Human Resources Development for TB Control

Report of a consultation held on 27 and 28 August 2003

World Health Organization / Rockefeller Foundation
Geneva, Switzerland
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Abbreviations and acronyms

DEWG  DOTS Expansion Working Group
DOTS  the internationally recommended strategy for TB control
GFATM  Global Fund to Fight AIDS, Tuberculosis and Malaria
GHEI  Global Health Equity Initiative
HBC  high-burden country
HR  human resources
HIPC  highly indebted poor country
HIV  human immunodeficiency virus
HRH  human resources for health
JLI  Joint Learning Initiative
MDG  Millennium Development Goal
MDR-TB  multidrug-resistant tuberculosis
MoE  ministry of education
MoH  ministry of health
NGO  nongovernmental organization
NTP  national tuberculosis control programme
PRSP  poverty reduction strategy paper
PVO  private voluntary organization
TB  tuberculosis
WG5  Working Group 5 of the Building Human Resources for Health Equity initiative
WHA  World Health Assembly
3 by 5  3 million people receiving antiretroviral therapy by the year 2005
Executive summary

A consultation of experts from various health system fields was convened by the DOTS Expansion Working Group (DEWG) to make recommendations to the Stop TB Partnership (the Partnership) for confronting the health care workforce crisis in tuberculosis (TB) control. Although addressed to the Partnership, the recommendations are broad and cover issues pertinent to other programmes.

After assessing the human resources (HR) situation in TB control, participants agreed that the role of the Partnership is to help influence or persuade governments (ministries of health, finance and education) and technical and financial partners to invest in or develop HR. The group identified three key areas for action:

**Building the evidence base for planning and advocacy**

Evidence on the HR/HR development gap, derived from properly collected and analysed data, is the best tool for advocacy; it will facilitate the Partnership’s role in assisting countries to develop their national HR planning capabilities. The group recommends that the Partnership:

- collect, analyse and disseminate lessons learned about HR in TB control and other past and current programmes;
- draw from published literature and other sources on HR in other programmes or areas while building evidence on HR in TB control (and disseminate lessons learned);
- design and promote a research agenda on policy and economic dimensions of HR issues in TB control (including economic returns and costs);
- develop/adapt, disseminate and support the use of tools to build databases on current and future HR needs based on tasks and workflow analyses;
- enable national TB control programmes to assess their health system environment (political, legal, professional, regulatory, workplace).

**Positioning and advocacy**

Positioning implies an understanding of HR for TB control within the current social, economic and political context. The Partnership should:

- establish collaborative links and engage in joint activities on HR issues with other programmes, particularly HIV/AIDS and other departments/ministries with responsibility for HR (including WHO);
- develop a strategy or plan for resource mobilization that includes raising resources to strengthen HR capacity for DOTS expansion and maintenance;
- link the Partnership’s objectives and strategies to Millennium Development Goals;
identify opportunities for HR support to TB control through stakeholder analysis;
recommend that countries incorporate a costed HR capacity development component into proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

At global level, the group recommends that the Partnership:
consider a second ministerial conference (to review progress and call attention to gaps);
proactively promote the inclusion of HR issues on the agenda of the international community (regional, international, national conferences and relevant health and development forums).

At national or local level, the group recommends that the Partnership:
assist ministries of health to insert HR development/HR capacity development for health systems (particularly for TB/HIV/malaria) into other poverty reduction processes such as poverty reduction strategy papers or highly indebted poor country initiatives;
ensure that HR issues are considered in the mobilization of the business sector and in expanding the Partnership;
galvanize popular demand by endorsing communities’ calls for improved personnel (quality and quantity) and by lobbying (at regional, international, national and local levels).

The group also recommends that DEWG focus on the health care workforce crisis by either creating a DEWG HR subgroup or an HR working group or by mainstreaming HR.

Capacity building

The group agreed that HR development needs to be understood as a broader undertaking than isolated training courses or initiatives and that building capacity in HR management and planning is required at national, institutional and individual levels. The group recommends that the Partnership:
support HR development capacity at national level through collaboration and coordination with other HR departments (including WHO), programmes and institutions at global and national level;
ensure that, at national level, HR development capacity for DOTS expansion is developed and maintained;
develop HR planning capacity, particularly in high-burden countries, through facilitating tasks analyses for DOTS;
actively collaborate with HR departments, ministries of education, professional associations and other programmes to develop and sustain HR capacity at institutional and individual levels;
develop training tools to ensure that NTP managers, particularly in HBCs, acquire public health skills to allow them to assess their HR situation at programme level and to analyse threats and opportunities for HR and act accordingly.
Human Resources Development for TB Control
1. Introduction

Tuberculosis (TB) ranks third among infectious diseases as a leading cause of death and disability,\(^1\) and its global incidence is growing at approximately 0.4% per year, with faster increases in sub-Saharan Africa and the former Soviet Union.\(^2\) In 2000, there were an estimated 8.2 million new TB cases worldwide (incidence rate of 136/100 000) and 1.82 million deaths from TB, of which 226 000 (12%) were attributable to the human immunodeficiency virus (HIV).\(^3\) The advent of multidrug-resistant TB (MDR-TB) poses an additional challenge for global TB control.\(^4\)

