アフリカ地域
保健システム強化（広域）協力プログラム準備
調査報告書

平成23年3月
（2011年）

独立行政法人国際協力機構
ケニア事務所

序　　文

独立行政法人国際協力機構は、サブサハラ・アフリカ地域の保健システム強化にかかる協力準備調査を実施することを決定し、平成 22 年 4 月から平成 23 年 3 月までこの調査を実施いたしました。

調査結果を踏まえて、国際協力機構内外の関係者との情報共有および意見交換を行い、解析された情報に基づく広域協力プログラム計画案が策定され、ここに本報告書完成の運びとなりました。

この報告書が、本計画の推進に寄与するとともに、アフリカ地域の友好親善の一層の発展に役立つことを願うものです。

終わりに、調査にご協力とご支援をいただいた関係各位に対し心より感謝申し上げるとともに、一層のご支援をお願いする次第です。

平成 23 年 4 月

独立行政法人国際協力機構
ケニア事務所
所長　加藤正明

要　　約

アフリカ域内における MDGs達成に向けた取り組みを加速させると共に、その成果を 2015 年を超えて自立発展的なものとするためには、保健システムの強化が必要不可欠である。各国で保健システムの強化に取り組むためには、保健システムを設計・構築するシステム研究者や中央政府レベルの保健行政官、保健システムを運営・管理する中央や地方レベルの保健行政官の能力強化が必要である。

2007 年 4 月のAU保健大臣会合では、保健システムの強化をアフリカにおける保健開発の共通の優先課題とすることが合意され、「アフリカ保健戦略」が採択された。2000 年の世界保健報告の中で保健システムに着目したWHOは、2007 年 11 月に保健システム強化のフレームワークを「Everybody's Business」として発表した。2008 年のTICAD IVで採択された「横浜行動計画」では、今後 5 年間に取られる保健分野の日本政府の措置として、「保健システムの強化」が「母子保健の向上」、「感染症対策」と並んで明記されている。「国際保健の課題と日本の貢献研究会[1]」は、保健システム強化を国際保健協力における最重要課題とすることを提唱し、特に保健人材、保健情報、保健財政の分野における国際協力のあり方について提言をまとめている。

このように国際的に保健システム強化の必要性が叫ばれる中、アフリカにおいても保健システムの設計・構築や、運営・管理にかかる教育プログラムを提供する大学等が増加しているが、それら域内リソースは、ケニア、南アフリカ、ナイジェリアなど一部の国に偏在している。また、域内リソースをつなぐネットワーク機関もアフリカ主導によっていくつか設立されているが、ネットワークを活かした活動は限定的である。さらに、世界銀行、USAID、JICA など、域内リソースと協力した人材育成事業を行っている援助機関もあるが、全体として体系的・戦略的に推進されていない。

国境を越えた知識や経験の共有を促進することで、従来の国別の支援を補完・強化することが期待される。そのためには、国際保健の課題と日本の貢献研究会が提唱した「高等教育機関による国際ネットワークを強化する」アプローチが有効である。アフリカにおいては、既に多数の「高等教育機関による国際ネットワーク」が設立されている。また、HHA を例として開発援助機関（開発パートナー）の協調を目指す動きも活発である。JICA は 2010 年 9 月に HHA に正式に加盟することで、援助協調メカニズムを活用し、効果的・効率的な広域プログラムの形成を図っていく。

本調査は、アフリカにおける持続的な保健システム強化への貢献を目指し、保健行政官を主たる対象とする広域的な人材育成プログラムの案を形成することを目的として実施された。具体的には、①アフリカ域内の既存の高等教育・研究機関およびそのネットワーク機関との協力、②他開発パートナーとの協調・協働の二つを基本方針としている。

①に関しては、アフリカにおける保健医療分野の高等教育機関の学術ネットワークである AHLMN の活用を念頭に置き、その事務局を務める AMREF と協力、また②に関しては HHA を活用して CoP を進めることとし、HHA を主導する世界銀行と協力し、いずれの場合もアフリカ域内を対象とした第三国研修のスキームを中心に実施していくこととした。

第三国研修は 2011 年度に開始することにしているが、それに先立ち、本プログラムの一環として AMREF、世界銀行、JICA の共催により、2011 年 3 月 21 日から 25 日の 5 日間、ナイロビの AMREF 国際研修センターにて東アフリカ域内ガバナンス研修が開催された。研修の成果品として国別アクションプランが作成され、研修修了者に対するフォローアップ支援活動を三機関（世銀、AMREF および JICA）で継続することが同意されている。

[1] 2008 年に開催された TICAD IV 及び G8 北海道洞爺湖サミットをターゲットに、政策提言を行うことを目的に官民協同（外務省、厚労省、財務省、大学、NGO、旧国際協力銀行、旧 JICA の代表が参画）で組織された。通称、武見ワーキング・グループ。

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付属資料

1. ローカルコンサルタント報告書 1 (Final report by Dr. Nangami)
2. ローカルコンサルタント報告書 2 (Final report by Dr. Kombe)
3. 「東アフリカ保健セクターにおける保健システム向上のためのガバナンスおよびアカウンタビリティ能力強化研修」報告書

東アフリカ保健セクターにおける保健システム向上のためのガバナンスおよびアカウンタビリティ能力強化研修、2011 年 3 月 21～25 日、AMREF 国際研修センター、ナイロビ

各国研修参加者、共催関係者および講師

ブルンジ

ウガンダ

ケニア

ルワンダ

タンザニア

歓迎会時

略 語 表

略語	英語	日本語
AHLMN	Africa Health Leadership and Management Network	アフリカ保健リーダーシップマネジメントネットワーク
AMREF	African Medical and Research Foundation	
AU	African Union	アフリカ連合
CESAG	Centre Africain d'Etudes Superieures de Gestion	(セネガル)高等経営学校
CoP	Communities of Practice	
ECSA-HC	The Eastern, Central and Southern Africa Health Community	東部、中央部、南部アフリカ保健コミュニティ
EQUINET	The Regional Network in Health in Southern Africa	南部アフリカ保健地域ネットワーク
GAVI	Global Alliance for Vaccines and Immunisation (GAVI Alliance)	GAVI アライアンス(ワクチン予防接種世界同盟)
HEALTH Alliance	Higher Education Alliance for Leadership Through Health	
HEP Net	Health Economics and Policy Network in Africa	
HHA	Harmonization for Health in Africa	
HRH	Human Resources for Health	保健人材
HSO	Health Systems for Outcomes	(世界銀行)広域プログラム
HSS	Health System Strengthening	保健システム強化
IHP^{+}	International Health Partnership and related initiatives	国際保健パートナーシップ
JICA	Japan International Cooperation Agency	独立行政法人国際協力機構
KEMRI	Kenya Medical Research Institute	ケニア中央医学研究所
LMSP	Leadership, Management and Sustainability Program	(USAID)リーダーシップ、マネジメントプログラム
MDGs	Millennium Development Goals	ミレニアム開発目標
MSH	Management Science for Health	(USAID)保健マネジメントプログラム
NEPAD	The New Partnership for Africa's Development	アフリカ開発のための新パートナーシップ
NGO	Non-Governmental Organization	非政府組織
NPO	Non-Profit Organization	非営利組織
RBF	Results-Based Financing	成果主義型資金拠出
SADC	Southern African Development Community	南部アフリカ開発共同体
SIDA	Swedish International Development Cooperation Agency	スウェーデン国際開発協力庁
TICAD IV	The Fourth Tokyo International Conference on African Development	第4回アフリカ開発会議
UNFPA	United Nations Population Fund	国連人口基金
UNICEF	United Nations Children's Fund	国連児童基金
USAID	United States Agency for International Development	米国国際開発庁
WBI	World Bank Institute	世界銀行研究所
WHO	World Health Organization	世界保健機関

第 1 章 調査の概要

1-1 調査の背景と目的

アフリカの多くの国においては、2015 年までの保健分野 MDGs の達成が危ぶまれている。その背景には複数の原因があるものの、保健サービスの普遍的かつ持続的な提供を支える保健システムの脆弱性、とりわけサービス提供を担う保健人材の危機的な不足が、最大の原因と認識されている。保健人材の不足は、アフリカ諸国も優先開発課題の一つに掲げている。2007 年 4 月の AU 保健大臣会合において「アフリカ保健戦略 2007-2015:公正と開発のための保健システム強化」を加盟 53 カ国の共通戦略として採択しており、保健人材の育成はその主要課題の一つと位置づけられている。

これらを背景として、日本政府は 2008 年 5 月の TICAD IV で採択された「横浜行動計画」において、2012 年を目標とする 5 年間にアフリカ域内で 10 万人の保健医療従事者の研修を行うことを表明している。さらに、TICAD IV 及び同年開催された G8 北海道洞爺湖サミットをターゲットに政策提言を行うことを目的に官民協同(外務省、厚労省、財務省、大学、NGO、旧国際協力銀行、旧 JICA の代表が参画)で組織された「国際保健の課題と日本の貢献研究会(通称、武見ワーキング・グループ)」は、保健システム強化を国際保健協力における最重要課題とすることを提唱し、特に保健人材、保健情報、保健財政の分野における国際協力のあり方について提言をまとめている。保健人材に関しては具体的に、「資源の限られている領域で保健・医学教育へのアクセスを保障するため、高等教育機関による国際ネットワークを強化する」ことが提言されている。

保健人材の危機において着目されているのは、一義的には保健サービスの提供を現場で担う医師、看護師、薬剤師、検査技師等の医療専門職である。しかし、持続的な保健システム強化を目指すためには、保健システムをつくり動かす「保健システム・マネジャー」すなわち保健行政官や保健施設の責任者の育成が不可欠である。JICA も従来から、タンザニア、ケニア、南アフリカ等で、地方レベルの保健行政官のキャパシティ向上を支援している。しかし、近年アフリカにおいても保健システム強化に向けた様々な取組みが試行・展開されていることから、国境を越えた知識や経験の共有を促進することで、従来の国別の支援を補完・強化することが期待される。そのためには、武見ワーキング・グループが提唱する「高等教育機関による国際ネットワークを強化する」アプローチが有効である。

なお、アフリカにおいては、既に多数の「高等教育機関による国際ネットワーク」が設立され、活動している。また、開発援助機関(開発パートナー)の協調を目指す動きも活発である。JICA は従来これらの枠組みに積極的に対応してこなかったが、広域プログラムの形成に際しては、これら既存の枠組みとの協調・協働を模索することが効果的・効率的である。

以上を踏まえ、本調査は、アフリカ域内の既存の高等教育機関およびそのネットワーク機関との協力および他開発パートナーとの協調・協働を基本方針とし、アフリカにおける持続的な保健システム強化への貢献を目指し、保健行政官を主たる対象とする広域的な人材育成プログラムの案を形成することを目的として実施された。

1-2 調査の方法

本調査は、文献資料、ウェブ公開資料等の二次資料を主として用い、東南部アフリカ諸国 10 カ国(ボツワナ国、エチオピア国、ケニア国、南アフリカ国、スーダン国、スワジランド国、タンザニア国、ウガンダ国、ザンビア国、ジンバブエ国)を対象に実施した(当初は、域内協力機構である東アフリカ共同体、ECSA-HC、Inter-governmental Authority on Development、SADC のいずれかに加盟する

24 ヵ国：ケニア国、南アフリカ国、タンザニア国、ウガンダ国、レソト国、マラウイ国、モーリシャス国、セイシェル国、スワジランド国、ザンビア国、ジンバブエ国、ブルンジ国、ルワンダ国、アンゴラ国、ボツワナ国、コンゴ民主共和国、マダガスカル国、モザンビーク国、ナミビア国、スーダン国、エチオピア国、エリトリア国、ソマリア国、ジブチ国を対象として計画したが、非英語圏については選定されたローカルコンサルタントによる情報収集・分析が困難であることから除外した。またウェブ等による資料収集にローカルコンサルタントが困難を来した国についても除外した）。文献調査に加え、ケニア、南アフリカ、タンザニア、ウガンダに対しては、ローカルコンサルタントによる現地調査を行い、追加情報を収集した。

ローカルコンサルタントによる情報収集および現地調査は 2009 年 11 月～12 月にかけて実施した。本邦コンサルタントによる追加情報収集ならびにローカルコンサルタントおよび本邦コンサルタントによる情報解析は 2009 年 12 月～2010 年 3 月にかけて実施した。解析された情報に基づく広域協力プログラム案の検討については 2010 年 2 月～3 月にかけて実施した。調査結果を踏まえて、JICA 内外の関係者との情報共有および意見交換を 2010 年 2 月および 2010 年 5 月に行い、協力プログラム案を策定した。

本調査は、以下のメンバーによって実施した。

氏名・所属先	担当業務
瀧澤　郁雄 JICA ケニア事務所広域企画調査員	総括
喜多　桂子 シニアコンサルタント グローバルリンクマネージメント（株）	候補ネットワークの選定案と協力プログラム案の検討、世界銀行・アフリカ開発銀行、世界エイズ・結核・マラリア基金、GAVI アライアンスの支援動向の整理
Dr. Yeri Kombe Director, Center for Public Health Research, Kenya Medical Research Institute [2]	東南部アフリカ地域の高等教育・研究機関に関するインベントリー調査
Dr. Mabel N. Nangami, Dept. of Health Management, Schoolof Public Health, Moi University	東南部アフリカ地域の高等教育機関・研究機関のネットワークに関するインベントリー調査
神谷　祐介 大阪大学大学院国際公共政策研究科 JICA 専門嘱託（2010 年 4 月以降）	世銀、世界エイズ・結核・マラリア基金、GAVI アライアンスの支援動向分析および連携可能性の検討

1-3 調査の制限

ローカルコンサルタントによる調査は、文献調査およびウェブ等で公開されている資料を主体とし、質問表調査および一部機関への現地調査（ケニア・南アフリカ・タンザニア・ウガンダ）を通じて追加情報を得るデザインであった。しかしながら、ウェブ上の情報が更新されておらずそのために入手した情報が古かったという、情報入手手段の制約がある。これは、調査の内容そのものだけでなく、質問票送付先やインタビュー対象としてアクセスすべきスタッフがネット上から得た情報と異なっていたために、しかるべきスタッフに辿り着くまでに時間を要した要因ともなった。また、現地調査のタイミングがクリスマス休暇中と重なってしまったことにより、一部の機関では予定していたスタッフへのインタビューを行うことができず、十分な情報を得ることができていない。従って、ローカルコンサルタントによる調査のうち、特に対象 24 ヵ国における高等教育・研究機関のインベントリー調査については、

[2] 2010 年 1 月以降、(Mr) Surow A. Adaw, Research Officer, KEMRI が アシスタントとして Dr. Kombe の作業をサポートした。

本邦コンサルタントの支援を得て追加収集されたケニア国内の機関にかかる情報を除き、情報の量および質のいずれも十分とは言えない。従ってその解析結果についてもデータの制約に注意して読まれる必要がある。

しかし、「アフリカ域内の既存の高等教育機関およびそのネットワーク機関との協力および他開発パートナーとの協調・協働を基本方針とし、アフリカにおける持続的な保健システム強化への貢献を目指した保健行政官を主たる対象とする広域的な人材育成プログラムの案を形成する」という調査の目的を達成するためにはほぼ十分な情報収集・分析ができた。

第 2 章　保健システム強化分野の援助動向

2-1 保健システム強化にかかる国際的潮流

国際政治および市民社会双方のレベルにおける保健開発への関心の高まりを受け、全世界の保健分野への開発援助総額は 2000 年の 107 億ドルから 2007 年の 218 億ドルへと 2 倍に、うちアフリカ向けは 10 億ドルから 50 億ドルへと 5 倍に拡大した。特に、GAVIアライアンス、世界エイズ・結核・マラリア基金、UNITAID[3]など、疾病対策に焦点を当てた大規模な国際保健パートナーシップの設立や、PEPFAR[4]、PMI[5]など大規模な二国間イニシアティブの設立により、感染症対策への集中的な資源投下がなされた。巨大な援助資金を背景として感染症対策が急激に進展する一方で、乳幼児死亡率の削減や妊産婦の健康改善の遅れに対する懸念が拡大し、開発援助資金が疾病対策以外の保健分野にも広く効果を及ぼすよう、保健システム全体を強化する必要性が広く認識されるようになってきた。

2007 年 4 月の AU 保健大臣会合では、保健システムの強化をアフリカにおける保健開発の共通の優先課題とすることが合意され、「アフリカ保健戦略」が採択された。また 2007 年に策定された世銀の新保健戦略においても、保健サービスが的確に提供されるよう保健システムの強化に注力していくことが明記されている。

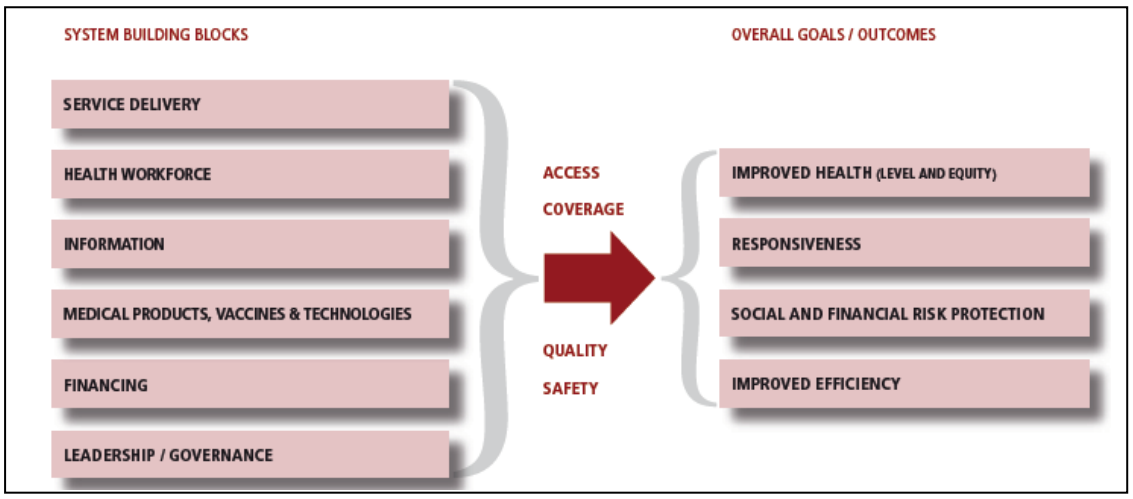
2000 年の世界保健報告の中で保健システムに着目した WHO は、2007 年 11 月に保健システム強化のフレームワークを「Everybody's Business」として発表した。同フレームワークによって、保健システムは以下のように概念化された（図1）。

保健システムの目的：①健康の改善（全体水準および公正）、②期待の充足、③社会的・経済的リスクからの保護、④効率の改善

保健システムの中間アウトプット：①保健サービスへのアクセス、②保健サービスのカバレッジ、③保健サービスの質、④保健サービスの安全性

保健システムの構成要素：①保健サービス提供、②保健人材、③保健情報、④医薬品等、⑤保健財政、⑥リーダーシップ・ガバナンス

図 1　WHO の保健システムフレームワーク



[3] 2006 年 9 月、国連総会の共同宣言に基づいて創設。航空券連帯税などの革新的資金メカニズムからの資金の提供を受け、開発途上国におけるエイズ、マラリア、結核の医薬品を支援する国際機関。本部ジュネーブ。
[4] (U.S.) President's Emergency Plan for AIDS Relief（米国大統領 HIV/エイズ救済緊急計画）の略。
[5] (U.S.) President's Malaria Initiative（米国大統領マラリアイニシアティブ）の略。

本来有機的に結びついて機能する保健システムの構成要素を 6 つに分解して捉えることの危険性にも留意する必要があるが、複雑な保健システムを整理して捉え、その強化のための具体的な切り口やアプローチを検討するためのフレームワークとして有効である。

2008 年の TICAD IV で採択された「横浜行動計画」では、今後 5 年間に取られる保健分野の措置として、「保健システムの強化」が「母子保健の向上」、「感染症対策」と並んで明記されている。具体的には以下 4 つの項目に取り組むべきであるとされている。

- アフリカにおいて、1000 人あたり最低 2.3 人の保健医療従事者を確保するとの WHO の目標達成に向けた共通の取組に貢献するため、保健医療従事者の育成及び定着を促進する。
- 保健インフラ及び施設の拡充等を通じ、保健医療サービスの供給を改善する。
- 正確な保健情報に基づいた政策決定を可能とするため、保健システムのモニタリング及び評価体制の構築を促進する。
- 野口英世アフリカ賞を通じて、アフリカにおいて感染症と闘うための医療研究及び模範的な医療活動を奨励する。

こうした国際的潮流や、官民合同の「国際保健の課題と日本の貢献研究会（通称、武見ワーキング・グループ）」による提言等を踏まえ、2008 年の G8 北海道洞爺湖会議では、保健システム強化が感染症対策や母子保健と並ぶ重要な課題として位置づけられた。「国際保健の課題と日本の貢献研究会」は、国際的なタスクフォースを組織し、「保健システム強化に向けたグローバルアクション（Global Action for Health System Strengthening）」を取りまとめており、その中で特に保健人材、保健財政、保健情報に焦点を当てた提言を行っている。

2-2 保健システム強化のアプローチ

保健システム強化が必要であるとの国際的な合意はできたものの、どうすれば保健システムの強化が実現するのかについては国際的な合意はなく、おそらく世界の全ての国に当てはまるようなモデルもあり得ないであろう。しかし、保健システム強化に有効なツールが開発され、また世界の様々な国における経験から、何がうまくいき、何がうまくいかなかったか、実証的な知識の体系化が進みつつある。

例えば、保健システムを構成する 6 つの要素の一つである保健人材については、以下のようなような資料が取りまとめられている。

保健人材計画に関して:

- WHO. Models and tools for health workforce planning and projections. Geneva: WHO; 2010.
- Bossert T, Barnighausen T, Bowser D, et al. Assessing financing, education, management and policy context for strategic planning of human resources for health. Geneva: WHO; 2007.

