

Hotline HRH

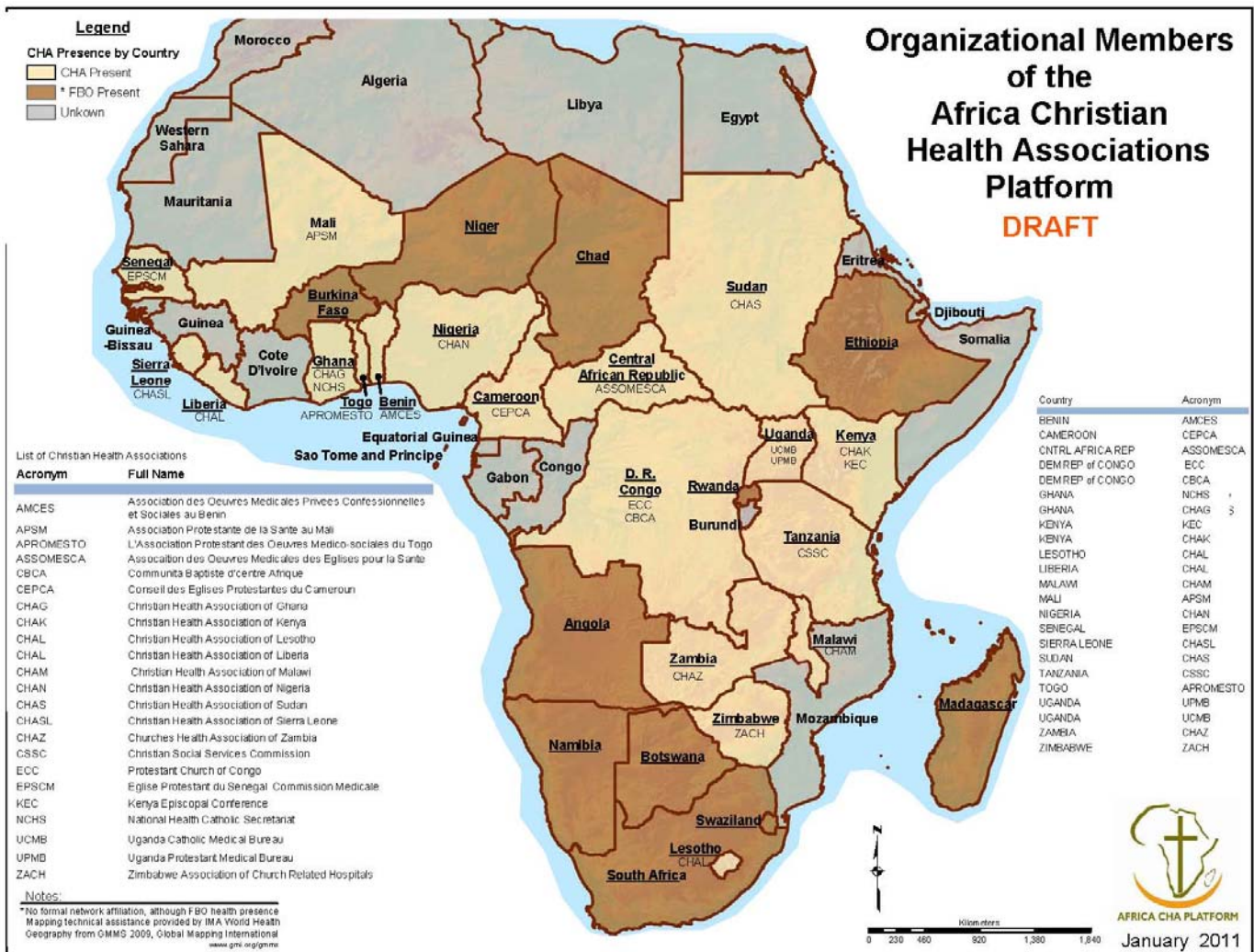


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RESOURCES

African Index Medicus

WHO/AFRO Library is pleased to share new developments on the African Index Medicus (AIM), <http://indexmedicus.afro.who.int> . Please note that 156 African medical journals are now indexed in AIM, some with open access. The full list of these journals is available at: <http://indexmedicus.afro.who.int/Journals/Indexj.htm>. Other documents such as medical dissertations/theses and grey literature are also available in AIM.