In May 1991, the World Health Assembly (WHA) proposed that all countries should aim to detect at least 70% of all new infectious TB cases (sputum smear-positive) and to cure 85% of them by 2000.\(^5\) In 1998, the First ad hoc Committee on the TB Epidemic, convened by WHO, recommended strengthening various elements of the DOTS strategy to accelerate progress in order to reach these targets.\(^6\) Given the slow progress, WHA deferred the initial targets until 2005.\(^7\) Furthermore, United Nations commitment to sustaining development and eliminating poverty throughout the world resulted in the publication of eight Millennium Development Goals (MDGs). The goal for TB is to halt, and begin to reverse, incidence of the disease by 2015.\(^8\)

In October 2001, the Stop TB Partnership (the Partnership) launched the Global Plan to Stop TB.\(^9\) It specifies the costed activities in implementation and research needed to reach the 2005 WHA targets. Although treatment success under DOTS reached 83%, for patients registered in 2000, case detection in 2002 was only 36%. Current case detection and treatment success rates are not sufficient to warrant a significant reduction in TB transmission; furthermore, if current case detection rates are maintained, the 70% WHA detection target will not be reached until

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\(^3\) Corbett EL et al. The growing burden of tuberculosis: global trends and interactions with the HIV epidemic. Archives of Internal Medicine, 2003, 163(9):1009–1021.


\(^8\) http://www.developmentgoals.org/About_the_goals.htm

2013. DOTS programmes must increase case-finding and improve cure rates in all countries, but particularly in the African region where current cure rates are substantially below average (72%). This requires the extension of DOTS coverage and the development of innovative interventions involving government and nongovernmental health care providers, beyond those public health services currently engaged in TB control activities.

The major constraints to DOTS expansion reported by national TB control programme (NTP) managers from the 22 high-burden countries (HBCs; countries that, together, account for more than 80% of the global TB burden) were lack of qualified staff at different levels; insufficient preparation for decentralization; non-compliance of the private sector with DOTS; inadequate health infrastructure; and weak political commitment.

The DOTS Expansion Working Group (DEWG) considered these constraints and convened the Second ad hoc Committee on the TB Epidemic with the tasks to (1) review the status of the TB epidemic and of control efforts; (2) review progress in implementing the recommendations of the First ad hoc Committee on the TB Epidemic (London, 1998); and (3) analyse the constraints towards achieving the WHA 2005 targets and formulating recommendations in order to inform the Partnership’s mid- to long-term strategic direction for DOTS implementation in the next crucial five years.

The Second ad hoc Committee on the TB Epidemic analysed the constraints and formulated them as challenges for the Partnership to enable countries to reach global TB control targets. These challenges fell within the scope of five broad public health themes:

1. Primary health care providers
2. Human resources for health (HRH)
3. Social mobilization and political commitment
4. Expanding the Partnership

Between June and August 2003, the DEWG secretariat convened five consultations involving selected groups of public health experts. The aim of each consultation was to make recommendations addressing the specific challenges faced by the Partnership within each public health theme.

A group of individuals with expertise in areas such as TB control, human resources (HR) development and health systems (Annex 1) participated in a Consultation on HR Development for TB Control convened jointly by WHO and the Rockefeller Foundation and held at WHO headquarters in Geneva on 27 and 28 August 2003. This report summarizes the results of the consultation and the recommendations presented to the Second ad hoc Committee on the TB Epidemic.

Although addressed to the Partnership, the recommendations of this report are concerned with broader HR issues and cover areas relevant to the global health care workforce crisis; they are therefore pertinent to other programmes and services.

1.1 Rationale for a consultation on HR development for TB control

Neglect of HR was described by the First ad hoc Committee on the TB Epidemic (London, 1998) as one of the main constraints to achieving rapid DOTS expansion. In 2003, inadequate HR ranked first within the top
five constraints to achieving global TB control targets in 17 of the 22 HBCs. Lack of skilled and/or motivated staff, inadequate distribution of staff, poor retention, deficiencies of staff at central level, inadequate planning, provision and technical support for staff at district or provincial levels following decentralization and staff with inadequate qualifications, were reported (Table 1).

**Table 1. Common constraints to DOTS expansion reported by NTP managers from 17 of the 22 HBCs**

<table>
<thead>
<tr>
<th>Constraint</th>
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<tr>
<td>Poor condition of health care infrastructure at primary care level</td>
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<td>Health sector reforms</td>
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<tr>
<td>Lack of financial and human resources</td>
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<tr>
<td>Lack of staff</td>
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<tr>
<td>Limited staff capacity at central and provincial level</td>
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<tr>
<td>Lack of human resources at local level</td>
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<tr>
<td>Lack of TB staff and TB programme managers</td>
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<tr>
<td>Lack of TB staff at provincial level</td>
</tr>
<tr>
<td>Lack of skilled staff</td>
</tr>
<tr>
<td>Lack of supervision</td>
</tr>
<tr>
<td>Low staff motivation and commitment</td>
</tr>
<tr>
<td>High staff turnover</td>
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<tr>
<td>Insufficient laboratory capacity, no quality assurance systems</td>
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<tr>
<td>Staff limited due to quotas set by government</td>
</tr>
<tr>
<td>Inadequate recording and lack of monitoring</td>
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<tr>
<td>High stigma and low community involvement</td>
</tr>
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Furthermore, the Global Health Equity Initiative (GHEI), sponsored by the Rockefeller Foundation, based on the understanding that HR are the most critical component of health and social systems for achieving improved, equitable health outcomes; that HR for health are all the people who deliver health actions and or influence non-health actions with the aim of improving health; that HR are in crisis, particularly in developing countries, with inadequate capacity to respond to health targets and increasing health demands; and that, unless new strategies are developed to improve HR, the short-term response to health crises and long-term improvement of health systems will not occur, has developed the Building Human Resources for Health Equity initiative.