保健人材の定着に関して:

- WHO. Increasing access to health workers in remote and rural areas through improved retention: Global policy recommendations. Geneva: WHO; 2010.

保健人材の M&E に関して:

- Dal Poz MR, Gupta N, Quain E and Soucat ALB, eds. Handbook on monitoring and evaluation of human resources for health, with special applications for low- and middle-income countries. Geneva: WHO, World Bank, USAID; 2009.

保健人材に関連するウェブページ:

- Capacity Plus. HRH Global Resource Center, [http://www.hrhresourcecenter.org/]

しかし、蓄積が進むこれらの知見を、実際に必要としているアフリカ各国の保健行政官等にいかに効果的に届けるかは、残された課題である。報告書やウェブを介した非能動的な情報発信・共有は迅速かつ効率的な方法であるが、その効果は限定的である。

2-3 保健システム強化にかかる人材育成プログラム(アフリカ域内)

ここでは、保健システム強化にかかる知見のアフリカ域内(アフリカを含む全世界)での普及を、フェース・トゥ・フェースの研修や遠隔教育を通じて支援している他開発パートナーの取組みとして、世界銀行/WBI によるプログラムと、USAID/MSH(Management Science for Health)によるプログラムを取り上げる。他にも散発的な研修や各国内での研修は多数実施されているが、①保健システム強化に焦点をあて、②アフリカ域内(を含む全世界)の複数の国を対称に、③アフリカ域内の協力機関とのパートナーシップによって、④継続的に実施されているプログラムとしては、これらが代表的なものである。

ア. World Bank/WBI: *Flagship Program on Health Sector Reform and Sustainable Financing*

保健システム強化に貢献する途上国の人材育成と協力機関・人材ネットワークの強化を目的として 1997 年に開始されたプログラムである。WBI の保健人材育成プログラムとしては最も成功しているものとされている。2008 年までに、51 ヶ国の、政策策定・研究・実施に携わるのべ 19,400 人に対して、合計 319 の短期トレーニングを行った。プログラムは、米国 Harvard School of Public Health を協力機関としてワシントン DC で開催されるグローバルコース、各地域・国の協力機関を通じて提供されるリージョナルコース/ナショナルコース、Global Development Learning Network 等を活用した遠隔コースから構成される。サブサハラ・アフリカでは、これまで 13 カ国においてリージョナルまたはナショナルコースが開催されている。最近では、2010 年 6 月に、National University of Rwanda を協力機関として保健財政をテーマとするリージョナルコースがキガリで開催され、JICA からも神谷専門嘱託がオブザーバーとして参加した。

本プログラムを対象とした評価によると、特にサブサハラ・アフリカのリージョナルコースの充実および同コースを実施する域内協力機関の能力強化の必要性が指摘されている。サブサハラ・アフリカにおけるこれまでの本プログラム協力機関は、南アフリカの University of Cape Town および Witwatersrand University、セネガルの Centre Africain d'Etudes Superieures de Gestion(CESAG)であり、上述のプログラムからルワンダの National University of Rwanda が加わったが、いまだ数は限られている。また参加者のニーズにより適確に応えるために、①「何をすべきか」ではなく「どのようにそれを行えばよいか」という実践上のノウハウが習得できるトレーニング内容とすること、②より根拠にも基づくベストプラクティスを紹介することが提言されている。これらの提言は、類似の人材育成プログラムを形成する際にも考慮すべき点である。

なお、これらのプログラムは従来 WBI によるプログラムとして実施されてきたが、キガリで実施された保健財政のコースについては、アフリカの保健開発に携わる開発パートナー間の協調を進めるための機構である Harmonization for Health in Africa (HHA)によるプログラムとして開催されており、より開かれたプログラム運営が志向されている。今後、保健財政以外の保健システム強化に関連したテーマでもリージョナルコースが構想されているが、現時点では具体的な計画はない。

イ. USAID/Management Science for Health: *Leadership, Management and Sustainability Program (LMSP), 2005-2010*

MSH のLMSPは、USAID の支援のもと、リプロダクティブ・ヘルス、HIV/エイズ、感染症、母子保健分野における効果的なマネージャー・リーダーを育成することを目的して、17 ヶ国（アフリカでは、ケニア、南アフリカ、タンザニア、エチオピア、南スーダン、ガーナ、ナイジェリア、コートジボアール、コンゴ民主共和国）を対象に実施されている。プログラムは、様々な保健活動やプログラムを運営管理する立場にある保健行政官や保健施設の長（マネジャー兼リーダー）の役割に着目し、彼らのキャパシティ・ディベロップメントを通じた、持続可能な保健システムの強化およびサービスデリバリーの強化を狙っている。具体的には、短期間の研修と職場での適用を組み合わせてモジュール化されたプログラムを中心とするLeadership Development Program に加え、ウエブサイト上と現場でのチームミーティングを組み合わせたVirtual Leadership Development Program、ウエブサイトを通じて指導を受けたりフォーラムに参加したりできるLeaderNetを組み合わせ、MSHが開発した、指導力（leading）：①Scanning、②Focusing、③Aligning /Mobilizing、④inspiringおよび管理力（managing）：①Planning、②Organizing、③Implementing、④Monitoring & Evaluationの、8 つの要素からなるフレームワークに基づく人材育成を行っている（図 2）。

図 2 LMS Results Model

LMSP の域内協力機関としては、タンザニアのアルーシャに本拠を置き、東南部アフリカ域内に複数の分校を持つ East and Southern Africa Management Institute が参画している。保健行政官および保健施設の長のマネジメントおよびリーダーシップ・スキルの重要性に着目したユニークなプログラムであり、JICA がケニアやタンザニアの地方保健行政官を対象として支援している内容とも親和性が高い。

保健システム強化のためには、「より良い保健システムを作る人材」（Designers＝政策研究者や特に中央レベルの保健行政官と、「保健システムをより良く機能させる、あるいは実践する人材」（Operators＝中央と地方レベルの保健行政官や保健医療従事者）の両者の育成が必要であるが、WBI の Flagship Program は前者、MSH の LMSP は後者により焦点を当てた取組みと理解される。

第 3 章　東南部アフリカの保健システム強化に関連した高等教育・研究機関ネットワーク

3-1 主要ネットワークの概要

ローカルコンサルタントのインターネット調査では、サブサハラ・アフリカにおいて保健システム強化に関連した活動を行っている約 50 の高等教育機関のネットワークが把握された。このうち、拠点をアフリカ以外に置いているネットワークや、西アフリカに拠点をおいているネットワーク、複数国を対象としていないネットワークなどは分析の対象外とした。残る 11 ネットワークの概要をまとめたのが、図 3 である（次頁参照）。個々の詳細については、ローカルコンサルタント報告書（別添1、2）を参照されたい。

3-2　協調・協働ネットワーク（候補）の選定

図 3 に含まれる11のネットワーク組織中、1.の ECSA-HC は各国政府が参画する保健分野に特化した域内協力機構であり、厳密には高等教育・研究機関のネットワークではない。しかし、保健分野における域内のネットワーク組織としては歴史も実績もあり、先方は JICA との協力にも関心を示している。9.の AHWO も、各国政府が中心的役割を果たすことが期待されており、高等教育・研究機関のネットワークではないが、各国で形成されることが期待されているナショナル・オブザーバトリーには高等教育機関・研究機関が参画する可能性はある。5.の IUCEA は、東アフリカ共同体加盟国における大学間協力を進めることを目的とする組織であり、高等教育機関の公的なネットワークではあるが、保健分野に特化したものではない。3.の SEAPREN は、東南部アフリカ 7 カ国の政策研究機関（主に民間）のネットワークであるが、同じく保健分野に特化したものではない。

8.の CREHS は、アフリカ 4 カ国の高等教育・研究機関が参画し、保健システムにかかる研究を行っているが、代表はイギリスの大学である。4.の GEGA は、南アフリカの民間組織が代表を務め、保健システムにかかる研究を行っているが、対象地域はアフリカに限定されず、グローバルである。2.の EQUINET および 7. の REACH Policy Initiative は、いずれも保健システムにかかる研究の促進と、研究結果（エビデンス）に基づく政策提言（アドボカシー）を主たる目的としている。EQUINET は、ジンバブエを拠点とする民間研究機関が代表を務めている。他方、REACH Policy Initiative は東アフリカ共同体のイニシアティブであり、公的な性格が強い。

11 のネットワーク組織の中で、域内の高等教育・研究機関によるネットワークであり、保健システムにかかる研究および研究結果に基づく政策提言にとどまらず、保健システムをつくり・動かす人材の育成に焦点を当てているのは、6. の HEP Net、10.の HEALTH Alliance、および 11. の AHLMN である。このうち、HEALTH Alliance は、設立の経緯から、米国と東部アフリカの大学間の連携という色が強い。

以上の分析から、協力プログラムの形成における協調・協働すべき既存の域内高等教育・研究機関ネットワークとしては、HEP Net および AHLMN が妥当である。2000 年に設立された HEP Net の代表は南アフリカの University of Cape Town (UCT)である。UCT は上述した WBI による Flagship Program の協力機関ともなっており、保健システムに関連した豊富な研究・人材育成実績を有する。HEP Net はアフリカ域内（英語圏）8 カ国から 37 機関が参加しており、地域的な範囲も広い。共通の教材（ティーチング・ケース）作成、メンバー機関からの学会参加の促進など、ネットワークとしての活動実績もある。これまでスウェーデン（SIDA）からの支援を得ているが、2010 年に支援が終わる予定である。

一方、AHLMN は、名称のとおり、保健分野におけるマネジメントとリーダーシップの強化に関心を持つ高等教育・研究機関が集まり、2008 年に設立された比較的新しいネットワークである。代表を務めるケニアの AMREF は国際的 NPO としてアフリカ域内各国で人材育成事業を展開しており、ナ

図 3　主要ネットワークの概要

	ネットワーク名	設立日	加盟国	加盟機関名	他のネットワークとのリンク	主な活動内容
1.	ECSA-HC The Eastern, Central and Southern Africa Health Community	1974 Convention of common-wealth Regional, later amended in 2002	10 countries – Kenya, Lesotho, Malawi, Mauritius, Seychelles, Swaziland, Uganda, Tanzania, Zambia, and Zimbabwe	Government Ministries of Health, Permanent Secretaries, Directors of Health, Deans of Medical and Public Health Schools, technical expertise from member states	EQUINET through University of Namibia / Limpopo;, SADC, East African Community) , Global Health Workforce Alliance	Advocacy HRH Capacity building Brokerage, Coordination, inter-sectoral collaboration and harmonization of policies and programmes partnerships & alliances
2.	EQUINET The Regional Network on Equity in Health in Southern Africa	1999 SADC	8 - Namibia, Botswana, Malawi, Mozambique, South Africa, Tanzania, Zambia, Zimbabwe	Research, civil society, health sector organizations - Each Country and institution is responsible for specific theme	HEP Net, ECSA-HC, GEGA, SADC Parliamentary Forum, African Network for Health, Research and Development	Promotes networking using bottom-up approaches
3.	SEAPREN - Southern and Eastern Africa Policy Research Network	1999	7 South Africa, Botswana, Zambia, Namibia, Tanzania, Uganda, Kenya	7 Policy research institutions in the 7 countries in Southern and Eastern Africa – Institute for Policy and Research, EPRC, ESRF, Department of Policy Research Unit in South Africa	NEPAD, AU, African Economic Research Consortium	Capacity building Research, exchange best practices Discussion papers newsletter
4.	GEGA Global Equity Gauge Alliance	1999	6 in Africa - Kenya South Africa, Zambia, Zimbabwe, Burkina Faso 3 in Asia - China, Bangladesh, India and Thailand 3 in Latin America – Chile, Ecuador, Peru	12 Equity Gauges based in each country with 9 having a national focus and 3 are district level focus	EQUINET, African Population and Health Research Centre, Health Systems Trust, WHO	Research Advocacy Community participation Parliamentary alliances Newsletter since 2002
5.	IUCEA Inter-University Council of East Africa	1980/2000 East African Community	5 in EAC - Tanzania, Uganda, Kenya, Rwanda, Burundi	All universities - private /public in East Africa	East African Community	Training QA, HIV & gender Research -HIV-LVP
6.	HEP Net Health Economics & Policy Network in Africa	2000 University unit, Cape Town	8- South Africa, Tanzania, Uganda, Zambia, Zimbabwe, Nigeria, Ghana, Kenya	37 Research, academic, government departments in countries	EQUINET Consortium for Research into Equitable Health Systems, Strategies for Health Insurance for Equity in Less Developed	Networking Capacity building Research Technical support Newsletter / Bulletin

					Countries	
7.	**REACH Policy Initiative** Regional East African Community Health (REACH) Policy Initiative	2003 East African Community	5 in East African Community - Kenya, Uganda, Tanzania, Rwanda, Burundi	Government Ministries of Health, Permanent Secretaries, Directors of Health, Deans of Medical and Public Health Schools, technical expertise from member states	ESCA-HC, IUCEA, WHO, EQUINET, GEGA, East African Integrated Disease Surveillance Network	Newsletter
8.	**CREHS** Consortium for Research into Equitable Health Systems	2004	4 in Africa - South Africa, Nigeria, Kenya, Tanzania, 2 in Asia – India, Thailand 1 in UK – London School of Hygiene and Tropical Medicine	10 –Indian Institute of technology, KEMRI-Wellcome Trust Research, HPRG, HEU, University of Cape Town, Center for Health Policy, Ifakara HI, KHPP	WHO, EQUINET, HEP Net, Alliance for Health Policy and Systems Research	Policy research Newsletter Publications on website
9.	**AHWO** African Health Workforce Observatory	2006 WHO-Congo	WHO partner states	National observatories and regional networks (institutions)	Global Health Workforce Alliance, Commission for European Community, NEPAD, ECSA-HC, Capacity project (USAID), WAHO, Council for Sustainable Health Development, OCEAC, WHO	Capacity building, research, practice, networking best practices
10.	**HEALTH Alliance** Higher Education Alliance for Leadership Through Health	2008 Legal status	6 in Africa- Uganda, Tanzania, Kenya, Rwanda, Ethiopia & DRC 1 – USA	7 Universities-SPH- Makerere, Muhimbili, Moi, Nairobi, Rwanda, Jimma, Kinshasa (Johns Hopkings University, Tulane University	East African Community, ECSA-HC,	Training - Leadership in Public Health in East Africa, Research Journal /newsletter
11.	**AHLMN** African Health and Leadership Management Network	2008 Legal status still pending	14 in Africa – Kenya, Uganda, Tanzania, DRC, Benin, Cote D'ivoire, Ghana, Senegal, Togo, Nigeria, Bukina Faso, South Africa, Botswana and Mozambique, 4- USA, Netherlands, Portugal, Switzerland	16 African leadership/ management org, international organizations, research and technical support organizations and individuals Paid membership ranging from $250 to $1000	WHO , ECSA-HC, Regional AIDs Training Network	Institutional capacity building, research, policy advocacy, ethics/standards technical assistance

イロビの研修所では多数の国際研修が実施されている。セネガルの CESAG はマネジメント分野の高等教育機関であり、WBI による Flagship Program の協力機関ともなっている。その他にも、MSH の LMSP の協力機関であるタンザニアの East and Southern Africa Management Institute、Ghana Institute of Management and Public Administration、ケニアの Strathmore Business School など、マネジメントに関しては域内でも名の通った実績ある高等教育・研究機関がメンバーとして参加しており、モザンビークも含めて英語圏に限定されない広範囲なメンバーを有しているのが特徴である。ただし、義務とされている参加費を支払った機関は少なく、外部からの支援もないため、ネットワークとしての活動はいまだ限定的である。

なお、HEP Net および AHLMN に共通する課題としては、いずれも高等教育・研究機関が私的に集まって作られたネットワークであるため、恒常的な財源がないという点である。この点、AHLMN は加盟機関からの参加費（正規メンバーは年間$1,000、準メンバーは年間$500）によってオーバーヘッドコストをまかなう計画であるが、参加費を支払った機関は限られており、仮に全メンバーが支払ったとしても収入規模としては大きくない。これらネットワークと協働で事業を行う場合には協力終了後の持続性の担保が鍵となる。そのためにも、他開発パートナーを巻き込む努力が必要である。

3-3 各ネットワークによるキャパシティ自己評価

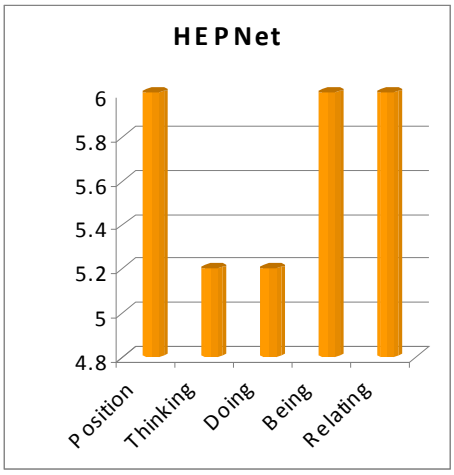
ローカルコンサルタントによる情報収集の一環として、各ネットワークの関係者による自らのキャパシティにかかる自己評価（一部はローカルコンサルタントによる聞き取り評価）を実施した。参考まで、HEP Net と AHLMN にかかる自己評価を掲載する。評価項目は、図 4 のとおりである。