Google Analytics (<http://www.google.com/analytics>) was integrated to track the use of AIM Database worldwide. Please click on the link below to read the statistics (geographical map report and visitors overview).

<http://indexmedicus.afro.who.int/iah/fulltext/Dec2010-jan2012GeoMapReport.pdf>

Free online database on health systems

Health Systems Evidence is the world's most comprehensive, free access point for evidence to support policymakers, stakeholders and researchers interested in how to strengthen or reform health systems or in how to get cost-effective programmes, services and drugs to those who need them. This continuously updated repository of syntheses of research has expanded dramatically since its launch less than two years ago. The redeveloped website offers new search functionalities, and is available in seven languages: Arabic, Chinese, English, French, Portuguese, Russian and Spanish. Other enhancements include a filter that allows users to identify evidence targeting low- and middle-income countries, and a customizable evidence service that will provide monthly e-mail alerts identifying new documents available in the database specific to someone's individual interests. Registration to the database is free.

<http://www.mcmasterhealthforum.org/healthsystemsevidence-en>

TRAINING/WORKSHOP INFORMATION

new Virtual Leadership Development Program (VLDP)

MEASURE Evaluation is pleased to announce a *new* Virtual Leadership Development Program (VLDP) focused on identifying and overcoming leadership challenges related to M&E and Gender by health teams working in M&E. The application deadline for the VLDP is **February 3, 2012** and the program will begin March 12, 2012.

PROGRAM EXPECTATIONS

If accepted to the program, participants are expected to: complete all pre-program reading and all

individual and team assignments during the program; work as a team during the VLDP and the 6-month implementation period following it; conduct face-to-face meetings at least every module (2 -3 hours per meeting); produce demonstrable results related to their participation in the VLDP; work on improving leadership skills; invest an average of 4 – 6 hours per week on the VLDP; participate actively in all aspects of the VLDP; and complete assignments in a timely manner.

In return, participating teams will (a) develop insights into their own leadership, management, and communications strengths and those of others on the team to create a stronger and more effective team, and (b) learn and apply leadership tools and approaches to strengthening their Gender-related M&E proficiency, including how to meet and overcome challenges in order to achieve their desired results.

NOTE: Unlike earlier offerings of the VLDP, this VLDP requires that PRIOR to submitting a team application, all team members need to complete the online Gender course at <http://www.globalhealthlearning.org/login.cfm> and submit their certificates of completion along with the team application.

EPN Forum 2012 registration

The next EPN Forum will take place from 21st to 23rd March 2012, in Addis Ababa, Ethiopia. The theme of discussions will be „Access to quality medicines: priority needs, priority actions for today and tomorrow“. The biennial EPN Forum and General meeting is an opportunity for EPN members to meet physically to discuss and make critical decisions in relation to the activities of the Network. Go to the EPN website to download the registration form for your participation.

<http://www.epnetwork.org/forum-2012>

Global Health Forum

The 4th edition Geneva Health Forum will take place in Geneva from 18-20 April 2012 - the theme of which is chronic conditions. The organizers are now inviting frontliners and health workers around the world to submit proposals -whether research abstracts or project experiences. Submissions along the entire health continuum- from upstream multi-sectoral policies for prevention of chronic conditions- both communicable and non communicable and related risk factors to downstream actions in the health sector for detection and treatment.

For further information: http://www.ghf12.org/?page_id=425

Advanced course on monitoring and evaluation: innovations in a dynamic health systems environment

August 2012 OR October 2012

What models, frameworks and tools are suitable for a specific evaluation? How to balance the perspectives of different stakeholders? This course aims to equip you with up-to-date knowledge and state-of-the-art M&E tools.

Monitoring and evaluation skills are essential tools for working in a dynamic development environment. Sectoral plans at national, regional or local levels require a strategic investment in management tools that facilitate informed decision making, planning and implementation. Contextual

changes such as the new aid architecture and multi-stakeholder environments will be examined. Participants will become familiar with new M&E frameworks, techniques and the changing role of information technology. Developing appropriate monitoring and evaluation and management information systems will receive particular emphasis. Rational data collection for optimal usefulness while imposing minimal burden on staff is highlighted. Special attention will, be given to making monitoring and evaluation systems equity aware and to balancing the ethical aspects of an evaluation.