The initiative consists of seven working groups that aim to advance global health equity by strengthening the production, deployment and empowerment of HR in developing countries. Its strategic objectives are to identify and analyse strategically important dimensions of the HR crisis to build an evidence base for new strategies and advocacy; and to develop and promote short- and long-term strategies and solutions for decision-makers at local, national, regional and international levels.

The aim of working group 5 (WG5) is to assess the current and future HR needs to fight selected diseases of poverty (including TB), to identify the HR gap using a supply and demand lens and to explore new models for control within an integrated health system. Its objectives are to determine, based on a needs and availability analysis, the HR required to effectively tackle selected key health problems of developing countries; and to collect and analyse HR information from current work on implementation of health initiatives in developing countries.

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Human resources for health are among the most important resources in health care delivery, and improving HR management will eventually improve health system performance. Developing countries urgently need health care workers with the right skills and experience, in sufficient quantity and at the right place. Factors contributing to the global HR crisis include poor HR planning and management, poor deployment practices, inflexible contracting arrangements, worsening local/global economic circumstances, poor pay and low morale (resulting in low recruitment and retention and migration of trained staff); and the HIV/AIDS epidemic, which has increased pressure on health systems and which causes death, disability and absenteeism of the workforce itself.

Some HBCs have experienced or are experiencing health sector reforms; this poses both threats and opportunities to TB control activities. Despite major investments, severe funding difficulties hinder the quality and quantity of HR, and work systems often stifle initiative and change, resulting in workforces unable to cope with new challenges. Many NTP personnel and others involved in TB control at different levels exercise considerable managerial responsibilities; only a few, however, have acquired managerial expertise, mainly through “hands-on” experience.

In some countries, poor communication between HR planning units in the ministry of health (MoH) and other technical programmes results in a health care workforce unable to meet programme needs. Education systems often develop curricula that disregard national development plans or health needs, thus failing to provide trained professionals with locally required skills. In addition, different global health programmes compete for finite HR, posing a strain on local health systems. Without creative solutions there will be insufficient trained health professionals to implement the strategies proposed by the various programmes.

In order to fully implement DOTS, countries, with the support of international organizations, need to intensify and improve their efforts in HR development. An HR strategy that considers training and skills requirements, working conditions and their relationship to the geographical distribution of health care staff, performance monitoring and supervision and the development of a coherent career structure, is needed. Developing HR for health in developing countries is a high priority for already overstretched health systems and for NTPs. Interventions often fail because they are implemented in isolation from the overall health system. The HR challenges for TB control will not be solved by countries working in isolation; NTP workers are a subset of a country’s health workforce, and their degree of integration with local health systems varies according to local conditions. Increasing the numbers and competence of health care workers for NTPs must therefore be considered from the perspective of the larger health care system.


2. Objectives

2.1 Aim
The aim of the consultation was to provide the Second ad hoc Committee on the TB Epidemic with a series of recommendations for the Partnership to confront the challenges posed by the health care workforce crisis and to ameliorate its impact in enabling countries to reach the global TB control targets.

2.2 Specific objectives
To discuss, build consensus and formulate innovative approaches to overcome the HR challenges faced by the Partnership. The six challenges, compiled by the Second ad hoc Committee on the TB Epidemic and reiterated by the MDGs and the Stop TB Partnership Coordinating Board meetings in Brasília in April 2003, were:

1) How can the Stop TB Partnership Coordinating Board explore ways of increasing the number of trained health staff in key posts for TB control, especially in those countries losing staff to economic migration and deaths from HIV/AIDS?

2) How can the Global Partnership to Stop TB influence bilateral overseas development assistance agencies to increase the amount of funding available for training increased numbers of health care staff, including a dramatic expansion in training of the paramedical staff who in many countries provide the largest part of the provision of TB control activities (e.g. laboratory technicians, nurses and clinical officers)?

3) How can the Global Partnership to Stop TB influence technical agencies to expand the scope and intensity of their technical assistance by training and mobilizing a dramatically expanded number of national counterparts, especially in priority countries?

4) How can the Global Partnership to Stop TB influence ministries of finance to devote extra resources to fund incentive schemes in order to retain key national staff?

5) How can the Global Partnership to Stop TB influence ministries of health to provide increased human resources to strengthen NTPs so that they are able to play their full role in stewardship of TB control activities?