図 4 ネットワークの自己評価項目

評価項目
1) Position： ネットワークの対外的なイメージと認知度はどうか。
2) Thinking & Learning：ネットワークは環境の変化に対応した戦略的な変化ができるか。
3) Doing：ネットワークはどのような活動をしているか。活動の結果、戦略書や計画書等において想定されていた成果が得られているか。
4) Being：ネットワークは組織規定等に基づいて活動を行っているか。
5) Relating & Balance：ネットワークがどれほどうまくその他のネットワークや関係者と関係を築いているか。

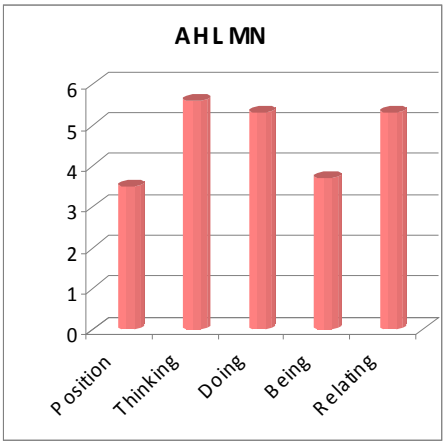
＜HEP Net＞

5 つのカテゴリーの平均 5.7 で、自己評価対象 6 ネットワークのうち最も高い得点である。域内において協力関係にあるネットワークを多く有することが、「Positioning（認知度）」、「Being（活動）」、「Relating（他ネットワークとの関係）」での高い得点に反映されている。特に、研究活動において他ネットワークとの堅実な協力関係を構築している。他方、5 つのカテゴリーでは「Thinking & Learning 」と「Doing」は、比較的得点が低い。これは、トレーニングプログラム（修士レベル）、ネットワーキング活動、組織のキャパシティ・ディベロップメント等の活動が SIDA による資金援助で実施されているために、戦略計画（Strategic Plan）の内容を変更することが難しいことが影響している。



＜AHLMN＞

他ネットワークと異なり、「Doing」 の得点が「Thinking & Learning」とともに比較的高い点数であるのが特徴である。2008 年に設立されたばかりではあるが、戦略計画(Strategic Plan)が既に作成されていることが高い得点に反映されている。他方、「Position」 と「Being」の得点は他カテゴリーと比較して低く、6 ネットワークのうちでも最も低いあるいは 2 番目に低い結果となっている。これは、未だ法的地位が獲得されていないことが関係している。新しいネットワークであっても、WHO とのパートナーシップを有していることや、域内での実績と多くのパートナー機関を有する AMREF が事務局となっていることにより、将来的な可能性が見込める。



3-4 本邦コンサルタントによるネットワーク評価

上述のネットワークによる自己評価結果と、ローカルコンサルタントによるSWOT分析[6]を参考に、本邦コンサルタントが整理したHEP NetとAHLMN の強みと課題を図 5 に示す。

図 5 本邦コンサルタントによるネットワーク評価

ネットワーク	強み	課題
HEP Net	・戦略計画が作成されている。 ・域内における多くのネットワークとパートナーシップを有する。 ・政策研究に関してメンバー機関と国際的機関との間のネットワークを促進している。保健分野のニュースレターやパンフレットも発行している。	・SIDA による支援が終了する 2010 年以降の財政が不明慮である。 ・各メンバー国国内でのメンバー機関間のネットワーキングが弱い(メンバーシップは国および機関である)。同時に域内におけるメンバー国を増やす必要がある。 ・研究活動は EQUINET 等を通じて行っているため、研究で得られたエビデンスを他分野の活動に十分に反映できていない。
AHLMN	・WHO の支援を得てネットワークが設立されていることから、WHO Management and Leadership Framework のすべての部分にフォーカスした活動を展開することを目指している。 ・アフリカの国々によるイニシアティブとオーナーシップのもとで設立され、域内に多くのメンバー機関を有する。 ・戦略計画書が作成されている。 ・域内において豊富な活動実績とパートナー機関を有する AMREF が事務局を勤めており、事務局長のネットワークに対する強いコミットメントは強い。	・設立間もないことから法的地位が未だ確立されていない。 ・メンバーは機関と個人であり、国(保健省)との公式的な関係がない。 ・メンバー全 33 機関のうち、会員費を払っているのは、6 ヶ国(ケニア、セネガル、ガーナ、ボツワナ、モザンビーク、南アフリカ)のわずか 16 機関・個人会員にとどまる。このため、計画された活動を実施するには財政的基盤が弱い。 ・メンバーによるネットワーク活動への支援は受身的である。

[6] 組織の戦略立案における現状分析手法の一つ。内部環境である強み(Strength)と弱み(Weakness)、外部環境である機会(Opportunity)と脅威(Threat)を整理し、評価する。それぞれの頭文字をとり、SWOT 分析という。

第 4 章　東南部アフリカ域内の保健システム強化に関連した高等教育・研究機関

4-1　保健システム強化にかかるプログラムを提供する高等教育・研究機関の分布

ローカルコンサルタントによるインターネット検索では、一般的なマネジメント（パブリックマネジメント、ビジネスマネジメント等）に関するトレーニングあるいは保健システム・マネジメントに関するトレーニングプログラムを提供している機関として、計 79 機関が選定された。後者の合計は 34 機関であり、国別の内訳は、ケニア 12 機関、南アフリカ 11 機関、タンザニア 3 機関、ウガンダ 5 機関、ボツワナ 3 機関であった。調査の制約として上述したように、本ウェブサーチは網羅的ではなく、域内で保健システム強化に関連するプログラムを提供している高等教育・研究機関の全体像を捉えてはいない。しかし、全体的な傾向として、ケニアおよび南アフリカに人材育成プログラムを提供する機関が集中していることは、事実と考えられる。

4-2　保健システム強化にかかるプログラムを提供する高等教育・研究機関の例

ローカルコンサルタントが選定した 79 機関のうち、比較的情報が正確と考えられるケニア、南アフリカ、タンザニア、ウガンダの 4 カ国において保健システム・マネジメントに関連するトレーニングプログラムを提供している機関のリストを、図 6 に示す。一般に想定される公衆衛生分野の大学院（school of public health 例：Maseno University、Moi University、University of Nairobi、University of Cape Town、University of the Western Cape、University of the Witwatersrand、Makerere University 等）に加えて、公共・ビジネスマネジメントを専門とする教育機関（Strathmore Business School、Kenya Institute of Administration、Mzumbe University など）、NPO（AMREF など）等、多様な機関がトレーニングを提供しており、コース内容（対象領域）や、コースのレベル（degree、diploma、certificate）も様々である。少なくともこれらの国々においては、国内に多数の技術リソースが存在することが想定される。

図 6　保健システム・マネジメントに関連するトレーニングプログラム提供する機関の例

（ケニア、南アフリカ、タンザニア、ウガンダ）

	機関名	スクール・学部	コース名またはコースに含まれる科目*	レベル
ケニア	African Medical Research Foundation	Nairobi International Training Centre	Monitoring & Evaluation, Health Service Organization & Management, Strategic Management in Health & Development Programs, Strategic Leadership in Health & Development Programs, Health Finance Management, Logistics Management for Drugs and Other Health Commodities.	Certificate Diploma
	Great Lakes University of Kisumu	Tropical Institute of Community Health	Health Informatics, Health Financing and Health Economics, Health Systems Development and Management, Health Services Planning & Management, Health Policy Analysis and Development, Development & Management of Decentralized Health Systems, Management of Essential Drugs, Human Resource Management & Development.	Certificate Diploma Higher degree
	Kenya Institute of Administration	Commerce and Business Administration Program	Human Resource Management, Management Information System, Operational Management & Strategic Management, Project Planning & Management.	Certificate

	Kenya Medical Training College	College	Health Systems Management offered as unit for every student admitted in any program.	Certificate Diploma
	Kenya Methodist University	Department of Health Systems Management & Medical Education	Health Care Financing, Health Care Law & Ethics, Health Management Information Systems, Health Policy Planning & Development, Projects Management & Evaluation, Management of District Health Services, Quality Assurance and Control in Health Care.	Diploma Higher degree
	Maseno University	School of Public Health	Management of Health Systems, Monitoring & Evaluation, Health Service Organization & Management, Strategic Management in Health & Development Programs, Health Finance Management, Logistics Management for Drugs	Higher degree
	Moi University	School of Public Health	Hospital Administration, Health Services Management, Human Resource Management, Health Policy & Planning, Health Care Financing, Health Economics.	Master
	Strathmore University	Business School	Strategic Health Care Management, Innovation in Health Care, Health Care Law and Ethics, Talent Management in Health Care, Health Management Information System, Supply Chain Management in Health Care, Health Economics and Health Financing, Health Policy Planning & Development.	Certificate Diploma
	University of Nairobi	School of Public Health, Faculty of Medicine	Health Services Administration and Evaluation, Health Planning and Development.	Master
南アフリカ	University of Cape Town	Faculty of Health Sciences. School of Public Health. Health Economics Unit.	Health Systems Management & Policy, Health Economics & Policy, Management of Health Resources, Financial Management, Health Management Theories, Health Information Systems.	Certificate Diploma Master
	University of Free State	School of Public Health	Principles of Management, Administration /Management of Health Services, Concepts in Health Care, Health Care and Law, Health Care Planning, Health Programs and Specialized Services, Human Resource Management, Quality Assurance	Diploma Masters
	University of KwaZulu Natal	Nelson Mandela School of Medicine. Howard College. College of Health Sciences. Department of Public Health.	Hospital Management and Medicines Management, Health Services Management, Human Resource Management, Health Economics and Financing, Corporate Hospital Governance.	Certificate Higher degree

	University of the Western Cape	Faculty of Community and Health Sciences, School of Public Health.	Health Management, Human Resource Management & Development, Planning & Resource Management, Budgeting Skills, Health Information Systems, Health Systems Research, Health Promotion.	Certificate Higher degree
	University of the Witwatersrand	Faculty of Health Sciences. School of Public Health. Centre for Health Policy.	Health Systems & Policy, Health care Financing, Health Systems Approaches to Planning, Hospital Management, Hospital Risk Management.	Certificate Masters
タンザニア	Muhimbili University of Health and Allied Sciences	Department of Public Health	Health Policy & Management, Financing & Financial Management of Health Systems.	Certificate Masters
	Mzumbe University	Faculty of Public Administration and Management	Administration & Management, Human Resource Management, Procurement & Supply Chain Management, Health Systems Management.	Certificate Diploma Bachelors Masters
ウガンダ	International Health Sciences University	Institute of Health Policy and Management	Health Management, Public Health (Economics & Policy), Health Care Leadership & Management.	Diploma Higher degree
	Makerere University	School of Public Health, College of Health Sciences.	Public Health Policy, Health Planning & Management, Health Economics & Finance, Primary Health Care & Health Systems Management.	Diploma Higher degree
		Regional Centre for Quality of Health Care	Quality of Health Care.	Diploma

* ローカルコンサルタントにより収集された情報の精度が機関によって異なるため、注意が必要である。ここに記される以上に様々な領域を対象として包括的にトレーニングを提供している機関もあるものと考えられる。

4-3 本邦コンサルタントによる高等教育・研究機関の評価

図 6 に掲げた保健システム強化に関連するトレーニングプログラムを提供する域内の高等教育・研究機関（全 18）のうち、本邦コンサルタントがローカルコンサルタントの作業結果について追加インタビューにて補足・確認でき、かつ/または、質問票の回答結果と記載内容を照らし合わせてその内容の正確さを確認できた、計 10 機関（ケニア 8 機関とタンザニア 2 機関）について、本邦コンサルタントが整理した強みと課題を図 7 に示す。

分析対象は限られるものの、比較的新しいテーマである保健システムではあるが徐々にコースの充実が図られてきていること、多くの機関がアフリカ域内からの留学生を受け入れていること、カリキュラム開発や講師陣の確保に関して高等教育機関の間で既に様々な協力関係が構築されていること（特にケニア国内）、一方で国を超えた域内の高等教育機関同志の協力関係はいまだ限定的であることがうかがえる。

ケニアについては、公衆衛生分野の大学・大学院、マネジメント分野の高等教育機関、国際的 NPO など、多様な機関が保健システム強化に関連する長期・短期の教育・研修プログラムを提供している。ただし、それらは相互に連携しながら運営されており、一部の大学（Strathmore Business School）では、講師の多くを海外から招聘してプログラムを実施していることから、実際の技術リソースとしては比較的限られている可能性もあることには留意すべきである。ケニアを拠点とした人材育成プログラムを検討する場合には、可能な限りこれら機関が有する技術リソースのプールの中からテーマに応じた適任者を選定する必要がある。

図 7 本邦コンサルタントによる高等教育・研究機関評価 （ケニア、タンザニア）

機関名	強み	課題
African Medical Research Foundation (AMREF)	・ Nairobi International Training Centre は 1957 年に設立されて以降、アフリカ地域内外での豊富なトレーニング実績がある。保健システムと政策強化はセンターの主な方針である。トレーニングセンターが提供しているプログラムは、Moi 大学と提携した修士コース（2 年）、ディプロマコース（1 年）、短期コース（1 週間～3 ヶ月）、E-learning プログラム、遠隔教育プログラムがある。保健システムマネジメントに関する短期研修コース(年間約 50 名)のカリキュラムはクライアントの要望を反映させたオーダーメイドである。 ・ センター内には研究結果をトレーニングとリンクさせる仕組みがあるため、トレーニング内容は科学的根拠に基づいた実践的な内容となっている。また、トレーニング後のフィードバックの仕組みもある。 ・ 充実したトレーニング設備を有する。 ・ リソースセンターには、約 10,000 のオンライン教材を備えているが、その 90%以上は保健分野の教材である。 センター関係者によれば、ケニアで最良の図書館である。 ・ Moi University、Kenya Methodist University、Strathmore University を始めとする、他機関とのパートナーシップを有し活発な活動を行っている。 ・ アフリカ域内外から多くの留学生を受け入れている。現在、シエラレオネ、ナイジェリア、ソマリア、南スーダン、タンザニア、ウガンダ、アフガニスタン、リベリア、カメルーン、マラウイ、ボツワナ、ザンビア、南アフリカからの留学生がいる。 ・ AMREF 本部, AMREF 資金調達事務所 (米国、英国、ドイツ、イタリア、オーストリア、スペイン、モロッコ、オーストラリア) を含む 14 の機関から財政的な支援を得ている。	・ 国内外から多くのトレーニング参加者を受け入れるが、敷地内に宿泊施設がない。 ・ トレーニングスタッフを他のパートナー機関に頼っている。 ・ ファンドの調達は今後の課題である。現行の短期トレーニングプログラムでは、1 週間当たり 300 ドルを標準的受講料として徴収している。 ・ 学術的な論文を重視する人にとっては、AMREF はアカデミックな機関でないので、魅力に欠けるところがある。このため、センターでは、Moi University、 KeMU、Strathmore University と覚書を結んで協力を行っている。
Great Lakes University of Kisumu	・ 保健システムマネジメント・トレーニングは、短期コース、修了証コース、学部コースで独立したプログラムとして設置されている。 ・ 地方ヘルスシステム強化のためのインターベンションパッケージの開発・実施に携わっている。	

	・トレーニングスタッフは十分な能力を有している。 ・多くの機関とのパートナーシップおよび支援を得ている。主なパートナーは、保健省、the National AIDS Control Council of Kenya、WHO アフリカ地域事務所、AMREF、UNICEF、UNFPA、国連教育科学文化機関、国連開発計画、デンマーク国際赤十字、Human Sciences Research Council of South Africa、 英国国際開発省、カナダ国際開発庁、the Commonwealth Secretariat、USAID 等。また、Universities in Solidarity for the Health of the Disadvantaged である。 ・Center of Excellence for Health System を現在建設中で、2010 年春の完成を予定している(建設費の一部にはウェレ博士に授与された野口英世記念アフリカ賞の賞金の一部が充てられている)。完成すれば、センターはケニアで初めての保健システムに特化した高等機関となる。Ph.D プログラムを設置、他の大学からの受け入れも予定している。 ・東南アフリカ地域から留学生を受け入れるキャパシティがある。 現在は、スーダン、エチオピア、エリトリア、ナイジェリア、ルワンダ等からの留学生がいる。	
Kenya Institute of Administration	・機関は、政府関係者のキャパシティを向上することを目的として独立前に政府機関として設立された経緯があり、政府からの財政的な支援のもとで安定した運営が行われている。また、講師陣も政府から派遣されている(講師料の支払いは政府予算)。 ・保健システムマネジメント・トレーニングは、Department of Public Administration, Management and Leadership のカリキュラムとして実施されており、短期コース(3ヶ月以内)と修士コース(9 ヶ月)で構成されている。部は 9 ヶ月前に設置されたばかりだが、学校としては長年に渡って短期コースを実施してきた豊富な実績がある。 ・トレーニング講師のキャパシティが高い。機関全体で 30 名の教授がおりすべて修士号以上の学位取得者である。この他、60 名の外部講師(元政府関係者、ケニア人の国際機関職員あるいは NGO 職員)がいる。 ・施設設備が整備されている。敷地内にはトレーニング受講者のための宿泊設備もあり、現在更に新たな宿泊施設も建設中である。また、遠隔教育施設も備えている。 ・多くのパートナー機関を有する。 Strathmore University 、University of Nairobi(覚書あり)、DANIDA Fellowship (覚書あり)、Kenyan Distance Learning Centre 、	・カリキュラムの内容は保健システムマネジメントというよりも、より広くリーダーシップに関して学ぶ内容となっている。従って対象者は、事務次官、シニアレベルのマネージメント人材が中心である。 ・トレーニング効果をいかに評価するか、そして長期的な観点からどのようにトレーニングのフォローアップしていくのかが取り組むべき課題として残されている。 ・情報通信技術を強化する必要がある。

	Common Wealth Secretariat 、 Common Wealth Secretariat 等。 ・東南部アフリカから留学生を受け入れるキャパシティがある。現在は、エリトリア、タンザニア、エチオピア、マラウイ、スーダンの学生が学んでいる。	
Kenya Medical Training College	・ケニア保健省（Ministry of Medical Services and Public Health & Sanitation）の中間層の保健医療従事者をトレーニングすることを目的として 1927 年に設立された機関である。ディプロマコース（年間 500 名）と病院のマネージャーを対象とした短期研修コース（年間 20 名）がある。機関関係者によれば、ケニアの 80%以上の保健人材は、本機関の修了証（Certificate）あるいはディプロマを持っている。 ・トレーニング費用は他機関と比べて割安である（ディプロマコースで年間 80,000 ケニアシリング）。 ・東南部アフリカから留学生を受け入れるキャパシティがある。現在は、ウガンダ、タンザニア、南スーダン、エチオピア、マラウイ、ナミビアの学生が学んでいる。	・独立した保健システムマネジメント・プログラムではなく、ディプロマコースではすべての学生が保健システムマネジメントに関する単位を履修することが求められている。短期コースでもその内容は総合的なものではない。 ・教員およびトレーニング設備が不足している。
Kenya Methodist University	・近年独立したカリキュラムとして保健システムマネジメント・コースを設置する機関は増加しているが、（大学関係者によれば）KeMU の Health System Management プログラム（Bachelor / Master）は、ケニアだけでなく、東南部アフリカで唯一、Exclusive かつ Comprehensive なプログラムである。カリキュラムの開発に際しては、保健省および AMREF の協力を得ている。WHO から直接的な支援は得ていないが、WHO とのパートナーシップを持つ AMREF の技術的な支援を得たことで、カリキュラムには WHO の保健システムの枠組みが反映されている。 ・多くの他機関とパートナーシップを有する。ケニア国内に 10 機関（Moi University 、AMREF、University of Nairobi、Kabarak University、Egerton University、 PCEA University、Kenyatta University、Kenya National Hospital and Kenya Medical Training Center, Kenya Agricultural Research Institute、KEMRI の他、米国 2 大学、マレーシア1大学と協力関係がある。AMREF とは覚書を取り交わしている。 ・2 つあるメインキャンパスのうち Nairobi キャンパスは中心街にあるためアクセスがよい。また、2 つの図書館と1つの電子図書館を持つ。国内 3 箇所にサテライトセンターも有する等現代的な設備を持つ。	・保健分野におけるマネージメント人材を対象とした短期プログラムを AMREF の協力を得て計画中で 2 年以内の開始を目指している。 ・東南部アフリカ地域のどのネットワークにも所属していない。 ・組織としての財政的安定性を強化する必要がある。ドナーからの支援は受けておらず、学費が主な収入源の 1 つである。そのため、他校と比較して割高である（学部：900,000 ケニアシリング 大学院：600,000 ケニアシリング） ・Health Management System プログラム用の教室は6つ（20－30 人収容可）あるが、生徒は学部生 70 名、大学院生 80 名おり、より多くの教室が必要である（現在、増設中）。