For further information: <http://www.kit.nl/-/INS/49464/Royal-Tropical-Institute/KIT-Development-Policy-and-Practice--/DEV-Training--/Health-systems/Advanced-course-on-monitoring-and-evaluation>

The 7th International Conference on Appropriate Healthcare Technologies for Developing Countries (AHT2012): World Health and Wellbeing

18 - 19 September 2012, London

Research carried out by the World Health Organization (WHO) reveals that almost 95 percent of medics practicing in less developed countries are reliant on medical technology that has been imported.

More than half of this technology, however, is not utilised as staff have insufficient means to maintain the equipment or insufficient knowledge to operate it. Subsequently, there is inadequate provision for administering healthcare in the developing world. Other problems include unreliable power and water supplies, inappropriate donations of equipment, consumables and pharmaceuticals, unsafe disposal of medical equipment and waste, political instability and war. The need is for appropriate, affordable, sustainable and quality equipment, supplies and support in both development and emergency situations.

The 7th IET International Conference provides delegates with a great opportunity to learn about the key issues surrounding healthcare provision in the developing world and to network with fellow workers.

For more information: <http://conferences.theiet.org/aht/index.cfm>

POLICY IMPLEMENTATION ASSESSMENT TOOL

A supportive policy environment is the foundation on which to scale up effective, sustainable health programs. Good policies are important, but they are not sufficient. They must be put into practice. Yet, even the best policies can encounter implementation challenges. Thus, the life of the policy does not end with its creation, which is in fact only the first step in the policy-to-action continuum. Policies are “living documents.” They require various inputs to help them thrive and fulfill their goals. These inputs include clear guidelines and implementation plans, strong leadership, multisectoral stakeholder involvement, adequate and accessible resources, and effective feedback and monitoring systems, among others.

The Policy Implementation Assessment Tool is designed to assist government and civil society advocates to “take the pulse” of policies in their countries. With this information, stakeholders can better understand policy implementation dynamics and identify recommendations for translating health policies into action. Through regular check-ups and renewed commitment, policies can keep on track toward achieving policy goals.

For more information: http://www.healthpolicyinitiative.com/policyimplementation/files/15_piat.html

ARTICLES OF INTEREST

The financial cost of doctors emigrating from sub-Saharan Africa: human capital analysis

The migration of health workers from developing countries to developed ones is a well recognised contributor to weak health systems in low income countries and is considered a primary threat to achieving the health related millennium development goals. In 2010 the World Health Assembly unanimously adopted the first code of practice on the international recruitment of health personnel, which recognises problems related to the global shortage of health staff and calls for all countries to mitigate the negative effects from the migration of health workers. The code also calls on wealthy countries to provide financial assistance to source countries affected by the losses of health workers.

The code is particularly important for sub-Saharan Africa where, according to the World Health Organization, the majority of countries are experiencing a critical shortage of doctors, nurses, and midwives. Many doctors from these countries have left to pursue better career opportunities in developed countries. The problem is exacerbated by the continent bearing the greatest burden of diseases such as HIV/AIDS. While Africa experiences 24% of the global burden of disease, it has only 2% of the global supply of doctors, and less than 1% of expenditures are on global health. Countries with a high prevalence of HIV are particularly affected by shortages of health workers for several reasons. Firstly, HIV has been documented as a leading cause of death among health workers—in the first five years of the AIDS epidemic, for example, an estimated 1 in 10 health workers in Malawi died of AIDS. Secondly, HIV leads to health workers' absenteeism owing to illness among staff or their relatives. Finally, the increased workload resulting from HIV/AIDS illness has not been met by a commensurate increase in staff, leading to increased burnout and fatigue.

For full article: <http://www.bmj.com/content/343/bmj.d7031>

Telecom, health tech companies tie up to offer medical advice on mobile (India) January 20, 2012

Airtel, India's largest mobile phone operator, has recently tied-up with Religare Technologies, a company controlled by promoters of the Fortis hospital chain, to offer healthcare solutions and guidance over telephone.

By paying an introductory tele-consultation fee of Rs 15 a call, Airtel customers can get basic medical guidance on non-emergency health problems through this service, 24 hours, seven days a week. Airtel charges just 50p for this call.