6) How can the Global Partnership to Stop TB influence the World Bank and the International Monetary Fund to revise regulations capping social sector spending in the least developed countries, releasing additional funding to allow these countries to increase salaries for health care staff promoting recruitment and retention?

2.3 Expected outcomes
A set of recommendations for action addressing each of the six HR challenges based on an understanding of the extent to which improving HR can and cannot contribute to achieving the global TB targets.

Recommendations were expected to be specific, actionable, doable and to identify the key stakeholders (doers).
3. Methodology

3.1 Plenary session 1
Chair: Dr Gijs Elzinga, Director of Public Health, National Institute for Public Health and Environment, Bilthoven, The Netherlands.

Dr Mario Raviglione, Director of the WHO Stop TB Department (STB), opened the meeting and placed the consultation within the context of global TB epidemiology, current challenges and progress of the Partnership towards the WHA, the Okinawa and the MDG targets. He stressed the need to attain political commitment, accelerate DOTS expansion to all sectors of care and to engage private providers, including traditional healers. The role of appropriate HR planning and development to achieve DOTS expansion was highlighted.

Dr Ariel Pablos-Mendez, Associate Director of the Rockefeller Foundation, introduced the Human Resources for Health and Development “Joint Learning Initiative” (HRH/JLI), instigated by the Rockefeller Foundation to advance global health equity by strengthening the production, deployment and empowerment of HR for health in developing countries. Human resources are one of the pillars of health, yet have been neglected. The JLI has increased the visibility of HR by facilitating seven working groups, each focusing on a specific dimension of the HR for health challenge. The aim of WG5, “Diseases of the poor”, is to examine current and future HR needs for fighting selected priority diseases including TB.

Ms Karin Bergström, STB, gave a brief account of the history of the Second ad hoc Committee on the TB Epidemic and introduced the six HR challenges identified by the Committee, the tasks and the expected outcomes of the consultation.

3.2 Working groups
Following the plenary session, participants worked in small groups focusing on specific HR challenges. The challenges identified by the Second ad hoc Committee on the TB Epidemic (see Specific objectives 2.2.) were grouped into those concerned with increasing funding for HR development and influencing international bodies (challenges 2 and 6), those related to increasing numbers of trained staff and technical assistance (1 and 3) and challenges related to advocacy at government level to increase posts and promote staff retention (4 and 5). Experts were allocated to a working group (Annex 3) and asked to consider the specific challenges and to make recommendations for action. Group facilitators and rapporteurs were identified and agreed. The group discussions were fed back to the plenary at the end of the day.

3.3 Plenary session 2
Chair: Professor Gilles Dussault, Senior Health Specialist, World Bank Institute, Washington, DC, USA.

Ms Karin Bergström reviewed the results of the working group discussions and introduced the common themes. These themes formed the basis for the discussion, and were further developed by the experts and redefined into three main areas. Experts then carefully considered each main area and worked together to formulate recommendations for action within each specific area.
4. Results

4.1 Working groups

4.1.1 Challenges 2 & 6: Increasing funding for training and influencing international bodies

Increasing training resources and influencing international bodies is part of the Partnership’s advocacy role. Within this context, five strategic, related areas for action were identified:

1. Building an evidence base of interventions used to tackle HR issues for TB control. It is important to identify what approaches work and what does not work, either by learning from past interventions in TB control and/or other programmes or by conducting new research. Stop TB has a relative advantage on evidence and advocacy compared with other programmes, because the Partnership has developed a learning and advocacy culture.

The HR development component of many programmes has often been limited to training courses. Experts thought it important to conduct research in this area to identify the opportunity costs of training courses. It is also vital to conduct research to understand the current HR environment (policies, regulations, existing incentives and disincentives, civil service, unions, professional associations/bodies, etc.) in order to facilitate identification of threats and opportunities to HR capacity and to develop effective interventions.

2. Positioning HR for TB control. Positioning refers to approaching HR for TB control within the current global, regional and national context; taking into consideration the social, economic and political agendas and the environment of the health system.

In doing so, it will be possible to identify possible collaborations (such as with HIV/AIDS programmes), champions and decision-makers for targeted advocacy; and it will facilitate the identification of opportunities to increase the profile of HR issues at global level.

3. Toolkit(s) for country assistance. There is a need to develop or adapt tools to appropriately measure or quantify HR needs for TB control. These tools will be invaluable when assisting countries, particularly HBCs, to include sustainable HR strategies within programme proposals and to develop effective HR management and planning capabilities; as well as important elements of the evaluation processes.

Some HBCs have already received funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and it is the Partnership’s role to support these countries to effectively plan and manage the execution of GFATM funds, appropriately addressing the health workforce crisis. It was also recommended that the Partnership assist countries to incorporate HR capacity development strategies for TB control into proposals to GFATM. The HR component of GFATM proposals could help to link TB control programmes with other programmes where HR issues are also relevant, particularly HIV/AIDS programmes and the 3 by 5 initiative.

4. Institutionalization of HR and raising its profile. The group considered that, given the global health care workforce crisis, it is important and timely to raise the profile of HR for TB control and HR for health care in general at global level. One possible mechanism could be to develop a multisectoral forum for HR...
(encompassing multiple programmes and disciplines).

