on World TB Day and opportunities were also provided to states to represents at national and international levels. Further strategies adopted were contractual staffs to fill up the resource gaps, as I mentioned earlier, we provided supervisory staff, senior treatment and senior TB level of supervisors. Additional manpower was provided to the states and the districts, in terms of medical officials, conference, data entry operators. Clearly defined qualifications requirements, induction training in terms of principle development of all the responsibilities are clear to everybody.

We have renewable annual contracts for the contractual workers, which are linked to performance appraisals. The budgetary provisions are made for competitive pay scales to commensurate other workers, annual pay raise be linked to performance. That leaves not available to the contractual staff were left and is has been made available now. And we have also ensured that mobility for supervision by providing vehicles and funds for vehicle hiring or to run

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the vehicles, which were made available. We have also addressed issues to programmatic need for streamlining healthcare providers in other sectors. We have in spite of [inaudible] for public health institutions, there is a gap which has been addressed by involving the private and NGOs sectors, which have arrived each as will acceptability in the community. The healthcare providers from other sectors will enroll in the planning process after taking them in various health societies at the state and district levels. Partnerships were developed with the NGOs and private practitioners. The specific areas for partnerships identified were advocacy and awareness generation provisional for the diagnosis and treatment services, management of PUs and TB units, and microscopy centers by the NGOs and private practitioners and taking them as [inaudible]. Grant and aid in terms of cash and commodity [inaudible], also provided. The capacity of the NGOs and private practitioners was built to sensitize transitions, trainings, seminars and workshops. And their efforts were recognized through certification or providing their works, as a result, we have more 12,000 private practitioners, more than 2,000 NGOs and more 120 corporate houses, which are enrolled in the program. And we have also enrolled other public sectors which were providing services through other ministries.

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Community by discretion we have ensured through enrollment of the community level workers which at present are village health guards, ordinary workers. Through the national rural health missions the community ladies are being enrolled and which are call [inaudible], accredited social health activities which will be used by the program as DOTS providers and to them we are providing training and supportive solution to build at capacity. The financial incentives are also provided to the community volunteers and their efforts are recognized by community, patients and family members and they are also provided on [inaudible] and awards. Through these efforts, we have been since the inception of the program, we have placed more than six million patients on TB treatment. Every month we place more than 100,000 patients on treatment and last year we provided treatment to more than 1.3 million patients. And we have been achieving very good success rates from the beginning and we have maintaining success rates close to 85-percent and our deduction rates are also improving and last year our reduction rates were 66-percent and it's improving.

To summarize human resources constraint for TB control, efforts have been made by the program to build capacity to standardize training and strengthen our public health system through additional contractual manpower, public priority accommodations enrollment of community enrolled

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volunteers, system for support the supervision, monitoring and []has been provided and there is a system for recognition of work performance. The future challenges are cross hiring of staff across various programs because of disparity in pay scales [inaudible] within our staff in the public health systems due to faster policies of the states, mail distribution in rural areas because of weak general infrastructure and systems, lack of centers quality of life which fills right back to manpower, poor attitude of sections of workforce including physicians. There is more emphasis on clinical work and inadequate supervision but and there's a failure to address HRD as a management issue. With these words I must say that although our [inaudible] have improving the gaps in human resources but a lot of effort has still required to be made. Thank you.

WILFRED NKHOMA: Thank you very much the three speakers if you could join us on the table in front here the three last speakers please. We have a couple of minutes but we can take a few comments and questions. I noticed that I had already offered the floor to someone who has seemed to disappeared, so I will I think be allowed to substitute. But I have one question right on my right and I will give her the chance to ask a question then I will let the lady on the mic also ask a question.

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FEMALE SPEAKER: What I've been struck with by the discussion of all of the speakers today is actually how we get this message across, that loss of one healthcare worker in any spot in the world, really has a ripple effect through out many other places. And I think this is really for me is very similar to message that at least in the United States, in TB control, that we had been working on for years was that poor TB control anywhere in the world is going to impact upon us. And so we need to pay more attention beyond our own borders. And this really seems to be so much of the message that people are talking about today that these push, pull factors or whether you are talking about NGOs, addressing human resource management or governmental agency or even as our last speaker spoke about TB control and HIV programs and who's moving where. That I'd like to have some people's comments on how we get this message across, that a loss of a worker in Zambia or loss of a worker in India impacts healthcare control everywhere.

WILFRED NKHOMA: Okay, skip that, and please take note that given the previous speakers can comment on this particular one. You have the floor, madam.

FEMALE SPEAKER 2: I can't think of a lot of good arguments of the receiver countries of human resources to reimburse the cost of all the years of training to the dollar countries of human resources. It doesn't have to be

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calculated in the exchange rate of the countries, who actually give the human resources. It can be higher it can be calculated at the price of the receiver countries but then the big challenge will be like, for example, for a country to raise the salaries of, let's say, health staff. It's not a light decision. First of all the money needs to be there for many years. The guarantee needs to be there. A slight increase in salary means a huge amount of budget that is needed and it needs to be guaranteed for many years. You can not suddenly decrease salary again, if the money is not available.