	・ 東南部アフリカから留学生を受け入れるキャパシティがある。現在はスーダン、タンザニア、ナミビアからの留学生がいる。	
Moi University	・ 保健システムマネジメントとして独立したカリキュラムを有する。 ・ トレーニングに関しては AMREF との覚書（Memorandum of Understanding）による協力関係が構築されている。 ・ トレーニングスタッフは十分な能力を有している。さらに、必要に応じて他機関のスタッフをアレンジすることが可能である。 ・ 東南部アフリカ地域から留学生を受け入れるキャパシティがある。	・ 現行の保健システムマネジメント・トレーニングは、2 年間の修士コースのみで設置されている。
Strathmore University	・ 保健システムマネジメント・トレーニングは、保健分野のプロフェッショナルを対象とした短期研修 コース“Executive Healthcare Management Program (EHMP)” として設置されている。主な対象は、病院などのマネージャークラスの人材であるが、医者、看護師、薬剤師、検査技師、NGO スタッフも可。 ・ カリキュラムは 4 つのモジュール（計 20 コース）で構成されている。カリキュラムの見直しは毎年大学が実施しており、その頻度は他機関と比較して多い。 ・ トレーニング方法は対話式（イントラアクティブ）が中心である。具体的には、ケーススタディの活用、グループディスカッション、シミュレーション、プレゼンテーション、講義である。 ・ 教授陣の能力を維持するために、研究能力の強化に重点を置いている。教授陣による豊富な研究実績はトレーニングに反映されている。トレーニングの実施には、Business School の教授陣の協力も得ている。 ・ 多くの機関とのパートナーシップのもとでトレーニングを実施している。カリキュラムは、保健省、University of Nairobi、AMREF 、KIA 等の協力を得て開発されている。AMREF は諮問委員会のメンバーでもある。 また、トレーニング実施に関しては、必要に応じてパートナー機関から教授陣を派遣してもらうこともある。 ・ 現代的な設備を有する。 ・ 国際的な学習環境がある。教授陣は外国人が多く、東南部アフリカ地域からの留学生受け入れ枠も 10 名と全体の 1/3 近くを占める。	・ EHMP コースとして独立したカリキュラムであるが、その内容は総合的なものではない。 ・ 教授陣の半分は外国人である。トレーニングで活用するケースは、Harvard Business School から購入している。教授陣とケースのコストが高いため、授業料は他機関のプログラムと比較してかなり高い（4 週間で 306,600 ケニアシリング）。これは、2010 年度学生数が定員（35 名）割れしている要因の 1 つでもある。 ・ 施設数が少ない。講義室が不足している（現在、新たなビルを建設中で来年完成予定）。 ・ 留学生の出身国で言えば地理的範囲が限られている（現在はタンザニア、ルワンダ、ウガンダ）。 ・ 保健省は諮問委員会のメンバーでもあるが、関係は強くない。

University of Nairobi	・ 機関として豊富なトレーニング実績を有する。 ・ 保健システムマネジメントに関するコンポーネントを含む新たなカリキュラム（学部コースと大学院コース）が最近開発された。学部のカリキュラムは大学によって、また大学院カリキュラムは政府の協力を得て開発しており、AMREF や WHO の支援は得ていない。 ・ 保健システムマネジメントに関する短期のコースの開設を現在検討中である。2年以内の開始を目指している。 ・ AMREF と Department of Community Health, College of Health Sciences とは覚書に基づくパートナーシップが構築されている。UoN は AMREF の外部諮問機関であり、AMREF トレーニングコースのカリキュラム開発を支援したり、必要に応じて教授陣を派遣したりしている。 ・ Department of Community は近く School of Community Health に格上げになる予定である。 ・ 東南部アフリカから留学生を受け入れるキャパシティがある。現在はコンゴ民主共和国、ルワンダからの留学生がいる。	・ 現行の保健システムマネジメント・トレーニングは独立したプログラムとしてではなく、MPH プログ ラムの中のユニットとして実施されている。MPH コースの全ての学生は 3～6 週間の保健システムマネジメントに関する科目を受 講する必要があるが、内容的には不十分である。 ・ 保健システムマネジメントを教える教授陣が不足している（特に保健計画と保健財政）。また、現代的なトレーニング設備が不足している。
Muhimbili University of Health and Allied Sciences	・ 独立した保健システムマネジメント・プログラムを学位コース（学生数は年間 250 名）と短期研修 コース（学生数は年間 30 名）で提供している。	・ 政府からの支援が十分に得られていない。 ・ School of Public Health and Social Sciences には教授が約 50 名いる（学部卒 15 名、修士：20 名、博士 15 名）が、保健システムマネジメントに関するトレーニングで言えば、教授陣のキャパシティが数・質ともに不足している。 ・ トレーニング施設設備が不足している。生徒数に照らし合わせると少なくともあと 3 教室は必要である。 ・ 学費は主要ドナーである NORAD による資金でまかなわれているが、援助は 2013 年に終了する予定である。その後は学生は各自で支払うか、スポンサーを得る必要がある。 ・ パートナー機関は University of Bergen （ノルウェー）のみ。 ・ 留学生は受け入れているものの、出身国で言えば地理的範囲が限られている（現在はウガンダのみ）。

Mzumbe University	・ 2001 年に当時の Institute of Development Management Mzumbe Management Training Institute の transformation としてタンザニア政府によって設立され、トレーニングの豊富な経験を有する。 ・ Faculty of Public Administration and Management の大学院に Masters of Health System Management コース（年間 3,250,000 タンザニアシル）が開設されている。 ・ Faculty of Public Administration and Management の学士コース（年間 1,200,000 タンザニアシル）には、Bachelor of Public Service Management 、Local Government Management 、Hearth Service Management 、Human Resource Management がある。 ・ 修了証コース（1,000,00 タンザニアシル）では、Human Resource Management と Local Goverment Management のみとなっている。 ・ アフリカ内外の他機関との広いパートナーシップを有する。University of Nairobi (Kenya), Sokoine University of Agriculture (Tanzania), Agder University (Norway), Virje Universiteit (Amsterdam) (Netherlands), University of Groningen (Netherlands)、Global Virtual University in various countries ・ 東南部アフリカから留学生を受け入れるキャパシティがある（出身国については不明）。	・ トレーニングスタッフが数・質ともに不足している。

第 5 章　東南部アフリカ域内の保健システム強化に関連した開発パートナー協調の枠組み

5-1　Harmonization for Health in Africa (HHA)

HHA は、アフリカにおける保健分野 MDGs 達成に向けた支援をドナー間の協調と協働によって進めるためのメカニズムであり、2007 年に発足した。2006 年のパリ宣言や、2008 年のアクラ・ハイレベルフォーラム（HLF）での合意でうたわれているアラインメントや調和化を基本理念としており、IHP+を初めとするグローバルもしくはリージョナルな援助協調のイニシアティブ／メカニズムとも理念を共有している。

HHA はもともと、アフリカの保健開発を支援する主要な国際機関（アフリカ開発銀行、世界銀行、UNFPA、UNICEF、UNAIDS、WHO）により設立されたものである。また設立当初は保健システム強化に焦点を当てた枠組みではなかった。しかし、その後メンバーシップが拡大され、2010 年 3 月現在では当初参加機関に加えて、二国間援助機関である USAID も参画している。また世銀アフリカ局による広域保健プログラムである HSO が積極的に関与することにより、保健システムの強化（援助協調を通じた保健システムの強化、保健システムの強化につながる援助協調）が一つの焦点となりつつある。

上述したとおり、2010 年 6 月にキガリ（ルワンダ）で開催された保健財政分野の Flagship Program については、WBI によるものとしてではなく、HHA によるプログラムとして開催されており、HHA をプラットフォームとして保健システム強化につながる広域的な人材育成プログラムを複数の開発パートナーが協力して実施するモデルが形作られつつある。こうした流れを受け、2010 年 9 月に JICA も HHA へ正式参加した。このため、本件プログラムの形成に際しては、HHA をプラットフォームとする他開発パートナーとの協調・協働にも配慮が必要である。

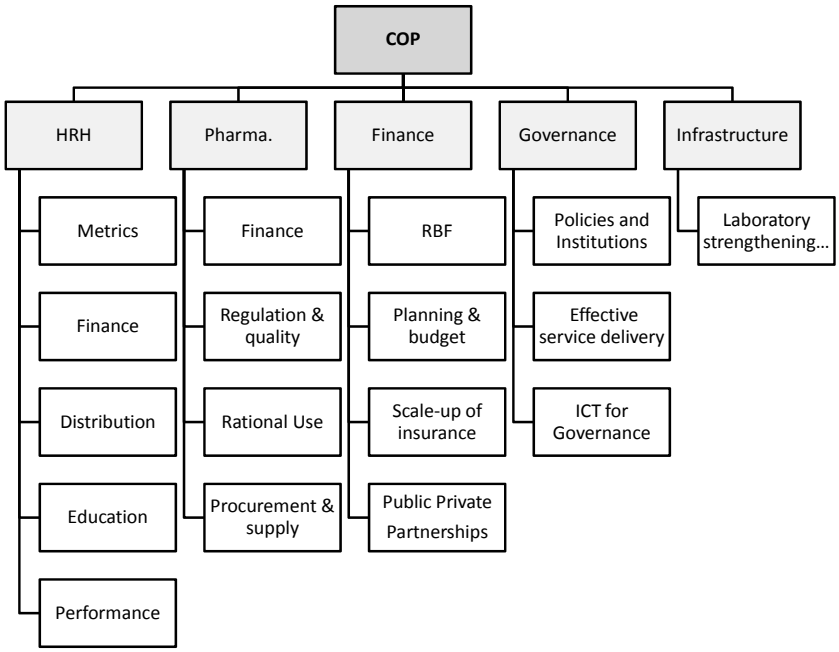
5-2　Communities of Practice (CoP)

CoP とは、アフリカ域内で保健システム強化に関わる関係者（個人）間の情報共有・協力を促進するべく、世銀 HSO が創設したフォーラムである。CoP は HSO における 5 つの Pillar（保健人材、保健財政、医薬品、ガバナンスとサービス提供、インフラと情報通信技術）それぞれに設置されている。また、各 Pillar の下には複数の Sub-Pillar も存在する（図 8）。CoP の目的として、域内の政府や開発パートナーからのリクエストに応じ、具体的な情報、技術支援、ツールや文書等を迅速に提供・シェアすることが挙げられる。

各 CoP には、政府、援助機関、大学、研究機関等から様々なメンバーが参加しており、各 Pillar に関するスキルや専門知識についての情報共有を随時行っている。ただし、CoP の構成メンバーの数・多様性、活動頻度、活動内容等は各 CoP 毎で大きなばらつきがある。

CoP は保健システムの主要な構成要素の強化に従事する世界的・地域的な専門家のネットワークとなることが期待されているものである。本件プログラムの形成に際しては、研修カリキュラムの作成や講師の人選等においてこれら CoP の活用を検討することが必要である。

図 8　CoP 構成図



CoP には Pillar レベルもしくは Sub-pillar レベルでフォーカル・ポイントが一人ずつ選ばれている。2010 年 3 月時点におけるフォーカル・ポイントは図 9 の通り。

図 9　CoP のフォーカル・ポイント

Pillar/ Sub Pillar	Focal Point	E-mail Address
Human Resources for Health	Christophe Lemiere	clemiere@worldbank.org
Pharmaceuticals and Supply Chain	Suvi Rautio UNICEF	srautio@unicef.org
Health Financing and Health Insurance Sub pillar	Francois P. Diop	fdiop1@worldbank.org
Planning and Budgeting Sub pillar	Netsanet W. Workie	nwalelign@worldbank.org
Results Based Financing Sub pillar	Claude Sekabaraga	csekabaraga@worldbank.org
Public Private Partnerships	Tonia Marek	tmarek@worldbank.org
Governance and Accountability	Ramana Gandham	gramana@worldbank.org
Laboratory Strengthening Sub pillar	Miriam Scheidman	mschneidman@worldbank.org

主な CoP について、その目的と活動内容をまとめたものが図 10 である。

図 10　主な CoP の目的と活動内容

CoP	目的	活動内容
Result Based Financing (PBF)	- RBF のベスト・プラクティスや教訓の共有 - RBF プログラムの協調支援の推進と重複の回避 - 共同事業の支援と RBF プロジェクトのモニタリング - 国家の RBF に係る能力強化	- 能力強化ワークショップ：ブルンジ、ブルキナファソ、マリで 3 回実施 - ベスト・プラクティス・ワークショップ - アフリカ・ベスト・プラクティスの出版：2010 年 3 月
Planning & Budgeting	- 継続的な交流、学習、知識共有のためのプラットフォームの提供 - エビデンスに基づいたプラニングにリージョナル・国レベルの焦点を当てること - 国のニーズに対応すべく効果的に技術資源を拡大すること	- 国家 HNP 戦略計画の支援 - 保健システム及びボトルネック分析 - ボトルネック解消戦略の開発 - インパクトの高い戦略のスケールアップに係るシミュレーション - 多様なシナリオに沿った戦略の Costing - IHP+国における政府-ドナー間のカントリー・コンパクトに係る支援 - 国家戦略実行に関する政府とドナーの役割・責任・コミットメントの設定 - Results framework の策定 - Joint Financing Arrangement 支援 - HNP、MDGs、国家戦略計画の財政ギャップ分析 - National Health Accounts、中期支出枠組み、Public Expenditure Review の支援
医薬品	- 世界銀行、WHO、UNICEF、UNFPA、その他多国間・二国間援助機関との連携推進 - 調達機関や主なロジスティクス・ハブの支援と薬品のロジスティクス・システム強化のための能力向上 - ベスト・プラクティスの共有	- 公共・民間調達並びに ARVs（UNICEF）、リプロダクティブヘルス用品（UNFPA）、エッセンシャル・ドラッグ（WHO、世界銀行）の supply chain management に係るリージョナル・レビュー - Central Medical Store procurement reforms（ケニア） - Policy review、薬品の品質保証システム強化への支援（ルワンダ、マリ） - Policy review, 国民健康保険制度強化のための cost-containment reforms（ガーナ） - 医薬品を含む HSS プロジェクト（ウガンダ） - 保健省 Pharmaceuticals Fund and Supply Agency による調達と supply chain management 改善のための支援（エチオピア） - 政府及び医薬品セクターの管理に係る分析（ベナン）
ガバナンス	- 保健セクターにおけるリージョナル・キャパシティとガバナンスのカントリー・アセスメントに関連したツールの開発 - ガバナンスを優先分野として認識した国への支援	- HSO ウェブサイト上での保健セクターの主なガバナンスに関連するイシューのリスト化 - アセスメントのためのケーススタディとツールキットの開発 - カントリーおよびリージョナルレベルでの能力開発のためのトレーニング・プログラムの整理
保健人材	- ツールの共有を通じたドナー連携の推進 - 医療従事者のパフォーマンスに関する共同事業（RBF や保健人材マネジメントの分権化含む）の開発	- CoP リージョナル・カンファレンス（過去、アディスアベバ、アクラ、アクラワガドゥグにて開催） - 医療従事者の離職に関する分析プログラム（WHO、世界銀行）最終バージョンは 2010 年 3 月に普及予定 - 僻地におけるインセンティブ調査の準備（マリ）HRH 政策のアセスメント（ニジェール） - 民間セクターの調査（ベナン）

第 6 章　協力プログラム(案)の検討

6-1　協力プログラム(案)形成の基本方針

冒頭に記したように、本調査は、アフリカにおける持続的な保健システム強化への貢献を目指し、保健行政官を主たる対象とする広域的な人材育成プログラムの案を形成することを目的として実施された。具体的には、①アフリカ域内の既存の高等教育・研究機関およびそのネットワーク機関との協力、②他開発パートナーとの協調・協働の二つを基本方針としている。

①に関しては、第 3 章での分析を通じて、HEP Net(代表 University of Cape Town)と AHLMN(代表 AMREF 及び CESAG)の二つを協力対象候補となる域内高等教育・研究機関ネットワークとして選定した。しかし、代表機関の所在国が異なる二つのネットワークを同時に相手として協力プログラムを形成するのは困難であることや、調査を担当するケニア事務所広域班とのコミュニケーションの容易さに鑑み、まずは AHLMN を対象として選定し、ナイロビに拠点を置く AMREF と協議を行うこととした。AMREF は 2009 年 4 月に「国際保健の課題と日本の貢献研究会」がアフリカ向けのセミナーを開催した際の共催機関であり、同研究会による政策提言等についても理解が得られているという利点もある。

また②に関しては、第 5 章での分析を通じて HHA と CoP を他開発パートナーとの協調・協働を進めるための枠組みとして同定した。

6-2　協力プログラム(案)

(1)協力形態

ケニアを拠点とする第三国研修を中心とし、研修参加者へのフォローアップや各国での取り組みについての事例研究を組み合わせた協力プログラム。主たる実施機関としては、AHLMN の代表を務め、ナイロビに国際研修センターを擁する AMREF を想定する。ただし、二国間協力の枠組みに載せるため、要請書はケニア政府を介して取り付け、合意文書(Record of Discussions)もケニア政府との間で締結する。また、第三国研修として実施するからには、ケニア側実施機関を選定し、AMREF等と一緒に研修を実施する必要がある。

(2)協力内容

図 11 は、本調査結果に基づき、AMREF(Dr Peter Ngatia, Director for Capacity Building, Mr Nzomo Mwita, Technical Specialist; Training)との協議を通じて形成した協力プログラム(案)である。本(案)に基づき作成された技術協力要請書は、ケニア政府公衆衛生省に提出された。

図 11　協力プログラム(案)

上位目標	To strengthen and harmonize regional training and joint learning capacity for sustainable health systems strengthening (HSS) in Africa.
案件の目標	To create a critical mass of professionals and their networks with state-of-the-art knowledge on issues around HSS in Africa, who can promote sustainable human resources for health development for HSS in their respective countries and settings, through coordinated training programs in partnership with regional networks of higher training institutions and other stakeholders.
成果	1. Platforms for stakeholder/partner coordination are consolidated 2. Regional training programs are developed based on coordinated inputs from stakeholders/partners to serve the needs of both health systems designers and operators 3. Regional trainings are conducted based on the programs developed 4. Follow-up activities for training graduates are planned and conducted

	5. Training programs are periodically revised reflecting the latest research results, case reports collected from training graduates, and other relevant information 6. Documentation of best practices and lessons learnt in HRH development for HSS.
活動	1. To consolidate platforms for stakeholder/partner coordination through NEPAD, Harmonization for Health in Africa, Communities of Practice established for thematic issues related to HSS and/or other relevant mechanisms 2. To develop regional training programs in partnership with AHLMN and/or other relevant networks of regional higher training institutions, based on coordinated inputs from stakeholders/partners 3. To conduct regional trainings in partnership with AHLMN and/or other relevant networks of regional higher training institutions, based on the program developed 4. To plan and conduct follow-up activities for training graduates in partnership with AHLMN and/or other relevant networks of regional higher training institutions 5. To periodically revise training programs in partnership with AHLMN and/or other relevant networks of regional higher training institutions, reflecting the latest research results, case reports collected from training graduates, and other relevant information 6. To document best practices and lessons learnt in HRH development for HSS.