5. Resource mobilization. All of the above areas for action will facilitate the development of a strategy for resource mobilization geared to raising resources to strengthen HR capacity for DOTS expansion. It is also advisable to broaden the target groups for resource mobilization to include multilateral donors (World Bank, International Monetary Fund); GFATM; bilateral donors; foundations; national governments; private sector; nongovernmental organizations (NGOs) and private voluntary organizations (PVOs).

The Partnership should assist countries to “get to know” and understand donors and thereby develop a targeted resource mobilization strategy. Understandably, donors want to know what has been achieved with their resources; developing evidence and tools to measure HR improvements would assist the evaluation of interventions and produce evidence-aiding advocacy functions.

4.1.2 Challenges 1 & 3: Increasing the numbers of trained health staff and of technical assistance

Challenges 1 and 3 need to be addressed within the context of the current health care workforce crisis, and particularly the HR for TB control environment, taking into consideration: the increased workload resulting from the additional burden posed by HIV and AIDS; the increased patient load due to staff losses (to AIDS, civil unrest or economic migration); and the more complex patients needs, such as those of MDR-TB and TB/HIV patients. Within this milieu, the basic challenge is to successfully implement a HR strategy that truly supports health staff (including health professionals, paramedics and voluntary workers).

Human resources development must be understood more broadly than as isolated training courses or initiatives. A more comprehensive HR development plan needs to be developed (Box 1). In order to inform HR planning, a systematic analysis of the tasks and functions involved in DOTS implementation – particularly in countries with high HIV prevalence – is needed. Tuberculosis control programmes encompass two broad staff components: clinical (health-related) staff and managerial (programmatic) staff. The task analysis must include a detailed definition of the tasks, identification of the staff categories, skills and numbers needed to perform them. The task analysis is a useful tool for appraising global staff statistics (current numbers as well as needs) and for identifying staffing categories and the mix needed. This analysis should also consider the roles of the public and private sectors, including workers at the community level (community health workers and volunteers) and should inform the required production of HR, i.e. education, re-skilling and up-skilling; as well as needs for ongoing (in-service) training and support.

Human resources management and planning capacity at national, institutional, programme and individual levels must be developed and sustained. This requires fostering of governments, professional organizations and policy development units’ duty and commitment to HR capacity building. The task analysis will provide the necessary data to facilitate rational HR planning (short and long term). The outcome of the task analysis will allow the development of a comprehensive training plan, working in close collaboration with HR departments, training divisions, ministries of education, health and finance, professional associations and regulatory bodies. The results of the task analysis can also be used as persuasive advocacy tools with local governments and multilateral and bilateral donor agencies.
Box 1. Developing an HR strategy that supports health staff

Identify programme components:
- Clinical
- Managerial (programmatic)

Plan the HR dimension:
Task analysis for DOT and HIV in HIV-prevalent countries:
- Systematic analysis to identify tasks and functions
- Define tasks in detail
- Identify staffing categories\(^a\) and mix in relation to require production, i.e. education, re-skilling and up-skilling
- Assess staff numbers (current and needed)

Use Task analysis outcome as:
- Tools for rational planning (short and long term)
- Advocacy, evidence to advocate for programme

Develop a comprehensive plan in collaboration with:
- HR departments
- Training divisions
- MOE and other ministries
Also in collaboration with HR departments, develop:
- A plan to retain trained staff
- Career paths

An integrated approach:
- Advocate for integration of health policies and educational practices across programme areas and educational institutes.
- NTP have to convince HR departments, training facilities responsible for TB and ministries of the value of integration.

Capacity building and appropriate pre-service and in-service training and support can be important tools in reducing staff turnover. Staff retention is a complex issue; a plan to retain trained staff must be developed at country level, working in collaboration with HR departments and professional organizations to further develop career paths, create quality improvement and capacity development mechanisms and to ensure continuous professional development and appropriate accreditation and accountability systems.

The private sector must also be encouraged to follow the same quality regulation, career development and accountability practices as the public sector. Lobbying statutory bodies and professional associations and advising regulators and authoritative bodies could facilitate the achievement of consistent practices across sectors.

An integrated approach to HR development is needed. The Partnership must advocate for integration of health policies and educational practices across programme areas and educational institutions; NTP managers have to persuade HR departments, training facilities responsible for TB and the various ministries of the value of integration.

4.1.3 Challenges 4 & 5: Influencing governments to increase posts and promote staff retention

Increasing HR is not an end in itself but rather a step towards improving access to services and attaining better disease control. The first step towards appropriate HR management will involve obtaining evidence of the HR gap by facilitating a task analysis for DOTS in HBCs – including an assessment of the services required – translated into HR needs.

\(^a\) Staffing categories within (a) current system, public sector; (b) private sector; and (c) community level, such as community health workers and volunteers.
There is consensus that technical agencies are not giving sufficient attention to HR issues. Human resources should be planned on the basis of needs rather than available funds. The HR impact of any proposed intervention should be assessed during the planning and grant application processes so that an HR development component can be incorporated into the proposal. Similarly, technical agencies must assess HR capacities and needs as part of their programme review processes. A task analysis will allow the identification of staff needs (numbers, levels and skills) and will demonstrate its rationale, facilitating in turn the advocacy function. The Partnership needs to emphasize the significant role of the use of task analyses during HR planning processes and disseminate this information to technical agencies in a comprehensible and convincing manner.