Then another problem which I think is also true, is that when the health staff is paid more, why is the teachers not paid more and why the police force is not paid more. It's really huge compromise that is made by increasing the salaries. Now, so this budget needs to be there I've seen a few reports, which also analyzed the revenue collection in countries and I see also that there is a lot of, maybe, lost opportunities of internal solidarity. I don't know how to call it where, in fact, the salaries are maybe increased but who pays the bill is the patient. And it's in everything is like hidden, all these money flows are hidden.

WILFRED NKHOMA: Okay thank you. Let's have the last intervention.

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MALE SPEAKER 1: Thank you mister chairman and all the speakers I think we have had a very reach presentation on a very important subject, human resources. And I think in my own view, this subject goes beyond probably this room. And it goes beyond health and TB control programs, to actual governments in our countries and probably in our own organizations, other than the countries. We have afternoon about, I think it was one of the previous presenters said, as we said that the 1,000 green card last year came from some 6 or 7 countries in Africa. Yes, those have 1,000 individuals with their own freedom of movement to went to the States.

Now I would like to devil's advocate in one way and ask is it really brain drain because we seem to be talking to much about brain drain. Is brain drain really a bad thing? Why can't we look at brain drain from a positive effects and I would like to give one example. Four weeks ago I think it was four or five weeks ago, I was reading about the economic reports of one of the countries in Africa and one of the major highlights was that income from professionals working abroad had just caught up with tourism, as the most major sources of revenue for this country. And I think this is real. This is one of the reports actually it was for Kenya about five weeks ago. And I still have that example here, which was present about Kenya, which said you have shortage of nurses in the public sector, which is true. And the other

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is about 10,000 or more unemployed nurses within the country, within the same country. So if you have nurses completing paramedical education, graduating and they don't have opportunities in the public sector, but you have some in the public sector who get opportunities elsewhere, why don't we encourage this kind of movement? But those who get opportunities as they go and replace them with some of these unemployed ones. Unfortunately in many countries that's not happened. If the ones in employment get opportunities, they don't get replaced despite the fact that there are vacancies.

And this is why you find the complexities of human resources go far, far beyond health, far beyond programs, and this is a political issue. It's a governance issue. I think the message we probably need to really blow up, as much as possible, and sell to our governments is that they've got to get some groups of thinkers to just sit down and in each distrection, think and address the human resource issue, specifically, for a particular country. Taking into consideration the particulars of that particular country. We know countries with a lot of constraints in the continent not because of drain but because they don't have any, have the need and they you have excesses across boards. Can we encourage cross boarder movement free movement of professionals within the continent if it's Africa or within the global communities. I think it's a challenge that we

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really didn't need to take far, far farther than this opportunity. Thank you.

WILFRED NKHOMA: Okay. Thank you so much for that comment. Brain circulation instead of brain drain. Let me ask the three last speakers to respond to the questions, specific questions paused but I will encourage also the initial speakers to make a comment on one or two. We only have five minutes to do that, so you better be very brief if in giving your comment. Please you can use the mic just behind you there. Briefly.

V.S. SAHOTRA: Thank you. I would like to agree with our colleague there, that, we need to encourage south movement. Because there are some countries that don't even have enough educational institutions to produce their healthcare work force. So if you have surplus in one African country, of course, why not go to another African country. It is a very good suggestion, however, I disagree completely.

I have looked at it with lots of colleagues. There is absolutely no positive effects on brain drain to any country. Maybe for individuals in terms of exposure for that training and so on and so forth, but let me just put in this way. If any country in Europe or in the north would be happy to 1. Return all of our healthcare workers, 2. Give us all of theirs and then they get the reparation from those people to their families. You will suddenly realize that, in fact,

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there is no gain. Because what would happen in those countries is that while the professionals are abroad will be sending money back home, there would be suffering, millions of losses of life. So are we then saying that you know six million lives lost a year in Africa, it's okay, but the people abroad send more money back to their families. It just doesn't work at all and, lastly, on the question of Kenya. Yes, countries like Kenya the paradox is clear on what we've identified as the solution, which one of the things I was talking about, which is that, the expenditures ceilings imposed by IFI's like IMF need to be removed so that you end this paradox of there are shortages but there are 10,000 people unemployed because government say we cannot allocate the budgets to employ them. That's the simple solution.

WILFRED NKHOMA: Yes. Jose, and let's not forget we also have two other issues on the table. The reimbursement of brain drain countries by receiver countries, and the other issue is unilateral increase of salaries in one sector within a government system, the challenges associated with that. And finally, how do we get across the message that loss over health worker in one place has ripple effects, not just in that one place, not only in that one country but across the regions, so please.