上記したように、本協力プログラム（案）は支援形態としては第三国研修を中心としている。しかし、通常の第三国研修にはない要素をいくつか備えている。

1 点目は、成果1および活動1として含まれる、ステークホルダー間の調整のためのプラットフォームの構築である。具体的には HHA や CoP に具体的な調整機能を持たせること、開発パートナー（援助機関）主体の調整メカニズムである HHA および CoP と域内の高等教育・研究機関のネットワークである AHLMN とを結びつけることにより、よりアフリカ主導の調整メカニズムとすること、それらの調整メカニズムを通じて研修カリキュラムの策定や研修の実施に必要な技術的リソースや研修の実施に必要な追加的資金を確保することを想定している。実施機関と JICA との協議により研修内容を確定し、実施機関と JICA が対応可能な範囲内で講師陣や教材を確保して実施される通常の第三国研修と異なり、カリキュラム策定段階からアフリカの保健システム強化に関わる様々な開発パートナーや域内の多様な技術リソースの知見を反映させることを意図している。

2 点目は、成果 2 および活動 2 に対応する、研修カリキュラムの策定である。上述した WHO の6つの構成要素からなるフレームワークにも示されるように、保健システム強化はいくつかの要素に分解して捉えることが現実的である。従って、第三国研修を立案する際にも、一つのコースではなく保健システム強化の異なる領域を対象とする複数のコース群として立案することが妥当であると考えられる。HHA および CoP を研修カリキュラム立案の技術リソースとして期待するなら、研修コース群についても CoP が設立されている領域ごと（図 8 参照）に設立することが考えられる。具体的には、保健人材、医薬品、財政、ガバナンス、インフラの 5 つの領域である。

しかし、これら全てに対応するコースを一度に立ち上げることは困難であり、また財政のように既にアフリカ域内を対象とする確立されたプログラムが存在する（2-3 参照）領域もある。サブサハラ・アフリカには 48 カ国が存在するが、対象国についても絞込む必要がある。これまでのJICAによるアフリカ域内における保健システム強化に関連した支援実績[7]も考慮するなら、対象領域としては保健人材および／またはガバナンス領域から検討を始めることが妥当であると考えられる。また対象国としては、まずはAHLMNメンバー機関の所在国（14 カ国）を選定し、メンバーとして参加する高等教育・研究機関の代表と、同機関が所在する国の保健省の代表をペアで招聘することを想定する。

3 点目は、成果 4 および活動 4 として含まれる、第三国研修修了者に対するフォローアップ活動である。具体的な活動としては、インターネットや電話・テレビ会議等を利用した定期的な情報共有や、帰国後研修内容に基づいて政策提言をまとめたり、各国で研修を行ったりする活動への支援が

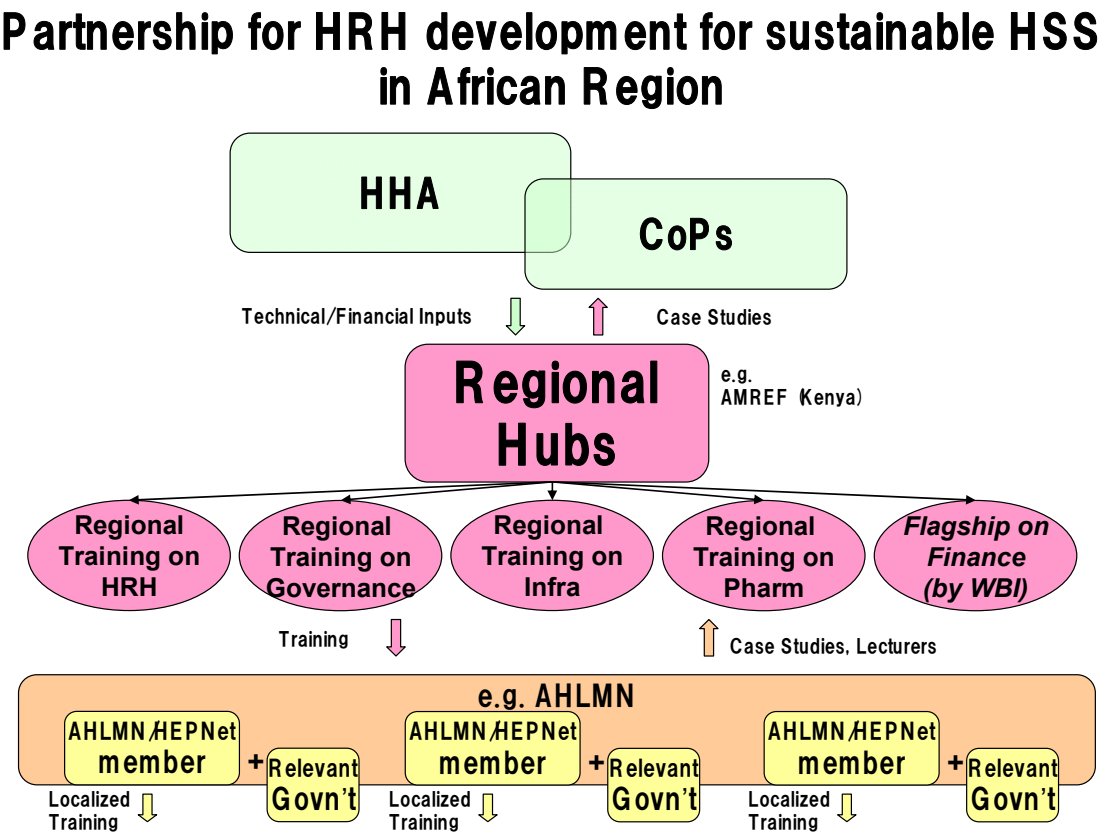
[7] タンザニアにおける保健人材データベース構築とデータを用いた計画策定支援、タンザニアおよびケニアにおける地方保健行政官のマネジメント能力向上支援など。

想定される。ただし、予算的な制約や各国 JICA 事務所との調整の問題もあり、この部分の活動をどの程度実施できるかは明確でない。

4 点目は、3 点目とも関連するが、成果 6 および活動 6 に対応する、研修に参加した各国での取組み事例の中から良い事例を抽出し、事例研究として文書化する活動である。保健システム強化にかかるアフリカ域内での国境を越えた学び合いを促進するための活動であり、各国での実際の経験に基づいて研修カリキュラムの内容を充実させていく上でも重要な活動となる。高等教育・研究機関からの参加者に対しては、それぞれの領域に関連した研究手法や、ケーススタディ・ケースティーチングの手法にかかる講義・演習等も研修カリキュラムに加えることを想定する。

以上を図式化したのが、図 12 である。

図 12　協力プログラム（案）の模式図



(3) 制約・限界

保健システムを強化するためには、保健行政官の育成だけではなく、現場で働く保健サービス提供者の育成や、制度構築、インフラ整備、医薬品の円滑な供給など、様々なボトルネックを解消する必要があり、そのための投資も必要である。これら取組みは、それぞれの状況にあわせて各国ごとに推進されるべきものである。本プログラムは、そのような国レベルでの直接的なインパクト発現を狙ったものではない。国レベルでの具体的なインパクト発現を狙った支援については、別途、各国事務所がそれぞれの政府と協議しつつ形成される必要がある。

しかし、国を単位とする取組みが基本となる保健システム強化ではあるが、同じような課題に取り組む他国の事例から学べることは多い。また、各国における中長期的な人材育成や政策立案の中

核となる人材の育成については、アフリカ域内に散らばる技術リソースを集め、世界的な研究成果や域内の多様な事例を参照しつつ取り組むことの利点が大きい。本プログラムは、そのような中核人材の育成および彼らの国を超えたネットワークの強化を狙って実施するものである。

第 7 章　AMREF および世界銀行とのパートナーシップの構築と第三国研修の実施

7-1 研修経緯

第 6 章 （6-1）に前述された協力プログラム形成（案）の基本方針に基づき、AMREF および世界銀行ナイロビ事務所（以下世銀）と協議を重ね、ケニアを実施国とする第三国研修を行う合意形成が 2011 年初旬になされた。また、本協力プログラム（案）に係る技術協力の要請書はケニア政府より外務省へ提出され、検討の結果、技術協力個別案件（研修）形態として 2011 年 3 月に早期通報案件として採択された。今後の案件の取り進め方については 2011 年度前半にケニア政府および関係機関と協議して決定する予定である。

また、第三国研修は 2011 年度に開始することにしているが、それに先立ち、本プログラムの一環として、保健システム強化に関連したアフリカ域内での支援実績と比較優位性を鑑み、東アフリカ地域を中心に、CoP の一領域である保健セクターのガバナンスとアカウンタビリティ分野を焦点とした研修を 2010 年度中にパートナーシップ第一弾として行うことが同意された。本研修については 7-2 に記載する。

7-2 研修概要

AMREF、世銀、JICA の三機関共催により、2011 年 3 月 21 日～25 日の 5 日間、ナイロビの AMREF 国際研修センターにて東アフリカ域内ガバナンス研修が開催された。研修の正式名称は「Promoting governance and accountability for improved service delivery in the Eastern Africa health sector （邦題：東アフリカ保健セクターにおける保健システム向上のためのガバナンスおよびアカウンタビリティ能力強化研修）」である。

本研修は、アフリカ域内の既存のネットワーク機関との協力および開発パートナーとの協調・協働を得て、アフリカにおける保健システム強化への貢献に取り組むものである。AMREF が事務局を務める AHLMN に所属する学術研究機関からの保健医療従事者を中心に、東アフリカ地域の能力強化に焦点を置いた。また、保健システム強化に携わる各国保健省行政官および民間団体から実務者レベルの参加を対象とした。

アフリカ地域における MDGs達成に向けた取り組みにおいて、保健システムの強化が必要不可欠なものとして共通認識されている。その中でも、ガバナンスおよびアカウンタビリティの向上と汚職の防止は、保健指標の改善や効率的に保健事業を実施するための重点要素となっている。ガバナンス領域は CoP の一重点領域であり、世銀の広域保健プログラムである HSO が積極的に関与しており、過去に域内研修を行った支援実績がある。

JICA は既存の域内ネットワークを持つ AMREF とガバナンス領域で知見を有する世銀とパートナーシップを構築し、研修の実施に必要な技術的リソースや追加的資金、調整業務に必要な人材を確保し、本研修の実現に積極的に関与してきた。研修の成果品として国別アクションプランが作成され、研修修了者に対するフォローアップ支援活動を三機関（世銀、AMREF および JICA で継続することが同意されている。

7-3 研修目的

保健システム強化に携わる保健医療従事者の経験を共有しつつ、保健セクターのガバナンスに関わる知識の向上と必須スキルの習得を目指し、各人が直面している国別課題に対処できる一助となることを目的とする。具体的には以下の通り。

1. 保健セクターに従事する医療関係者がガバナンスやアカウンタビリティの重要性と概念を十分に理解し、基本的な分析ツールを習得する。
2. 各国の直面している保健システム強化策の成功例、戦略、課題、新規試み等を共有し、事例を通じた学びの場とする。
3. アカウンタビリティ向上および汚職防止のための国別アクションプランの作成。
4. 今後継続して開催される類似研修のための研修カリキュラム立案。

7-4 研修構成

研修は講義形式とディスカッション形式で行われた。保健セクターにおけるガバナンスの概念を確認、分析ツールの理解と実践、5S-カイゼン－TQM[8]の概要説明、汚職に関するケーススタディとリスク回避策、アクションプラン作成のための計画立案方法、評価手法やコミュニケーションツール等、幅広い項目がカバーされた(詳細は添付資料を参照)。

東アフリカ地域 5 カ国(ケニア、ブルンジ、ルワンダ、ウガンダ、タンザニア)から実務者レベル計 19 名が参加した。各国から 3－4 名、保健省、学術研究機関、民間団体に所属する医療従事者代表をそれぞれ招聘し、チームとして研修課題に取り組んだ。

経費は世銀および JICA ケニア事務所が分担して負担、AMREF は研修参加者の窓口および研修所として研修全体に関わる調整業務を担当した。AMREF 本部、世銀(ナイロビ事務所および本部)、JICA ケニア事務所の関係者およびゲストスピーカーを加え、計 19 名が本研修の協力者として携わった。

7-5 研修内容と成果

(1) 供給者側ガバナンス (Supply-side governance):リスク回避策の検討

Political Economy Analysis、Value Chain Analysis、Public Expenditure Tracking Surveys などの分析ツールを利用し、国別にリスクアセスメントを行った。

(2) 受益者側ガバナンス (Demand-side governance):透明性の確保の検討

Citizen Report Cards 、 Community Score Cards 、 Participatory planning and budgeting、Information and Communication Technology など、様々な手法例が紹介された。

(3) 医薬品調達・供給のガバナンス促進

概要説明の後、ケニアの医薬品調達・搬送組織である Mission for Essential Drugs and Supplies (MEDS)からの事例報告。各国の医薬品搬送経路のガバナンス促進について協議。

(4) 5S-カイゼン－TQM の概要説明

JICA の 5S-カイゼン－TQM 事業取り組みの概要説明。ケニア保健省より事例を紹介。特に初めて耳にする学術関係機関や民間団体参加者からの反響が大きく、今後の支援を要請された。

(5) 国別アクションプラン

[8] 日本の産業界で発展した品質管理手法。5S(整理、整頓、清潔、清掃、しつけ)の考え方を病院管理に導入し、病院の施設や業務環境を改善する活動(業務環境改善)。カイゼンとは、継続的な取組により保健医療サービスの品質の向上に取り組む活動。TQM(Total Quality Management)とは、参加型プロセスにより保健医療サービスの総合的な品質改善に取り組む手法。これらの活動によりサービス提供者(組織)である病院は生産性(効率的な業務、質の高い保健医療サービス、患者の満足度向上等)を高めることができる。

研修の最終課題として、帰国後に実施するためのアクションプランを作成してもらい、各国毎に発表およびフィードバック。下記に発表内容を簡略化して列挙する。

- ガバナンスとアカウンタビリティにおける保健人材のスキル向上計画（ルワンダ）
- 医薬品調達・搬送における透明性の確保計画（ブルンジ）
- コミュニティレベルにおけるガバナンス向上計画(タンザニア)
- 郡病院における人材確保とサービス改善計画（ケニア）
- マラリア対策サービス改善計画(ウガンダ)

なお、研修内容は別添 3 のとおり。

7-6 今後の取り組み

参加者の要望として、アクションプランの実施や国レベルでのガバナンス向上に関し、持続的な支援が求められた。今後も研修修了者に対し、電子メール、電話、テレビ会議等を利用した定期的な情報共有や、アクションプランに基づいて政策提言をまとめたり、各国で研修を行ったりする活動への支援が想定される。パートナー三機関でフォローアップへの取り組みを協議をし、詳細をつめる作業の必要があるが、現段階で提言されていることは以下の通り。

1. 今回作成されたアクションプランの実施、モニタリングおよび評価に関し、JICA(広域班)と世銀（HSO）からの技術的側面支援を行う。
2. 四半期毎にテレビ会議を行い情報や課題を共有する、国毎の進捗をニュースレターにまとめる、CoP 推進開発パートナーからの支援を国レベルで要請する。
3. 西アフリカ、東アフリカ、仏語圏アフリカを対象に同様の域内研修を行う。
4. CoP や AHLMN などの既存のネットワークを活用し、アフリカ域内全体の持続的な能力強化のため、AMREF には主要な役割を担当してもらい、他開発パートナーは側面的支援という位置付けにする。
5. 各国での取り組み事例の中から参考になるものを抽出し、事例研究として文書化および対外的に発信する。
6. 保健セクターのガバナンス領域能力向上のためのプールファンド基金の設置（世銀案）。

第 6 章で記述されているとおり、本協力プログラム(案)ではガバナンスの一領域を焦点とするのではなく、保健システム強化の異なる領域を対象としている。HHA および CoP を研修立案の協力枠組みに設定していることや、JICA によるアフリカ域内における保健システム強化に関連した支援実績を考慮し、将来的には保健人材（HRH）領域への域内研修も検討していく。また、財政(Health financing)領域における研修も他開発パートナーとの連携で可能と思われる。ただし、2011 年度からは二国間協力の枠組みを考慮し、ケニア政府との合意に基づき本案件を実施していくことになる。また、各該当国 JICA 事務所による本案件への国レベルでの協力やパートナーシップの拡大連携も利点が大きいと考えられ、今後の検討課題となる。

付属資料

FINAL REPORT

Preparatory Survey on JICA Cooperation Program (Regional) for Health Systems Strengthening in Africa

Sub-title

Situation analysis of
regional networks of higher education and research institutions
for
Health systems strengthening in
Eastern and Southern Africa

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January 29, 2010

Disclaimer

Opinions or points of view expressed in this report, *including the selection, profiling and capacity assessment of various organizations and networks,* represent those of the author and do not necessarily represent the official position or policies of Japan International Cooperation Agency.

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ABBREVIATION AND ACRONYMS

AFRO-NETS	The African Network for Health, Research and Development
AHLMN	African Health and Leadership Management Network
AHPSR	Alliance for Health Policy and Systems Research
AHWO	African Health Workforce Observatory
AMREF	African Medical and Research Foundation
APHRC	African Population and Health Research Centre
AU	African Union
CHP	Centre for Health Policy
COHRED	Council on Health Research for Development
COSECSA	The College of Surgeons for East, Central and Southern Africa
CPS	Centre for Policy Studies
CREHS	Consortium for Research into Equitable Health Systems
DPRU	Department of Policy Research Unit
EAC	East African Community
EAIDSNet	East African Integrated Disease Surveillance Network- EAIDSNet
ECSACON	The East, Central and Southern Africa College of Nurses
ECSA-HC	The Eastern, Central and Southern Africa Health Community
EQUINET	The Regional Network in Health in Southern Africa
GEGA	Global Equity Gauge Alliance
GHWA	Global Health Workforce Alliance
HEALTH Alliance	Higher Education Alliance for Leadership Through Health
HEPNet	Health Economics and Policy Network in Africa
HESA	Higher Education South Africa (HESA) in South Africa
HEQA	Higher Education Quality Assurance Committee (HEQA) in South Africa
HRH	Human Resources for Health
HSAN	Health Systems Action Network
HST	Health Systems Trust
HSR	Health Systems Research
ICT	Information and Communication Technology
IGAD	The Inter-governmental Authority on Development
IPAR	Institute for Policy and Research
IUCEA	Inter-University Council of East Africa
JICA	Japan International Cooperation Agency
JHU	John Hopkins University
KEMRI	Kenya Medical Research Institute
LIPHEA	Leadership in Public Health in East Africa
LSHTM	London School of Hygiene and Tropical Medicine
MRC	Medical Research Council
MDGs	Millennium Development Goals
NEPAD	The New Partnership for Africa's Development
REACH Policy Initiative	Regional East African Community on Health Policy Initiative
SADC	Southern African Development Community
SEAPREN	Southern and Eastern Africa Policy Research Network
SHIELD	Strategies for Health Insurance for Equity in Less Developed Countries
TICAD	Tokyo International Conference on African Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

Despite the well-publicised concerns regarding weak health systems in most African countries dating back to the 1980s, there is still no consensus on a clear framework with operational steps on how to strengthen health systems in Africa. It is also widely acknowledged that Primary Health Care principles and health systems approach that integrates all the elements of a health system are essential for synergy and ensuring sustainable outcomes. In the last ten years, interest has shifted to human resources as the pillar upon which health systems in Africa are to be strengthened. Regional strategic direction contained in the African Union "Africa's Health Strategy" and global leadership under the WHO have inspired several development partners to engage and support national and regional efforts involving governmental and non-governmental organizations and networks undertaking training, research, technical and financial support among other initiatives. It is against this background, the recommendations of the Takemi working group, and previous experience in health systems strengthening in Eastern Africa that drove the Japan International Cooperation Agency (JICA) to commission a situation analysis on institutions and networks of training and research in health systems management covering 24 countries in Eastern and Southern Africa between October 2009 and January 2010. The primary objectives were to identify, profile, analyse and recommend networks with potential for strengthening capacity building for health systems management in partnership with JICA.