Increasing HR for TB control is a priority in most HBCs, and in some of them national governments are unable to create new posts or to increase health workers’ salaries as a result of caps in social sector expenditure as a result of international pressure. Different elements, such as increasing staff motivation; improving training and skills to increase quality and, given spare capacity, productivity; mobilizing community resources, NGOs and PVOs through partnership working; increasing training and the stock of health personnel and addressing migration (“brain-drain”) issues, are all important elements of the strategy to improve HR capacity. Training health staff involves training from medical specialists to community workers. When developing training interventions, it is important to think beyond professional health staff-groups; other groups include large numbers of paraprofessionals and health support staff as well as community health workers.

Staff retention needs to be addressed within a systematic, multidimensional framework, taking into consideration country-specific particulars. Elements of a strategy for increasing HR retention are to improve motivation; create career development mechanisms and in-service support; improve remuneration and working conditions and address migration issues in both sending and receiving countries. In many HBCs, there is limited capacity to manage and plan HR. An initial step towards improving staff retention has to be creating or developing HR management capacity (central or decentralized) at country level.

Governments should also ensure that policies and systems are in place to facilitate the production, employment, deployment and retention of the staff needed. It is important to ensure government commitment to the HR for TB control agenda; possible mechanisms for this will be to link the TB control programme to other poverty reduction strategies such as poverty reduction strategy papers (PRSPs) or highly indebted poor country (HIPC) processes and to show the economic analysis (returns and costs) of the programme; to mobilize the business sector; and to assist countries in including costed HR capacity-building strategies as an important component of their grant applications.

GFATM understands that HR issues are a priority in health systems. Technical partners should therefore assist countries to include HR development in their grant proposals to GFATM.

A comprehensive HR plan containing an element to strengthen the health workforce and build HR capacity should be developed. This is particularly important in countries with high HIV prevalence, where additional workload due to increased patient load, more complex cases (TB/HIV), loss of health staff to AIDS and brain-drain results in an
overburdened, demoralized health workforce. In such settings, high priority should be given for preferential HIV treatment for health professionals, particularly nurses.

A huge advocacy campaign is needed to move forward HR development issues, and WHO needs to take the leading role. WHO could call a meeting of technical agencies around DOTS. There is evidence that DOTS works; HR development strategies for DOTS implementation need therefore to be supported to achieve TB control. Technical agencies should be encouraged to assist countries in defining their HR needs; governments in turn, supported by WHO, should be more cooperative with technical agencies.

4.2 Summary

Participants agreed that the Partnership should play a crucial role in influencing, persuading and encouraging players (governments (ministries of health, finance and education) and development and funding agencies) to mobilize additional resources to strengthen the HR component of TB control programmes. Strengthening the HR component of NTPs does not mean merely increasing funding for training courses but, in addition, assisting countries to generate or develop HR management and planning capabilities at country level to ensure appropriate supply of HR in order to achieve improved access to services, better coverage and quality of services, DOTS expansion and enhanced TB control.

Human resources are one of the most important inputs of health programmes and are essential to improve coverage and achieve disease control. However, issues related to HR have been underestimated in scope and complexity, and largely under-resourced. Human resources for TB control should not be considered in isolation but within the overall context of the global health care workforce crisis. It is important to position TB control within the current health system environment, taking into consideration current priorities as well as social, political and economic agendas. This process will facilitate the identification of opportunities for collaboration with other programmes (such as HIV/AIDS or the 3 by 5 initiative) as well as threats to TB control programmes and help to identify champions and decision-makers facilitating targeted advocacy. Human resources development interventions need to be understood more broadly than as mere training initiatives. The Partnership can lead an advocacy initiative to change technical and donor agencies’ narrow concepts of HR development issues.

A solid evidence base constitutes the best tool for advocacy and planning. There is a need to develop an evidence-based approach to assessing the current HR situation, identifying HR needs and gaps, measuring opportunity costs and gathering data for the most effective interventions for HR production, deployment and retention strategies. This approach will help countries to assess their HR needs and to develop HR planning capabilities. Similarly, sensitive methods for HR forecasting are needed to facilitate HR planning and management. It is important to develop or adapt toolkit(s) to standardize research methodology and to facilitate evaluation processes. Evidence on the HR gap or the HR development needs derived from appropriately collected and analysed data will facilitate the Partnership’s advocacy role. Evidence-based advocacy is key to rallying political support and influencing other government departments, donor agencies and the private sector to mobilize resources to attain TB control.
Three main areas for action were identified:

1. Building the evidence base for planning and advocacy
2. Positioning and advocacy
3. Capacity building/development.

**4.2.1 Building the evidence base for planning and advocacy**

There is a scarcity of published literature on HRH in low- and middle-income countries and on HR for TB control or other disease control programmes. The group therefore recommends that the Partnership facilitate or support activities to create/increase/improve the evidence base.