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JOSE FIGUEROA: I will start with the last point, the one about brain drain and economy. The impact, just to continue and then I will go to the other two points. The issue of brain drain should be called brain drain isn't a matter of governance. But it's a matter of ethics, really. And yes it's true in many economies that move of workers to more developed countries produces the best revenue for those countries. But why is that? Is it perhaps because their local economy was stagnant because all the workers work in the US or in Europe that the local economy is not going to be able to compete at the global level of economy where people has moved to, and therefore the resources coming from the outside are higher than the countries are able to produce. I mean this an example for a very well developed country like Colombia or Mexico. Increased the amount of not only health workers but all kinds of workers working abroad. It's producing a lot of revenue coming from foreign countries but what is happening to the current economy of those countries. And if the money coming in going to cover human resources, can you replace one human resource? Usually one healthcare worker that leaves the country to go to a more developed country is one of the best quality of healthcare workers. Europe and America are not going to bring to their countries healthcare that are not particularly well trained and aren't going to represent a good investment for them.

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So what happened, how can you replace that in the country that is costing six, seven, ten years of development to produce that one human resource. So, I will say it's more an issue of ethics and it's not just measurable by the economic impact of it but also by the social impact of the problem.

From the point of view of what happens to one healthcare worker in one country will effect the global healthcare economy and that's absolutely true and it's even more so now that we have globalization. I mean Europe is already quite worried thinking what is going to happen when more and more countries are using the European union and how that's going to be ensured that some of the underdeveloped or less developed countries in Europe are going to still have an adequate human resource supply. And this is a matter of planning and it's a matter of being able to identify that this is a global issue and you cannot really put barriers into it. I completely agree that a country that receives human resources from another country should be prepared to pay but I don't think that it's necessarily economic terms is the best way. But perhaps to encourage and exchange of resources.

So many universities in Europe already got exchange programs where actually people will benefit a lot about having an experience working in developing countries and

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sometimes conditions they won't necessarily find in their local healthcare centers. It needs to be looked at with a lot of care as a point of view of governance of insuring good quality of services and not to send training who is unable to do the task because you don't want to practice with people in their own country, so they can practice in developed countries that's not the idea. The idea is that it could be a way to encourage people to start working in other countries otherwise they wouldn't have thought about it and it will also increase the concept of what is the social responsibility of professions within the healthcare agenda.

WILFRED NKHOMA: Any other comments from the other speakers please.

MALE SPEAKER 2: Yes. I have a few comments to make. I fully agree with the comment about the unilateral increase of the salary of the one sector.. Why other sectors should be left out? What we have experienced we have been implementing TB services through doctor strategy for a long time and we have tried to address the human resource gaps by providing additional manpower. However, over a period of time, this manpower is losing their motivation to work. We need to make at first to keep the motivational levels at higher levels. That will be a very debatable to provide one or two incentives but there can be other ways and means and with a

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kind of objectively to decide how to really want the good work.

And the second comment is about having a common policy for addressing the human resource gap within the public health system and within the national programs. So that there is no migration of health workers from one program to the other.

MALE SPEAKER 2: That issue you also have to contemplate reverse incentives and from European, western European countries, TB workers get paid double salary because of their danger of being infected of tuberculosis. And what had happened is there is a resistance to de-specialize TB treatment management. They do want, they do not like dots particularly because dots can be implemented by nurses not necessary by pulmonologist or technologist, as such, so they do not want to de specialize TB treatment. And the other thing is that they get paid more for patient that are hospitalized, so many patients have accurately undergone three, four months of hospitalization not even having the dots, the medication given by the nurse, they actually have at their bedside table and they are administered by themselves. But if only because healthcare staff will get paid more if the patient is hospitalized. So you need to be very careful for with the balance of how do you manage these issues.

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WILFRED NKHOMA: Well I'm afraid the our time has run out we'll have to bring this to a close now. Let me frankly free speak because that I've just spoken now and it's three area speakers as well. The objective of our session, as you remember, was to look at the human resource situation the challenges and the opportunities that exist. We where able to be guided through that by presentations on the pull and push factors, but also looking at the impact of HIV/AIDS epidemic, and then we have expositions of on how can be best deal with this kind of situation including examples of what governments endures and bilateral can do. I thank everyone for their contribution I now hand over to the coordinators. Thank you.

FEMALE SPEAKER 3: We just wanted to thank everyone who stayed to the very end for what was really I think one of the keynote symposiums that went with the theme of the overall conference. And I'd like to thank our chairman and actually my colleague, Dr Wandwalo for putting together such a wonderful symposium, and I hope that we will see everyone next year at the IUAT meeting in South Africa, thank you.

[END RECORDING]