Methodology

This report describes the second part of the two-part consultancy, which surveyed regional training and research networks for building capacity in health systems management. Using a rapid assessment survey design, the study used two questionnaires to collect the appropriate information: the general profile tool and the in-depth capacity assessment tool. Information for the general profiles, primarily gathered from the websites, covered elements of a logical framework. In-depth interviews, assessing the organizational and operational capacity of each network, were conducted with directors/coordinators of networks in Uganda, Kenya, Tanzania and South Africa, as it was not feasible to visit all the countries hosting the networks. Based on the inclusion criteria (Secretariat in Africa, regional scope and focus on capacity building), eleven networks/alliances/consortiums were profiled of which six completed in-depth interviews.

Findings

The general profiles of the 11 networks were instructive in determining those with potential for strategic impact on development of human resources for health in the area of health systems management. The networks were thus ranked on the basis of clear strategic direction (HEPNet, ECSA-HC, AHLMN and IUCEA); broad geographical coverage (AHWO, ECSA-HC, HEPNet, AHLMN, EQUINET, SEAPREN, GEGA and CREHS); legal mandate (all except the newly established AHLMN; type of member institutions – mixture of research, training, government and non-governmental, civil society and legislators - (HEPNet, HEALTH Alliance, AHLMN, and IUCEA); overall organizational capacity (HEPNet, ECSA-HC, AHWO; decentralized governance structures (HEPNet, EQUINET, GEGA and HEALTH Alliance; demonstrated achievements focusing on training for capacity building in health systems management (HEPNet, ECSA-HC, AHLMN (AMREF), HEALTH Alliance (LIPHEA)).

The large number of networks set up in the last 10 years is an indication of having taken advantage of the opportunities of good will from the AU, WHO and regional economic and political integration bodies such as EAC and SADC. HEPNet's strength lies in strategic direction, demonstrated effectiveness of linking training, research and networking among health economist by establishing Africa's health economist association. Its major trap is weak institutionalization of the network and thus a weak funding base. HCSA-HC is the only intergovernmental organization networking 10 countries that focuses on health and capacity building through short and diploma courses in collaboration with its two key professional institutions (COSECSA and ECSACON). Its weak points are representation at country-level and regional frameworks for monitoring and evaluating progress. AHLMN barely one-year old has a strong foundation among partner members such as AMREF and strategic leadership but lacks the legal mandate (at present) and has weak links with Ministry of Health. Two weaknesses affect all networks: absence of regulatory/vetting/ global monitoring body to ensure relevance and transparency in their operations, which is clearly a weak link; and secondly the lack of a professional association (for health managers) to standardize and monitor quality educational and training programs on health systems management. The opportunities are immense: enthusiasm and political support of regional bodies and WHO. HEPNet and HEALTH Alliance link networking to research and training at district level while EQUINET and SEAPREN are the only networks working closely with civil society and legislators.

Conclusions

This work on networks of health systems management (along with work conducted on training institutions for health managers and health administrators) should provide JICA with key information on potential regional partners in designing a programme to strengthen health systems. This study identifies four high performing networks with great potential for influencing capacity building for training and research in health systems management in Africa. Two networks have had evaluations of their activities but two represent potential as they are newly established.

1.0 INTRODUCTION

1.1 BACKGROUND TO SITUATION ANALYSIS

There is a concern that many countries in Africa are behind in the progress toward achieving health-related Millennium Development Goals (MDGs) by 2015. Though there are several impeding factors, the vulnerability of the health systems in most of the African countries, especially the critical shortage of human resource for health, is considered to be one of the biggest constraints.

African countries, through the African Union (AU) resolution in the Africa Health Strategy 2007-2015, collectively regard development of the human resource for health as one of the priorities in health development in the region. As part of the responses from the donor community, the Government of Japan made a commitment to train 100,000 human resources for health in Africa over 5 years and in accordance with the Yokohama Action Plan, which was adopted in TICAD IV in 2008. Takemi Working Group, an independent working group organized by former Japanese parliamentarian, Mr. Keizo Takemi, with an aim of informing the policy formulation process of TICAD IV and G8 on global health, published a series of thematic papers on health systems strengthening. One of the recommendations on human resource for health was *to strengthen the international networks of higher education institutions to provide access to health and medical education in areas with limited resources*.

In the 1980s and early 1990s, most health systems in sub-Saharan Africa were performing poorly and in dire need of the now infamous 'health sector reforms'. It would appear that although discussions on how to reform the health systems started in the early 1990s no networks were established until 1999 (ten years later). Similarly, effort by the World Health Organization to improve the coordination of health programmes in Africa dates back to 1987. The Joint Health Systems Research (HSR) Programme, a collaborative enterprise of Ministries of Health in participating countries in Eastern and Southern African region ended in 2000. It had eighteen participating countries, namely Angola, Botswana, Guinea Bissau, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Namibia, Sao Tome, Seychelles, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. Later Mali and Ethiopia joined the programme. The goal of this programme was to improve primary health care by empowering policy makers and health managers at all levels in decision-making based on health systems research. One key objective was to strengthen structures and mechanisms to promote health systems research by establishing HSR units in Ministries and Universities in participating countries. The programme used annual review meetings, newsletters, a journal and collaboration with other research agencies to network. The programme trained a critical mass of staff in HSR – about 1,250 health workers, 295 health and university level facilitators and 145 studies completed. The major challenges then were structural adjustment programmes, droughts, AIDS epidemic, internal conflicts and wars, brain drain and lack of careers in health systems research. The programme recommended that future efforts focus on policy related research in health sector reforms and strengthen use and implementation of research evidence.

Like other building blocks of the health systems, the issue of human resource for health should be addressed by individual countries reflecting needs and constraints unique to each country. However, regional networking of research and training institutions is deemed important and effective for the training of health administrators and managers, as the participants will benefit from exposure to experiences of other countries and from mutual learning process. Besides this task of exposure to experiences, effective networks facilitate the timely dissemination and sharing of best practices among researchers, policy makers and host communities as well as contribute to building sustainable institutional mechanisms that facilitate transparent and accountability and leadership for health systems management in Africa. This may take place at national, regional and global levels and involve south to south or south to north collaborations amongst institutions.

It is in the context of these events and concerns that JICA commissioned two consultants to conduct a situation analysis of existing programs and institutions engaged in health systems management training and research and how they network within and across regions. JICA is expected to use such information to explore the possibility of supporting regional programs and networks in Eastern and Southern Africa, which can contribute to the sustainable development of human resource for health (HRH) in the region. This report focuses on the component of the study that identified existing networks linking institutions and organizations involved in health systems management training, research and other support and assessing how well they function based on their core business.

1.2 JICA HISTORICAL CONTEXT IN HEALTH SYSTEMS DEVELOPMENT AND STRENGTHENING

The funding arrangements of the Japanese International Cooperation Agency (JICA) are primarily bilateral with strong collaboration and working relationship with the Government and Ministries of Health. The health portfolio is the smallest compared to infrastructure and agricultural development. With strategically located country offices in eastern and southern Africa, JICA is best placed to scale up activities to regional rather than country-level programming. JICA has successful history of strengthening health systems by supporting development of infrastructure such as renovation of health facilities and logistical support for drug supply in Nyanza, Kenya, regional offices in Tanzania and a phased programme to provide medical equipment and supplies to health facilities in Uganda. Based on these experiences in eastern Africa and drawing on the strategic direction provided by the Takemi report and Africa Health Strategy, JICA is best placed to scale up its programming in health systems development and strengthening to regional level.

1.3 SPECIFIC OBJECTIVES TO NETWORKS FOR HIGHER EDUCATION AND RESEARCH IN HUMAN RESOURCE FOR HEALTH

The specific objectives of this situation analysis were as follows:

i. To identify higher educational and research networks in Eastern and Southern Africa which pose strategic implications for sustainable development of human resource for health (HRH) in the region.
ii. To profile networks offering training and research programs in the general areas of health systems management
iii. To analyse the Strengths, Weaknesses, Opportunities and Threats (SWOT) to identify gaps and unique selling points for each network
iv. To recommend strategies for strengthening existing networks for training, research and technical support in health systems management as well as highlight potential areas for possible collaboration with JICA

2.0 METHODOLOGY AND ANALYSIS PLAN

In this situation analysis, we employ the Rapid Assessment Technique using a combination of data collection tools to address the four primary objectives. The tools included a general profiling tool formatted along the principles of the logical framework model and an in-depth interview tool used for self-assessment of the capacity of the networks or alliances.

The theory behind the tool is based on the Organizational scan model. The organizational scan tool gives a picture of what is going on in the organization and how it conducts its business. The scan provides an assessment of all main aspects of an organization: (1) position refers to the identity or image of the network or alliance; (2) the thinking and learning – whether the organization is ready for change (3) the doing – what is the network doing, what is the output and are these in compliance with documented practices yielding an operational audit; (4) being the way the organization operates or conducts the day-to-day business in order to provide services, the values and common beliefs giving a cultural audit of the organization; finally (5) relating – how the organization interacts with its stakeholders and other networks. The tool was self administered and in most cases gave a summary of the director's or coordinator's judgement of the organization's ability, efficiency, which can be narrow. To improve the validity of the responses, respondents were asked to prove examples of strengths and weaknesses (internal to the organization) and opportunities and threats (external to the organization). The organizational scan tool yields valid and reliable data because a combination of techniques were used to collect the data: self-assessment (senior representative completing the questionnaire); interviews during field visits and observations and finally review of documents such as strategic or business plans, annual reports among others. The sampling and analysis procedures are detailed below.

2.1 WEB-BASED SECONDARY DATA SEARCH AND REVIEW

The first internet-based scan to identifying potential relevant networks, alliances and consortiums included the full name, geographical coverage, vision, mission or purpose. This information was used to determine the eligibility status of the network. A secondary outcome of this initial process was the opportunity to clarify the meaning of the term 'networks' as some of those listed as networks were projects. For the purposes of this study, the term 'network' was considered a synonym to 'Alliance' or 'Consortium' as long as the vision, mission and purpose were relevant to the study theme.

The general profiling based on website data and any other secondary information, yielding 23 networks in Eastern and Southern Africa with strategic implications for sustainable development of

Human Resource for Health (HRH) in the region. The tool used for network profiling is attached to this report as Appendix A. This covered all information in the first tool while detailing the background, challenges, recommendations and any documentation published and available through the website.

2.2 In-depth interviewing in the field

The purpose of the field and site visits to network offices in host countries was two-fold: one, to fill in the gaps on the general profiling tool; two, to directly interview directors and coordinators and secure a self-assessment of the organizational capacity of the network using the second questionnaire – the in-depth organizational scan. Preliminary analysis of data and information was carried out immediately each set of tools were completed. However due to the rush to complete field visits before the holidays, the analysis was incomplete. As a result, where possible, nearly all institutions were asked to complete both questionnaires during the scheduled interviews in the field.

The primary tool for in-depth organizational scan is attached to this report as Appendix B. The purpose was to provide key information on the capacity of each existing network or alliance in terms of its image, strategic thinking, performance, internal procedures and networking. The tool also asked for specific information on range of network partners and sponsors to help verify that obtained from the network as some were not updated. Lastly, the tool included questions on perceived strengths, weaknesses, opportunities and threats to the network.

2.3 Analysis plan

Similar to most international development initiatives in Africa, irrespective of the sector, there has been a tendency for international organizations to be headed or coordinated by partners based in developed countries. While this trend is changing, especially over the last ten years, it therefore, comes as no surprise that the initial internet search yielded over fifty international and regional networks of which slightly over half had their base outside Africa. For this study, the formal definition of a network refers to formal relationships among institutional members guided by clear roles and responsibilities for each partners. The criteria included: must draw memberships from at least two countries in Africa, focus on capacity building and have a secretariat based in Africa.

Initially, twenty-three (23) networks were selected for profiling. Based on the criteria, five global networks were dropped with head offices in countries outside Africa. Although the rest (eighteen) were targeted for in-depth interviews only eight institutions returned duly completed forms on in-depth network capacity assessment. One did not respond at all, three acknowledged receipt but did not return the forms and five that promised to return the tools in January 2010 did so. This puts the response rate at 66 percent. The final analysis profiled eleven networks or alliances that met the strict criteria were included, of which six (55 percent) completed the in-depth capacity assessment tool. Appendix C shows the sampling approach and breakdown of responses by each tool as well as an indication of the quality of the data.

The preliminary analysis yielded over 23 networks and alliances. However, of these, only 18 were selected for further analysis in this study. The general profiling tool was then used to detail the information on each network. Upon completion of this exercise, analysis of the profiled networks focused on accuracy and completeness of the information found on the internet/website, prior knowledge of the network operations by the consultant or other know expert contacted during the

profiling. Based on the analysis, 11 networks and alliances were selected and targeted for in-depth interviewing.

The second level of analysis was based on the detailed general profiles (Appendix A). The primary objective was to give a general assessment of vertical linkages within each network or Alliance by comparing inputs to processes and to outputs. An attempt was also made to assess the horizontal linkages by mapping the relationships among member institutions and to other networks with similar vision and mission.

The third and final level of analysis examines six (6) in-depth organizational scan, which was a self assessment of the capacity of the organization reflecting the extent to which the organization is perceived in the following five areas: (1) its position and image; (2) 'strategic thinking and learning' in relation to how it responds to external changes; (3) 'doing' refers to the its core business and outputs; (4) 'Being' which details internal procedures of conducting its business; and (5) 'relating and balance' that addresses the extent of collaboration and networking with like-minded organizations. Each component is described in detail under the introductory section above.

The analysis compares the capacities of these networks taking into account how opportunities can be used to build on their strengths as well as eliminate or minimize the weaknesses. The goal is to identify organizational priorities or what needs to be changed to improve performance through a variety of potential intervention activities. Recommendations on the strategic role of JICA are then outlined drawing from the analysis as well as communication from JICA such as expressed interest to pilot the programme in Kenya and South Africa before scaling it up to cover more countries in the region.

2.4 Ethics review and clearance

JICA requested Kenya Medical Research Institute (KEMRI) to consider the study protocol and provide ethical clearance for the study between October 2009 and January 2010.

2.5 Study limitations

The timing of the study, conducted over the Christmas holiday period posed a major challenge as most key staff had either proceed on leave and/or did not have adequate notice for the interview or time to contact key staff who were more appropriate for filling out the questionnaires. Indeed, no interviews were conducted in Arusha as EAC offices were closed for the long-holidays. To address the challenges, the consultant planned to give more time to agencies to fill out the tools and return them by email. However, this attempt also suffered the same fate as most agencies were busy trying to clear pending activities before the long holidays and only three emailed the tools in December 2009. Follow-up in January 2010 yield more promised to submit the tools by mid- or end-month. To date five interview schedules have not been returned.

The second most common problem was incorrect email and telephone contacts on the websites as most had not been recently updated. While this problem was addressed by visiting offices of those networks that had not acknowledged receipt of requests for interview from JICA and the consultant, the challenge remained as most were not available for direct interviews. Of the 15 contacted for interviews several non-responses but most were interviewed during the field visits. The various reasons ranged from (1) in-correct email address or member of staff sent the email had since left the organization (Centre for Policy Studies (CPS), Health System Trust (HST), Medical Research Council (MRC) in South Africa, Higher Education Quality Assurance (HEQA), The Southern and

Eastern Africa Policy Research Network (SEAPREN); (2) network reconstituted and merged or re-named (Centre for the Study of Higher Education (CSHE), Tertiary Education Linkages Project (TELP)); and (3) not available for meeting on the scheduled day for interview (Centre for Health Policy (CHP) at Witwatersrand University and EAC and ECSA-HC in Arusha). Four networks emailed the two sets of questionnaires in January and one in Febraury 2010.

The last shortcoming of this situation analysis is JICA's decision to limit the field visits to a few countries. As a result, no interviews were scheduled in countries hosting some key networks such as EQUINET in Zimbabwe and the Southern and Eastern Africa Policy Research Network (SEAPREN) based in Namibia.

3.0 FINDINGS

One major general finding of this assessment is that there are very many health and development networks (over fifty) engaged in capacity building in training and/or research in sub-Saharan Africa. Of these, about one third have their head offices base outside Africa. This includes global networks and alliances such as the Alliance for Health Policy and Systems Research (AHPSR), Global Health Workforce Alliance (GHWA), The African Networks for Health Research and Development (AFRO-NETS) an electronic network and Health Systems Action Networks (HSAN). The networks overarching goal is to enhance access to information that would facilitate development of equitable, accountable and sustainable health systems for improved health outcomes. The idea is to avoid duplication of effort and therefore inefficient use of scarce resources. Another fifteen of these networks focus on research-based activities and/or are exclusively for Western Africa, which were both outside the scope of this study. Another six had national rather than regional networks or alliances and were thus excluded from the study. The rest of this report presents and discusses findings based on the analysis of eleven (11) general profiles and six (6) in-depth capacity assessment interviews.

3.1 GENERAL PROFILING OF NETWORKS FOR HUMAN RESOURCES IN HEALTH

Table 3.I summarizes the basic information for the eleven networks and alliances based on the general profile tool. These are: African Health Workforce Observatory (AHWO) based in Brazzaville, Congo; African Health Leadership and Management Network (AHLMN) based in Nairobi, Kenya; The Eastern, Central and Southern Africa Health Community (ECSA-HC) and the Regional East African Community Health (REACH)-Policy Initiative both based in Arusha, Tanzania; The Higher Education Alliance for Leadership Through Health (HEALTH) which hosts LIPHEA project based at Makerere University, School of Public Health, Uganda and Inter-University Council of East Africa with a secretariat in Kampala, Uganda; The Regional Network on Equity in Health in Southern Africa (EQUINET) in Zimbabwe; Southern and Eastern Africa Policy Research Network (SEAPREN) in Namibia; Health Economics and Policy Network in Africa (HEPNet) at University of Cape Town, South Africa; Global Equity Gauge Alliance (GEGA) based at Health Systems Trust in Durban South Africa; and Consortium for Research into Equitable Health Systems (CREHS) which is based at the London London School of Hygiene and Tropical Medicine (LSHTM) in United Kingdom. Five of

these networks are based in Eastern Africa, four in Southern Africa, one in Central Africa and only one outside Africa but with member institutions in 4 African countries.

The table shows the date of establishment and current legal status, geographical coverage by country, membership by institution, linkages to other networks and core business.