- There are many lessons to be learned from HR development interventions in TB control and other past and current control programmes. Published literature and other sources on HR interventions in other programmes should be drawn from while building evidence on HR for TB control.
- There is a dearth of research on policy issues (policies, regulations, existing incentives and disincentives, civil service, professional bodies, unions, etc.) and economic dimensions of HR issues on TB control (including economic returns and costs).
- There is a need to develop or adapt methods to identify and quantify HR, such as tasks and workflow analyses, in order to aid detection of current HR needs and gaps.
- Methods for identifying future HR needs (forecasting) based on trends of economic migration or increased disease burden are also needed.
- Countries should be assisted to understand the environment (political, workplace, professional) of the current health care workforce crisis.

**4.2.2 Positioning and advocacy**

Positioning HR for TB control within the current global, regional and national political and socioeconomic landscapes, and in context with other health agendas and programmes (particularly HIV/AIDS), through activities such as lobbying and engaging with the media, will allow the Partnership to:

- Collaborate and carry out joint activities with other programmes, particularly HIV/AIDS, and with other HR departments.
- Link the Partnership’s objectives and strategies to Millennium Development Goals in order to raise the profile of HR for TB control.
- Facilitate a stakeholder analysis to identify champions and decision-makers to aid the Partnership’s advocacy role.
- Place and maintain HR on global and national agendas.

Advocacy strategies need to be developed at both global and national levels. At global level this would include:

- Considering a second ministerial conference (to review progress since the Amsterdam meeting and to call attention to HR gaps).
- Developing formalized, multisectoral international HR forums with technical, political and financial components to increase the visibility of HR, promote dialogue between different stakeholders and advance advocacy.

At national/local level this would include:

- Obtaining government commitment by demonstrating the financial gain for the country and by linking TB programmes to other poverty reduction strategies, such as the PRSP/HIPC processes, and showing the economic returns of well implemented NTPs.
Mobilizing the business sector, galvanizing popular demand for improved access to services and quality and quantity of HR and continuing to lobby.

The Partnership should develop a targeted and marketed plan for resource mobilization to support the Global Plan to Stop TB.

Positioning HR within the global agenda will facilitate assistance to countries, including an HR component, when writing grant proposal applications to GFATM; countries should be compelled to assess the HR impact of such proposals.

DEWG should increase its focus on HR issues either by developing a DEWG subgroup on HR or by identifying other means to mainstream HR.

4.2.3 Capacity building/development

Developing and sustaining institutional capacity. Different sectors involved in the production and deployment of health care staff (clinical and managerial/programmatic) need to develop and maintain HR planning and management skills. This should be done in coordination with the different institutions (multisectoral) and involve:

- Planning the HR dimension (task analysis for DOTS and HIV in countries with high prevalence of coinfection) and linking the outcomes of task analysis with the production and deployment of HR.
- Developing management structures and mechanisms for HR planning and development.
- At the level of educational institutions, medical schools and professional organizations should be encouraged to adopt the DOTS strategy.
- Strengthening the links between specific programmes and educational departments, ministries, institutions and professional organizations up to implementation level.

Developing and sustaining individual capacity. National TB control programmes and country-based staff should be assisted to develop and maintain individual HR planning and management capabilities by developing a comprehensive training plan. Continuing education/development should be part of the training plan, and it should also have a follow-up component. The training package should be developed in collaboration with:

- HR departments
- MoE and other ministries
- Training divisions
- Professional associations and regulatory bodies.
Government responsibility for good quality health care does not end at government office level but is maintained throughout the health system. It is therefore necessary to assist countries to develop mechanisms to regulate the quality of practice in the private sector. The private sector can be encouraged to adapt the same comprehensive HR plan, through advocacy, or to use statutory bodies to advise on regulations and authorize/legislate practices.

The issue of retention requires a systematic approach that takes into consideration the multiple dimensions and complexity of the problem. Strategies should be country specific and based on the identification of local threats and opportunities. The Partnership can advocate for:

► Developing, in collaboration with HR departments, a plan to retain trained staff.

► From the capacity building perspective, retention strategies to include strengthening of pre-service and in-service training, developing continuous education and support activities, generating career paths and quality control and accountability mechanisms.

► Staff retention issues (policies, ethics, economics) to be discussed both in countries losing their health staff as well as in receiving countries.
Area 1: Building the evidence base for planning and advocacy

The group recommends that the Partnership:

► collect, analyse and disseminate lessons learned about HR in TB control and other past and current programmes;
► draw from published literature and other sources on HR in other programmes or areas while building evidence on HR in TB control (and disseminate lessons learned);
► design and promote a research agenda on policy and economic dimensions of HR issues in TB control (including economic returns and costs);
► develop/adapt, disseminate and support the use of tools to build databases on current and future HR needs based on tasks and workflow analysis;
► enable NTPs to assess their health system environment (political, legal, professional, regulatory, workplace).

The Partnership should also assess the environment in which it operates in order to identify champions, threats and opportunities for HR, and to facilitate its advocacy role.