With a customer base of 173 million, Airtel's latest value addition is expected to provide a productive platform for Religare to promote their e-health service. Says the latter's senior vice-president, healthcare IT, Nitin Goyal, "Mobile health is an interesting area, with tremendous growth potential. The play is huge. We plan to build a credible base through this exclusive partnership."

Airtel is not the first to introduce a mobile health scheme in the country, a recent trend. Some months earlier, telecom operators Aircel and Idea had launched a similar service in association with the Apollo Hospital group-promoted Healthnet Global. Such tie-ups are increasingly seen as a good value addition for telecom companies and a business opportunity for healthcare providers.

For full article: <http://www.business-standard.com/india/news/telecom-health-tech-companies-tieto-offer-medical-advicemobile-/462363/>

Toward Development of a Rural Retention Strategy in Lao People's Democratic Republic: Understanding Health Worker Preferences

This technical report presents the results of a discrete choice experiment (DCE) conducted by the Lao People's Democratic Republic Ministry of Health, in partnership with the World Health Organization and *CapacityPlus*, using *CapacityPlus*'s rural retention survey toolkit. The DCE surveyed health professional students and health workers practicing in rural provinces to investigate their motivational preferences for potential strategies to increase attraction and retention in the country's rural and remote settings.

For full report: <http://capacityplus.org/files/resources/Toward-Development-of-a-Rural-Retention-Strategy-in-Lao-PDR.pdf>

The human resource for health situation in Zambia: deficit and maldistribution

Introduction

Current health policy directions in Zambia are formulated in the National Health Strategic Plan. The Plan focuses on national health priorities, which include the human resources (HR) crisis. In this paper we describe the way the HRH establishment is distributed in the different provinces of Zambia, with a view to assess the dimension of shortages and of imbalances in the distribution of health workers by province and by level of care. Population and methods We used secondary data from the "March 2008 payroll data base", which lists all the public servants on the payroll of the Ministry of Health and of the National Health Service facilities. We computed rates and ratios and compared them.

Results

The highest relative concentration of all categories of workers was observed in Northern, Eastern, Lusaka, Western and Luapula provinces (in decreasing order of number of health workers). The ratio of clinical officers (mid-level clinical practitioners) to general medical officer (doctors with university training) varied from 3.77 in the Lusaka to 19.33 in the Northwestern provinces. For registered nurses (3 to 4 years of mid-level training), the ratio went from 3.54 in the Western to 15.00 in Eastern provinces and for enrolled nurses (two years of basic training) from 4.91 in the Luapula to 36.18 in the Southern provinces. This unequal distribution was reflected in the ratio of population per cadre. The provincial distribution of personnel showed a skewed staff distribution in favour of urbanized provinces, e.g. in Lusaka's doctor: population ratio was 1: 6,247 compared to Northern province's ratio of 1: 65,763. In the whole country, the data set showed only 109 staff in health posts: 1 clinical officer, 3 environmental health technologists, 2 registered nurses, 12 enrolled midwives, 32 enrolled nurses, and 59 other. The vacancy rates for level 3 facilities (central hospitals, national level) varied from 5% in Lusaka to 38% in Copperbelt Province; for level 2 facilities (provincial level hospitals), from 30% for Western to 70% for Copperbelt Province; for level 1 facilities (district level hospitals), from 54% for the Southern to 80% for the Western provinces; for rural health centres, vacancies varied from 15% to 63% (for Lusaka and Luapula provinces respectively); for urban health centres the observed vacancy rates varied from 13% for the Lusaka to 96% for the Western provinces. We observed significant shortages in most staff categories, except for support staff, which had a significant surplus. Discussion and Conclusions This case study documents how a peaceful, politically stable African country with a longstanding tradition of strategic management of the health sector and with a track record of innovative approaches dealt with its HRH problems, but still remains with a major absolute and relative shortage of health workers. The case of Zambia reinforces the idea that training more staff is necessary to address the human resources crisis, but it is not sufficient and has to be completed with measures to mitigate attrition and to increase productivity.