Table 3.1: Basic characteristics of networks developing and managing human resources for health in Africa

	Characteristic	***Date set – up & legal status***	***Geographical Coverage by country***	***Membership of Network (institution/ government Ministry***	***Links to other networks***	***Core Business*** *Capacity building training, Research, Networking*
1.	**ECSA-HC** The Eastern, Central and Southern Africa Health Community	1974 Convention of common-wealth Regional, later amended in 2002	10 countries - Kenya, Lesotho, Malawi, Mauritius, Seychelles, Swaziland, Uganda, Tanzania, Zambia, and Zimbabwe	Government Ministries of Health, Permanent Secretaries, Directors of Health, Deans of Medical and Public Health Schools, technical expertise from member states (institutions)	EQUINET thro Un of Namibia / Limpopo;, SADC, EAC-HC,) , GHWA	Advocacy HRH Capacity building Brokerage, Coordination, inter-sectoral collaboration and harmonization of policies and programmes partnerships & alliances
2.	**EQUINET** The Regional Network on Equity in Health in Southern Africa	1999 SADC	8 – Namibia, Botswana, Malawi, Mozambique, South Africa, Tanzania, Zambia, Zimbabwe	Research, civil society, health sector organizations – Each Country and institution is responsible for specific theme (institutions)	HEPNet, ECSA-HC, GEGA, SADC Parliamentary Forum, AFRO-NETS	Promotes networking using bottom-up approaches
3.	**SEAPREN** – Southern and Eastern Africa Policy Research Network	1999	7 South Africa, Botswana, Zambia, Namibia, Tanzania, Uganda, Kenya	7 Policy research institutions in the 7 countries in Southern and Eastern Africa (IPAR, EPRC, ESRF, DPRU -SA, (institutions)	NEPAD, AU, AERC	Capacity building Research, exchange best practices Discussion papers newsletter
4.	**GEGA** Global Equity Gauge Alliance	1999	6 in Africa – Kenya South Africa, Zambia, Zimbabwe, Burkina Faso 3 in Asia – China, Bangladesh, India and Thailand 3 in Latin America -Chile, Ecuador, Peru	12 Equity Gauges based in each country with 9 having a national focus and 3 are district level focus (institutions)	EQUINET, APHRC, Health Systems Trust (HST), WHO	Research Advocacy Community participation Parliamentary alliances Newsletter since 2002
5.	**IUCEA** Inter-University Council of East Africa	1980/2000 EAC	5 in EAC – Tanzania, Uganda, Kenya, Rwanda, Burundi	All universities – private /public in EA (institutions)	EAC-HC	Training QA, HIV & gender Research –HIV-LVP
6.	**HEPNet** Health Economics & Policy Network in Africa	2000 University unit, Cape Town	7- South Africa, Tanzania, Uganda, Zambia, Zimbabwe, Nigeria, Ghana, Kenya	37 Research, academic, government departments in countries (institutions) – see list on profile in apprendix	EQUINET CREHS SHIELD	Networking Capacity building Research Technical support Newsletter / Bulletin
7.	**REACH Policy Initiative** Regional East African Community Health (REACH)-Policy Initiative	2003 EAC	5 – Kenya, Uganda, Tanzania, Rwanda, Burundi	Government Ministries of Health, Permanent Secretaries, Directors of Health, Deans of Medical and Public Health Schools, technical expertise from member states (institutions)	ESCA-HC, IUCEA, WHO, EQQUINET, GEGA, EAIDSNet (The East African Integrated Disease Surveillance Network)	Newsletter
8.	**CREHS** Consortium for Research into Equitable Health Systems	2004	4 in Africa – South Africa, Nigeria, Kenya, Tanzania, 2 in Asia - India, Thailand 1 in UK -LSHTM	10 -Indian Institute of technology, KEMRI-Wellcome Trust Research, HPRG, HEU, UCT, CHP, Ifakara HI, KHPP, (institutions)	WHO, EQUINET, HEPNet, AHPSR	Policy research Newsletter Publications on website
9.	**AHWO** African Health Workforce Observatory	2006 WHO-Congo	WHO partner states	National observatories and regional networks (institutions)	GHWA, Commission for European Community, NEPAD, ECSA-HC, Capacity project (USAID), WAHO, Council for Sustainable Health Development (ACSHD), OCEAC, WHO	Capacity building, research, practice, networking best practices
10	**HEALTH Alliance/** LIPHEA Higher Education Alliance for Leadership Through Health	2008 Legal status	6 in EA- Uganda, Tanzania, Kenya, Rwanda, Ethiopia & DRC USA	7 universities-SPH– Makerere, Muhimbili, Moi, Nairobi, Rwanda, Jimma, Kinshasa (JHU, Tulane (Institutions)	EAC, ECSA-HC,	Training –LIPHEA, Research Journal /newsletter
11	**AHLMN** African Health and Leadership Management Network	2008 Legal status pending until May 2010	14 African Countries Kenya, Uganda, Tanzania, DRC, Benin, Cote D'ivoire, Ghana, Senegal, Togo, Nigeria, Bukina Faso, South Africa, Botswana and Mozambique, 4– USA, Netherlands, Portugal, Switzerland	16 African leadership/ management org, international organizations, research and technical support organizations and individuals Paid membership ranging from $250 to $1000	WHO , ECSA-HC, Regional AIDs Training Network (RATN)	Institutional capacity building, research, policy advocacy, ethics/stds technical assistance

3.1.1 Establishment and legal status of the network

In most instances, organizations are set up as an urgent response to felt needs among stakeholders as partnerships between the South and North or South to South. To enable us understand the chronological background of these networks, we break-up the period into five groups: pre 1990s; 1990- 1994; 1995 -1999; 2000 – 2004 and post 2005.

Table 3.2 shows the distribution of the networks by period of establishment suggesting that all except for two networks were set up in the last ten (10) years. The ECSA-HC, then known as 'The Commonwealth Regional Health Community for East, Central and Southern Africa (CRHC-ECSA)' established in 1974 and the IUCEA in 1980 but revamped in 2000 after the signing of the new EAC treaty, are inter-governmental organizations. Both are based in East Africa primarily because the East Africa Community was set up earlier than the South African Development Community (SADC) regional body, established in 1992 along with the Health Systems Trust.

Table 3.2: Distribution of networks by date of establishment

Period	***Pre-1990s***	***1990-1994***	***1995-1999***	***2000-2004***	***2005-2009***
Networks	ESCA-HC IUCEA	SADC	EQUINET SEAPREN GEGA	HEPNet EAC-REACH CREHS	AHWO AHLMN HEALTH Alliance
Total (11)	**2**	**-**	**3**	**3**	**3**

EQUINET and SEAPREN, both founded in 1999, were the first regional networks to cover both eastern and southern Africa. During the same year, GEGA represented the global effort to monitor equity and efficiency of health systems. Soon after, in 2000, two other major networks were established – the HEPNet based in South Africa and REACH initiative under EAC-HC. The last three years (2006-2008) witnessed a renewed interest by the WHO to support global and regional efforts to address the human resources in health as a cause and consequence of inequitable and inefficient health systems in Africa. Interestingly, despite these early initiatives, the Africa Health Workforce Observatory was only established in 2006 to support actions that address human resources for health development in Africa in order to strengthen national health systems to provide efficient and effective health services through promoting, developing and sustaining firm knowledge base.

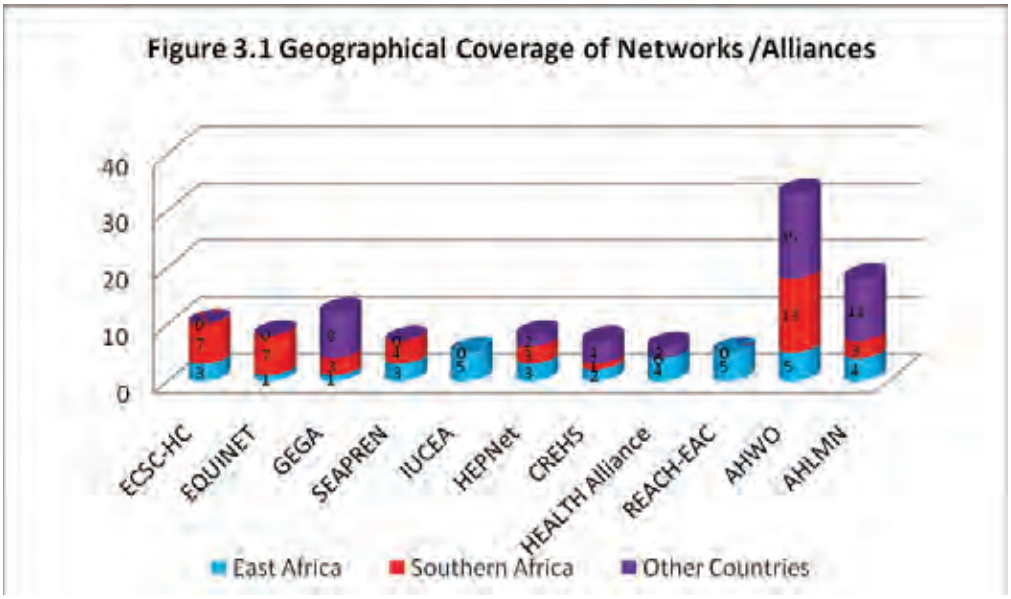
Irrespective of the year of establishment, nearly all networks sampled were legal entities. The legal status ranges from convention of Commonwealth powers (which include immunity) to Acts of Parliament and legal cover under the legal Acts governing NGO registration in countries where the secretariat is located. The exception is the African Health Leadership and Management Network (AHLMN) established in 2008 and is still pursuing the process of securing the legal status by May 2010.

Only three agencies have inter-governmental authority with permanent legal status covering the member states: ECSA-HC, IUCEA and EAC-REACH policy Initiative. The IUCEA, which focuses on quality assurance and harmonization of educational programmes in East Africa and ECSA-HC, which is the only health body with inter-regional intergovernmental authority. EAC- REACH policy Initiative, although linked to EAC has not taken off and like IUCEA is limited to EAC. All the other networks work with government departments but do not derive their authority directly from regional intergovernmental authorities. This means the three agencies have greater potential to implement the health and educational agenda for NEPAD, IGARD, SADC and EAC.

3.1.2 Membership of Networks by Geographical coverage

Figure 3.1 shows the distribution of networks by country membership. In total, the eleven networks cover about thirty (30) countries in Africa and ten (10) from outside Africa namely Asia (4), Latin America (3), Europe (2) and America (1). Country-level membership ranges from five (5) for the IUCEA and REACH policy Initiative to over 30 for the AHWO network.

It is clear that the East African Countries are well represented in all the eleven networks selected with membership ranging from at least one to all five countries under the EAC region. The SADC based networks cover most of the countries in Southern African. The membership ranges from three to thirteen countries under SADC. Only three networks do not include any countries from southern Africa and understandably so because of the links to the EAC.



3.2 STRATEGIC DIRECTION OF THE NETWORKS: VISION, MISSION, PURPOSE

In this section, we present the results of the strategic direction of the eleven networks as presented in Table 3.3.

Table 3.3: Comparison of Strategic Positioning among select networks

	Characteristic Network/ Alliance	*Vision*	*Mission*	*Purpose*	*Have strategic plan*
1	**AHLMN-** AMREF-African Health Leadership and Management Network	Vision: Towards Better Health Leadership and Management in Africa	Mission: To build capacity through organizational strengthening, institutional development, innovative training, applied research and technical support to health leadership and management institutions and individuals in Africa towards supporting the country health systems programs to meet their MDGs.	Purpose: Improving health systems through leadership and management in low and middle income countries	2009 -2011
2	**AHWO-** Brazzaville , Congo Africa Health Workforce Observatory	The mission of the observatory is to support actions that address HRH challenges urgently through promoting, developing and sustaining a firm knowledge base for HRH information that is founded on solid and updated HRH information, reliable analysis and effective use at sub-national, national and regional levels.		The purpose of the observatory is to contribute to HRH development in the African region in order to strengthen national health systems to provide more effective and efficient service delivery.	Not have
3	**EAC-REACH –** **P**olicy Initiative Regional East African Community Health Policy Initiative	Mission To access, synthesise, package and communicate evidence required for policy and practice and for influencing policy relevant research agendas for improved population health and health equity.		Purpose: To improve people's health and health equity in East Africa through more effective use and application of knowledge to strengthen health policy and practice	Prospectus 2008
4	**ECSA-HC** – Arusha, Tanzania East, Central and Southern Africa Health Community	Vision: A health population in the ECSA region	Mission: To promote the highest standards of health in the regions through research, advocacy, capacity building and provision of technical advice to member states and institutions	Purpose: To contribute to the improved health status of the people in the region The mandate of ECSA is to foster and encourage regional cooperation in health and to strengthen capacity to address the health needs of its member states so as to attain the highest standard of health for the people of the region.	2008-2012
5	**EQUINET** - Regional Network on Equity in Health in Southern Africa,– hosted by TARSC in Zimbabwe)	Mission EQUINET is building a forum for dialogue, learning, sharing of information and experience and critical analysis. We do this to build knowledge and perspectives, shape effective strategies, strengthen our voice nationally, regionally and globally and our strategic alliances to influence policy, politics and practice towards health equity and social justice		Purpose: EQUINET, the Regional Network on Equity in Health in Southern Africa, is a network of professionals, civil society members, policy makers, state officials and others within the region who have come together as an equity catalyst, to promote and realise shared values of equity and social justice in health.	Not sure
6	**SEAPREN –** Namibia Southern and Eastern Africa Policy and Research Network	Not stated on website	Purpose The aim of the Network is to collaborate on national and regional research projects and capacity building; exchange best practices and mutual learning in research as well as institutional management; and monitor international developments and new approaches within the field of policy analysis to ensure that network members use best practices and techniques.		Not sure
7	**GEGA**- The Global Equity Gauge Alliance-SA	Not stated on website	Purpose: Created to participate in and support an active approach to monitoring health inequalities and promoting equity within and between societies. An Equity Gauge is a health development project that uses an active approach to monitoring and addressing inequity in health and health care. It moves beyond a mere description or passive monitoring of equity indicators to a set of concrete actions designed to effect real and sustained change in reducing unfair disparities in health and health care.		Not sure
8	**IUCEA** Inter University Council of East Africa	Vision: UCEA becomes an effective regional advocate and catalyst for the strategic development and management of higher education in East Africa.	Mission: IUCEA shall coordinate; facilitate stakeholders so as to promote strategic, sustainable and competitive development of the higher education sector in East Africa.	Overall Goal is that IUCEA is transformed into a strong, competitive and responsive regional body in higher education	2009-2011

9	**HEPNet** Health Economic Policy Network	Vision To develp capacity in health economics adn health policy research in SSA	Mission: To improve the performance of health systems through informing health policy and enhancing technical and managerial capacity in Sub-Saharan Africa	Purpose: Lead in publishing innovative research which addresses priority conceptual and methodological issues in low- and middle-income countries. It will play a key role in global post-graduate training in health economics and offer expert policy advice on relevant issues in SSA. It will pursue a balance of mainstream and developmental health economics drawing on the strong human resource base with a full range of relevant skills and a diversity of nationalities and backgrounds	Have
10	**HEALTH Alliance**/ LIPHEA- Uganda	Not stated		Purpose: Build public health leadership capacity in E.A. through strategic training and networking approaches	Not have
11	**CREHS**–Consortium for Research in Equitable Health Systems	Mission: To improve equity and contribute to poverty reduction		Aims to increase knowledge on how to strengthen health systems in ways that preferentially benefit the poorest and to strengthen the capacity to support policy development	Not sure

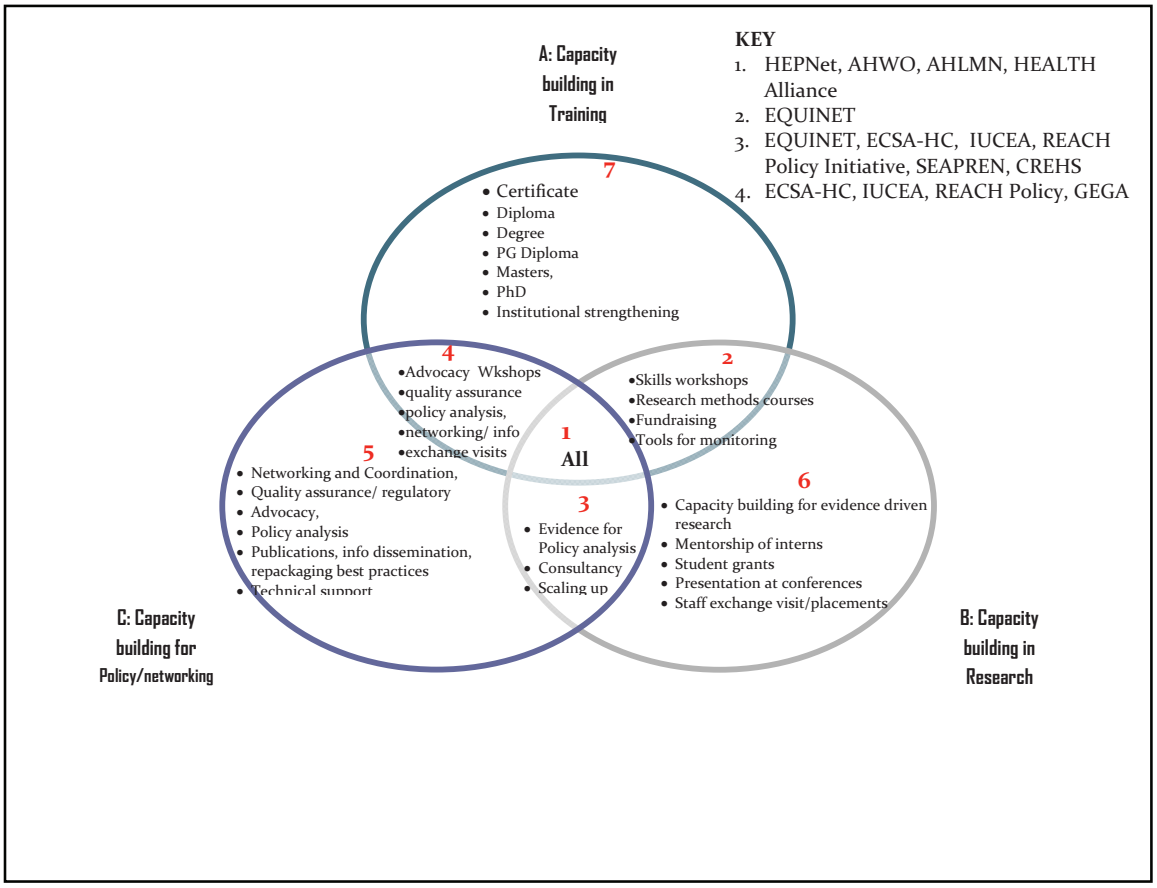
Of the eleven networks sampled, only four (4) stated their vision and submitted strategic plans for the networks (IUCEA, AHLMN, HEPNet and ECSA-HC); however eight (8) networks stated the mission of the network or alliance (AHLMN, AHWO, REACH-Policy Initiative (EAC), ECSA-HC, EQUINET, IUCEA, HEPNet and CREHS); Interestingly, three (3) alliances (GEGA, HEALTH Alliance and SEAPREN) did not state both the vision and mission.

Not all the vision and mission statements are in harmony with the African Health Strategy or the Takemi report, which emphasize a holistic and integrated approach to health system strengthening. Several variations are notable when the purposes or aims of the networks or alliances are compared. Three (3) networks focus on leadership and managerial capacity (ANLMN, HEPNet and HEALTH Alliance); five (5) on capacity for addressing equity and social justice (EQUINET, GEGA, HEPNet, HCSA-HC, CREHS, REACH) and three (4) on improving capacity for research and policy analysis (CREHS, SEAPREN, REACH and HEPNet). Only one AHWO focuses on building the HRH knowledge base and capacity to use the information to improve health systems. None of the networks combine or link management of human resources for health to other health system elements such as healthcare financing and health information management. However, most of them address research, training and policy practice through advocacy, capacity building and networking of policy-maker and civil society (CREHS, AHLMN, REACH, ECSA-HC, EQUINET, SEAPREN, HEPNet) . Additionally, the IUCEA is unique in that it serves as a consortium of higher education institutions and has a policy and regulatory role to standardize and harmonize training curricula for health management programmes in Eastern Africa. There was no equivalent body handling higher education training programmes across all south African countries. However, individual country bodies in South Africa had the Higher Education South Africa (HESA) and Higher Education Quality Assurance Committee (HEQA) in South Africa, National Higher Education Commission in Uganda and Commission for Higher Education in Kenya are already in the process of harmonizing curricula and have completed some, for example MBA in South Africa.