Area 2: Positioning and advocacy

The group recommends that the Partnership:

► establish collaborative links and engage in joint activities on HR issues with other programmes, particularly HIV/AIDS and other departments/ministries with responsibility for HR (including WHO);
► develop a strategy or plan for resource mobilization that includes raising resources to strengthen HR capacity for DOTS expansion and maintenance;
► link the Partnership’s objectives and strategies to Millennium Development Goals;
► identify opportunities for HR support to TB control through stakeholder analysis;
► recommend that countries incorporate a costed HR capacity development component into GFATM proposals.

At global level, the group recommends that the Partnership:

► consider a second ministerial conference to review progress since the Amsterdam meeting and to call attention to gaps;
► proactively promote the inclusion of HR issues on the agenda of the international community (regional, international, national conferences and relevant health and development forums).
At a national/local level, the group recommends that the Stop TB Partnership:

- assist MoHs to insert HR development/HR capacity development for health systems (particularly for TB/HIV/malaria) into other poverty reduction programmes/strategies such as the PRSP/HIPC processes;
- ensure that HR issues are considered in the mobilization of the business sector and in expanding the Partnership;
- galvanize popular demand by endorsing communities’ calls for improved personnel (quality and quantity) and by lobbying (at regional, international, national and local levels).

The group also recommends that DEWG focus on HR (either by creating a DEWG HR subgroup or an HR working group or by mainstreaming HR).

Area 3: Capacity building

The group recommends that the Partnership:

- support HR development capacity at national level through collaboration and coordination with other HR departments (including WHO), programmes and institutions at global and national level;
- ensure that, at national level, HR development capacity for DOTS expansion is developed and maintained;
- assist countries, particularly HBCs, to develop HR planning capacity through facilitating tasks analyses for DOTS;
- actively collaborate with HR departments, MoEs, professional associations and other programmes to develop and sustain HR capacity at institutional and individual levels;
- develop training tools to ensure that NTP managers, particularly in HBCs, acquire public health skills to allow them to assess their HR situation at programme level and to analyse threats and opportunities for HR and act accordingly.

These recommendations will be presented to the Second ad hoc Committee on the TB Epidemic in September 2003.
Annex 1: Participants

Joint Consultation on Human Resources Development for TB Control

27 and 28 August 2003, WHO headquarters, Geneva, Switzerland

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Annex 2: Agenda

Joint Consultation on Human Resources Development for TB Control

27 and 28 August 2003, WHO headquarters, Geneva, Switzerland

Wednesday, 27 August, 2003

Chairperson: Dr Gijs Elzinga, Rapporteur: Dr José Figueroa

<table>
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<tr>
<th>Plenary</th>
<th>Time</th>
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<tr>
<td>09:00–09:10</td>
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<td>Introduction and keynote remarks</td>
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<td>Dr Mario Raviglione, Director, STB, WHO</td>
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<td>09:10–09:20</td>
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<td>The Rockefeller Foundation WG5 initiative</td>
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<td>Dr Ariel Pablos-Mendez, Rockefeller Foundation</td>
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<td>09:20–09:30</td>
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<td>Consultation objectives and expected outcomes</td>
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<td>Ms Karin Bergström, TBS/STB, WHO</td>
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<th>Working groups</th>
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<td>Feedback from working groups, Rapporteurs (30 min each)</td>
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<td>Discussion – Defining what can be done</td>
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## Plenary

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<td>Ms Karin Bergström, TBS/STB, WHO</td>
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<td>09:15–10:30</td>
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<td>Outlining an action plan</td>
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<td>Plenary discussion: Defining recommendations for the Second ad hoc committee</td>
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<td>Recommendations for action</td>
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<td>16:30–17:00</td>
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<td>Dr Léopold Blanc, Acting TBS Coordinator, WHO</td>
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End of the meeting
## Annex 3: Provisional distribution of participants by working group

### Joint Consultation on Human Resources Development for TB Control

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<tr>
<th>Working Group</th>
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<tr>
<td><strong>Challenges 2 &amp; 6: Increasing funding for training and influencing international bodies</strong></td>
<td>Dr Ariel Pablos-Mendez&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Mr Orville Adams</td>
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<td>Ms Susan Bacheller&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Dr José Figueroa</td>
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<td>Dr Saidi Egwaga</td>
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<td><strong>Challenges 1 &amp; 3: Increasing the numbers of trained health staff and of technical assistance</strong></td>
<td>Professor David Sanders&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Dr Léopold Blanc</td>
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<td>Dr Carmelia Basri</td>
<td>Ms Joanne Sheppard&lt;sup&gt;b&lt;/sup&gt;</td>
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<td>Dr Gijs Elzinga</td>
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<td>Dr Kaspar Wyss</td>
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<td><strong>Challenges 4 &amp; 5: Influencing governments to increase posts and promote staff retention</strong></td>
<td>Dr Peter Hornby&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Dr Mario Dal Poz</td>
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<td>Prof Gilles Dussault&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Dr Dermot Maher</td>
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<td>Dr Alberto Romualdez</td>
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<td>Ms Christiane Wiskow</td>
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<sup>a</sup> Suggested facilitators are in italics.  
<sup>b</sup> Suggested rapporteurs are in bold.