For full article: <http://www.human-resources-health.com/content/9/1/30/abstract>

Human Resources for Health: Strengthening health systems - assuring service delivery - improving health

Getting the right workers with the right mix of skills to areas where they are needed most is key to improving health service delivery outcomes. Sub-Saharan Africa will not meet any of the health Millennium Development Goals (MDGs) by 2015 if current rates of progress continue. This is primarily due to weak health systems characterised by the limited capacity, low motivation, absenteeism and overall severe shortage of health workers at all levels. This paper highlights some of the reasons behind the HR crisis and presents the experiences, lessons learned and future strategies of SolidarMed to strengthen the health workforce in SSA.

For position paper: http://www.solidarmed.ch/silvia/publikationen/sm_publications/2011_3_SolidarMed_publications_HR4H.pdf

Using information and communication technology to revitalise continuing professional development for rural health professionals: evidence from a pilot project

This project revitalised continuing professional development (CPD) among rural health professionals in Uganda, Africa, using information and communication technology (ICT). The project was piloted in 3 rural hospitals where CPD activities were failing to meet demand because activities were not properly coordinated, the meetings were too infrequent, the delivery methods were inappropriate, and the content was highly supply-driven and generally irrelevant to the performance needs of the health workers. The project intervention involved the installation of various ICT equipment including computers, liquid crystal display (LCD) projectors, office copiers, printers, spiral binders and CDs. A number of health workers were also trained in ICT use. Three years later, an evaluation study was conducted using interviews, focus group discussions and document review. The results indicated that there had been a rapid increase in the number of staff attending the CPD sessions, an increased staff mix among participants, improved quality of CPD presentations, increased use of locally produced content, more relevant topics discussed and an increased interest by hospital management in CPD, manifested by commitment of staff training funds. Staff motivation, attitude and responsiveness to clients had also improved as a result of the invigorated CPD activities.

For full article: <http://www.rrh.org.au/articles/subviewafro.asp?ArticleID=1222>

Faith-inspired health care providers in Africa: targeting the poor?

“Faith-inspired institutions (FIIs) state as their mission the aim to provide quality health services to all, and in particular to serve the poor or the rural poor. Are FIIs then more willing to (cross)subsidize services for those who can least afford such services? And do FIIs serve the (rural) poor more or better than other providers?”

For full article: http://www.oikoumene.org/fileadmin/files/wcc-main/documents/p4/contact/Contact%20193_EN.pdf

A Comprehensive Framework for Human Resources for Health System Development in Fragile and Post-Conflict States

Responding to the global crisis in human resources for health (HRH) requires systems thinking if a more comprehensive approach is to be promoted. This differs substantially from the traditional emphasis on pre-service education, in-service training, and personnel management. The elements to be included in a more comprehensive assessment and response to HRH system development need

to be derived from experience and evidence from the field, and should be validated into the future in different settings.

In post-conflict situations, large numbers of development partners, including United Nations (UN) agencies, international and local non-government organizations (NGOs), and various others, literally “rush in.” The situation is often characterized by a weak health system, and is complicated by the limited quantity and quality of human resources. New governments and emergent ministries typically have limited capacity to manage all the tasks necessary for reconstruction. Development partners have their own mandates and agendas, and their support usually focuses on specific components of the HRH system even if they are operating within a functional aid coordination mechanism. Disease-specific programs tend to receive priority, often promoting rapid expansion of service delivery through vertical programming. While human resources are recognized as a key, or indeed the key component of the health system, this vertical orientation to addressing needs may well weaken the overall functioning of the HRH system. Innovative thinking that considers the wide range of actors and agencies, both internal and external, is therefore particularly necessary in post-conflict and fragile states.

The World Health Organization (WHO) and technical partners developed the HRH Action Framework in 2005. This Framework and set of tools are used to guide the situation analysis or planning process at the country level. Field experiences in post-conflict and fragile states encourage us to ensure that key elements are identified so as to draw the attention of stakeholders to the prerequisites for effective reconstruction and the development of an HRH system.

For full article: <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001146>

MISCELLANEOUS INFORMATION

Hotline HRH 2012 Monthly Schedule

January 25	July 25
February 22	August 29
March 28	September 26
April 25	October 31
May 30	November 28
June 27	December 26

For questions regarding the *Hotline HRH* please contact:

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HRH Document Portal Access Information

<http://www.imaworldhealth.org/InsideIMA/Resources.aspx>

USER NAME: guest

PASSWORD: twghrh

Documents

<http://africachap.org>

Document Section