3.3 SCOPE OF NETWORK TRAINING ACTIVITIES RELEVANT FOR HEALTH SYSTEMS MANAGERS AND ADMINISTRATORS

This section highlights the networks that focus on training activities related to health systems management for health managers and administrators.

Figure 3.1b: Distribution of Networks by Core business/Activities



The main activities grouped into three themes included capacity building for training; capacity building for research and policy analysis /networking for information and evidence dissemination through advocacy among others. The Venn diagram Figure 3.2b represents the natural overlaps in activities as evident from the listed main activities and strategies of the eleven networks.

All networks associated with WHO or its institutions such as the AHPSR and GHWA during inception (HEPNet, AHWO, AHLMN and HEALTH Alliance) adopted a broad approach and covered all the main activities. Over half the networks focused on capacity building for research, policy analysis and advocacy as their core business (EQUINET, IUCEA, ECSA-HC, REACH Policy Initiative, SEAPREN, GEGA and CREHS). Those that were predominately research –based networks also

conducted training for developing the capacity of health workers and mangers as researchers and/or provided internship opportunities for young researchers to learn leadership and management skills under mentorship programme.

Networking as a core activity was listed by six organizations: AHWO, HEPNet, ECSA-HC, EQUINET, HEALTH Alliance and AHLMN.

3.4 Organizational Capacities of Networks in Eastern and Southern Africa

The results presented in this section are based on the capacity assessment tool, which is attached to this report as Appendix B. Only six networks sampled were able to complete the self-assessment tool. The information on the forms is reliable as they were completed by the networks in part through self-assessment, direct interviews during field visits and consultation with documents provided on the website and networks/alliances. The reasons for the 55 percent response rate are discussed in chapter two of this report.

Based on a scale of 1 to 6 respondents were asked to indicate the most appropriate response to reflect the true picture of the network/organization at the time. For this analysis, the score interpretations will be as follows. 1- 3.0 low potential and should go into Intensive care; 3.1 to 5.0 is average suggesting room for improvement and a score of 5.1 to 6 is interpreted as good performance. This interpretation applies to the two Figures 3.2 and 3.3.

3.4.1 Overall institutional capacity

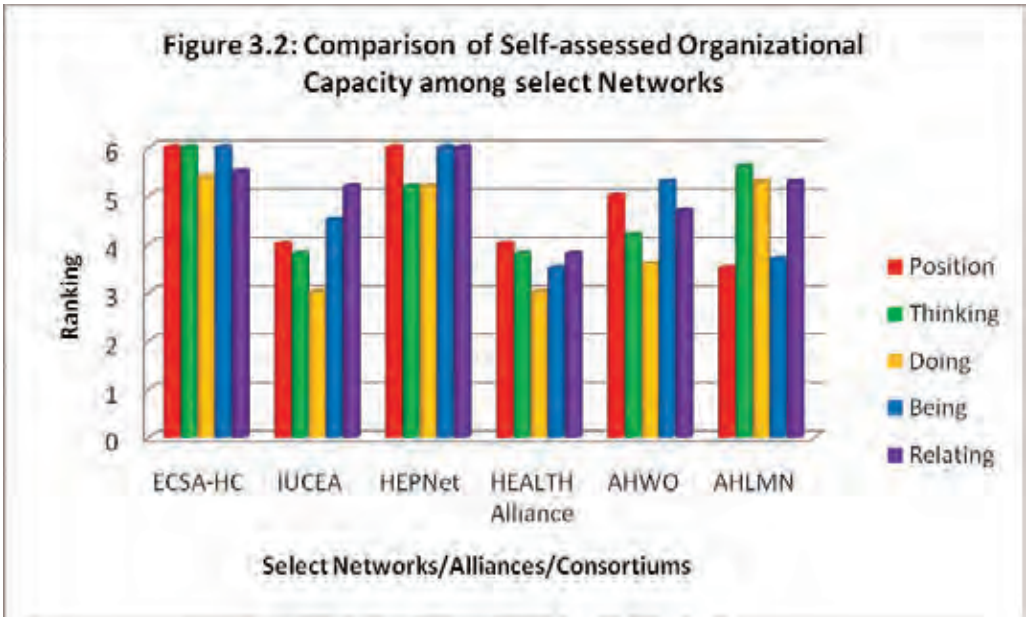


Figure 3.2 compares the performance of five networks across various indicators of organizational capacity assessment based on self assessement. It emerges that ECSA-HC and HEPNet are the high performing networks as their scores on all five attributes is above 5 with an average of 5.7 for both. The assessment suggests that the two networks are relatively weak on the 'Thinking and learning' and 'Doing' attributes (HEPNet) and on the 'Doing' for ECSA-HC. That is the networks are not ready for major changes because the slow or rigid ability to internally respond to external changes. This may be due to bureaucracy (ECSA-HC) and restrictive model – based on Sida's model of funded masters training programme, network activities and institutional capacity building (HEPNet). For both networks, the engagement in research has primarily been through links to other networks such as EQUINET. There is limited use of existing evidence to inform the network activities. On the 'doing' the major shortcoming was that operational aspects may not necessarily be cost effective and this was highlighted during the interview. This can also be attributed to weak information systems on human resources for health and monitoring systems.

The medium potential category includes AHLMN, AHWO and IUCEA with averages ranking tied at 4.5 and 4.1 respectives. The leadership network and observatory are both newly established and therefore represent potential rather than actual achivements. The main strenght is the links to WHO. IUCEA is the only intergovernmental body engaged in education and relevant for setting standards and harmonizing curricula. However, it is restricted to eastern africa and there was no comparable body for southern africa.

The HEALTH Alliance is depicted as having the relatively weak organizational capacity with a mean score of 3.6. The weakest link was poor institutionalization of systems with reported inefficient allocation of resources for network activities. Similarly, the support seems to be weak as the network proposed in 2006 did not acquire a legal mandate until 2008.

Among all the networks/alliances, the 'relating' attribute was rated highly, which means that most knew and named other networks and were able to engage in active collaborations and communicatgion with other networks. However, these collaborations were not necessarily in line with the 'doing' – that is the institutional norms and policies. The results also indicate that some networks did not have clear strategic direction as required under the 'thinking and learning' dimension. From our previous review we noted that only four networks had strategic plans (AHLMN, IUCEA, HEPNet and ECSA-HC).

3.4.2 Institutional capacity: Position and image

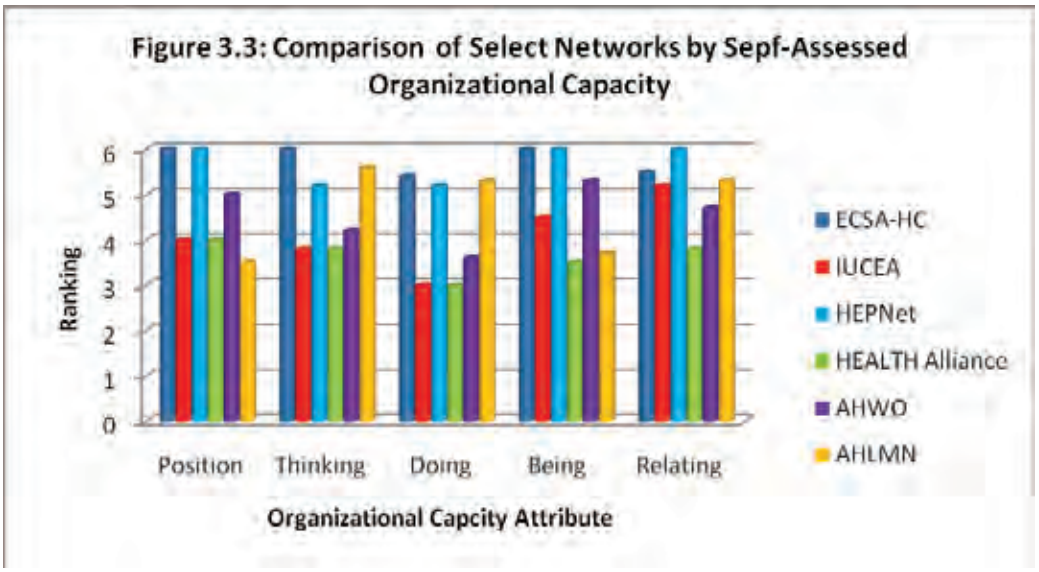


Figure 3.3 shows that most networks did well overall with a score of 4.5 on the position attribution of the network. The scores ranged from 3 to 6. Two networks were high performers on the image attribute, HEPNet and ECSA-HC, which scored 6. This was followed by AHWO with a score of 5. The rest IUCEA, HEALTH Alliance scored an average of 4 with AHLMN scoring 3.5 and understandably so because it was established in 2008. Thus, overall, networks had a very good image, among peers and relevant stakeholders and were well known in the region in the area of health and human resource development. This analysis is reliable as the highest ranked were inter-regional networks reflecting a true picture of covering at least two regions eastern and southern Africa.

3.4.3 Institutional capacity: Thinking and learning

The 'thinking and learning' function shows whether the organization is ready for change by the way it prepares strategically to respond to its external environment. The preparations include strategic plans, equitable allocation of resources, application of best practices and use of evidence and quality assurance systems in decision-making, among others. The average scores ranged from 3.8 to 6 giving an overall score of 4.7 on this attribute. ECSA-HC, AHLMN and HEPNet are the best performing networks with scores of 6, 5.6 and 5.2 respectively. The medium performing networks are the observatory AHWO with a 4.2. The IUCEA and HEALTH Alliance averaged a 3.8 score. The main reason for the weak performance is delays in formulating strategic plans and probably the slow regional integration in Eastern Africa.

3.4.4 Institutional Capacity: Doing

This attribute refers to what the network doing and whether its output comply with documented practices yielding a favourable physical operational environment for the organization. Figure 3.3 again shows that among the five components, the 'doing' function was the worst in performance based on self-assessment by directors and other respondents representing the organization or

agency. The overall score was 4.0 with average scores ranging from 3 (HEALTH Alliance and IUCEA) to 3.6 (AHWO), to 5.3 (AHLMN and HEPNet) and to 5.4 (ECSA-HC). The main weakness as acknowledged by the networks was cost-inefficiency and/or ineffectiveness. None of the networks (except HEPNet and ECSA-HC) pointed out the specific areas of influence or improvements in competencies of the human resource and/or the performance of health system. One coordinator remarked that upon training district level staff most use these new competencies to find new and better jobs and/or do not return to the country if the training is held outside the country.

3.4.5 Institutional Capacity: Being

The 'being' attribute refers to the way the organization operates or conducts the day-to-day business in order to render services, the values and common beliefs that drive the organization giving it its cultural identity. Examples include internal controls for accountability and transparency vested in the constitution, merit-based practices in human resource management. As Figure 3.3 shows, there are some significant differences in the ranking of the networks on the 'being' component. With an overall average score of 4.8, three networks scored over 5.0 (ECSA-HC, HEPNet and AHWO) and one (IUCEA) averaged 4.5 but two (2) organizations show some relative weakness at 3. 7 (AHLMN) and 3.5 (HEALTH Alliance). The major challenges were low commitment and none visionary leadership, non-sustainable financial plans and in-equitable and weak structures for transparent and equitable resource allocation. The exception being AHLMN that is newly established and are yet to be given legal mandate for regional operations.

3.4.6 Institutional Capacity: Relating and Balance

Finally, the graph shows how well the organization relates or interacts with other like-minded organizations or stakeholders. It assesses the capacity of the social environment of the network. The was the best performing attribute for most networks, four networks scoring above 5 (HEPNet, ECSA-HC, AHLMN and IUCEA). The medium performing networks include AHWO at 4.6 and lastly HEALTH Alliance at 3.8. Part of the reason for this good performance is attendance or participation in conferences, association meetings and workshops. For HEPNet the relating also involved strong research links with other networks such as EQUINET and research centres such as Centre for Health Policy, Centre for Policy studies and CREHS among others. ECSA-HC has strong ties with regional bodies such as NEPAD, AU, SADC, EAC and WHO among others. While AHWO is a strong regional body it is relatively unknown due to weak marketing strategies and limited funding for operations currently being undertaken since 2006. The obvious link to WHO has probably made it a bit passive in its approach to marketing its vision and mission.

3.5 Overall SWOT analysis

To understand further the capacities of the networks and alliances, respondents to the in-depth tool were asked to provide a considered assessment of the strengths, weaknesses, opportunities and threats of their networks/alliances. The strengths and weaknesses represent internal issues that the institution or organization can address, while opportunities and threats are specific to external factors not easily influenced by or within reach of the network. However, management of the

network can take advantage of the opportunities to address the weaknesses and use the position of strength to minimize the impact of the threats. Table 3.4 summarizes the SWOT issues for the six networks and Alliances.

Table 3.4: SWOT Analysis identified by Networks and Alliances

Internal to network/Alliance	**Strengths** 1. *Competencies and Technical* expertise in theme areas – policy analysis, development, advocacy, harmonization of policies and programs, capacity building, dissemination and repackaging of research, monitoring and evaluation (ECSA-HC); Competencies of staff at the secretariat – AHWO; capacity building through LIPHEA- HEALTH Alliance 2. *Business/strategic plan*- AHLMN, ESCA-HC, IUCEA, HEPNet 3. *Have newsletter and brochures* – IUCEA, HEPNet, ECSA-HC 4. *Forum* for public health practitioners in EA together through website, sponsorship to meetings, – HEALTH Alliance; Opens opportunity for teaming up in multi-agency/disciplinary work –AHLMN 5. *Strong Political Support* –from member countries as they established inter-governmental agency and set the agenda (ECSA-HC for health and IUCEA for education); Support of WHO and partners – AHWO 6. *Practices* – transitioning from policy to programming to implementation - ECSA-HC 7. *Minimize duplication* among members by sharing strategic /operational concerns – AHLMN (potential as just starting) 8. *Effective governance bodies and institutions* (only intergovernmental agencies and at strategic level) in region for coordination and quality assurance (IUCEA), for health (two regions) with recognition and respect among regional bodies such as NEPAD, SADC, EAC, AU, WHO, World Bank – ECSA-HC ; can utilize WHO offices in some member countries- AHWO 9. *Effectiveness* – contributed to health sector development by promoting networking activities between member institutions (inaugurated the African Health Economics and Policy Association (AfHEA) and with international organizations, strengthening scope of capacity building in health economics and policy research – HEPNet; regional formal health agenda for AU, NEPAD, EAC and SADC -ECSA	**Weaknesses** 1. *Inadequate financing* –ECSA-HC (member contributions), AHLMN, IUCEA, HEALTH Alliance, HEPNet 2. *Inadequate technical capacity* for HRH theme area – ECSA-HC; Staff overloaded at regional level and low capacity to undertake research in HRH – AHWO; Lack human resources and funding to implement plan – IUCEA, ECSA-HC 3. *High expectations* of ECSA-HC responsibilities of member states; Unrealistic /misunderstanding of the observatory's mandate - AHWO 4. *Passive members* - Not all members (states) are active- ECSA; Requires a champion with commitment as members tend to be very passive- AHLMN 5. *Weak legal mandate* – AHLMN (just established) 6. *No formal relationship with Government* /MoH – AHLMN 7. *Inadequate corporate culture* leading to poor image and news letter not widely circulated, Website not attractive – IUCEA 8. *Weak HRH information systems* and monitoring and evaluation in member country – AHWO; ECSA-HC 9. *Lack transparency* especially in financial planning and management through late invitations– HEALTH Alliance 10. *Limited membership* to network – need to expand and cover more countries in Africa –HEPNet; some members are passive –ECSA-HC 11. *Governance/representation;* Difficult linking with country plans since ECSA-HC has no country level offices
External to network / Alliance	**Opportunities** 1. *Regional block to lobby* for voice on international issues affecting health in Africa – ECSA_HC; Implementation of EAC protocol gives rise to a common market and political integration for harmonization and coordination of training programmes- IUCEA; Marketing opportunity – invited to address the Health Ministers Conference organized by ECSA in Feb 2010 – AHLMN; established platform to improve capacity development – set up AfHEA -HEPNet 2. *Willingness of the stakeholders to work together* – AHWO; and enhanced public/private partnership opportunities- ECSA; 3. *Ownership opportunity* as based in Africa – AHLMN 4. *Willingness of donors* to support strategic programmes- ECSA-HC; IUCEA; Observatory is attractive–AHWO 5. *Momentum to move forward HRH crisis* in SSA and as key component of health system–increased demand for HRH services and agencies seeking to collaborate with ECSA-HC; AHWO 6. *Similarities* - Disasters common in the region – HEALTH Alliance; Ready market in EAC for short courses _ HEALTH Alliance	**Threats** 1. *Poverty* and declining financial capacity in regions – ECSA-HC, IUCEA, 2. *Conflict i*n the region- leading to increased internal, regional and international migration -ECSA-HC; Unpredictable funding support from EA Governments due to conflicts - IUCEA 3. *Already too many networks* focusing on public health which increase competition leading to some selecting just one regional body (ECSA-HC) and competition for funding as some are well funded - AHLMN 4. *Institutional transformation* has been slow - IUCEA 5. *High brain drain at Universities* - IUCEA 6. *Competing priorities and donor fatigue* at times difficult to integrate with government – HEALTH Alliance 7. *Termination of Sida funding* (main funders of HEPNet) the continuity of HEPNet is very doubtful – HEPNet 8. *Nature of organization:* does not allow for participation of Heads of \state but operates through Ministries of Health – ECSA-HC

3.4.1 Strengths

Institutional representatives were either interviewed or completed the tool and sent it through email. The factors are arranged by the ranking from the most common response to the least mentioned issue.

The most important strengths were competencies of staff and technical expertise in various thematic areas such as policy analysis, capacity building for research, for disaster management and advocacy. Most networks also had strategic plans, newsletters, brochures and websites. These were mentioned by ECSA-HC, IUCEA, AHWO, HEPNet and HEALTH Alliance. The AHWO, ECSA-HC and IUCEA pointed out that strong member support was a key asset. This strength in part lies in the fact that ECSA-HC (health) and IUCEA (Education) are the only inter-governmental bodies with broad and direct working arrangements with institutions and government agencies in member countries. AHWO too has direct mandate as an organ of WHO. However, this strength is weakened by passive support among some members as pointed out by ECSA, IUCEA and AHLMN. Another related strength in ECSA, IUCEA and AHWO is direct links and implementation of regional agenda from AU, NEPAD, SADC and EAC among others through the inter-governmental organs and through WHO member countries.

3.4.2 Weaknesses

Inadequate financing was the leading problem as five out of the six networks mentioned it. The range of activities included funding action plans, budgeted activities, support for internship programs and research. Although some networks mentioned that technical competence was strength, the scope of the competence was limited to areas of policy, economics, research, disaster management and did not cover all aspects of health systems management. It is clear that lack of and/or unclear vision and mission statements as well as objectives at the various levels of the networks may in part explain why member countries and institutions have unrealistic expectations from the networks/alliances. One network (HEALTH Alliance) singled out weak transparent systems especially financial planning and management.

Most regional bodies, networks and alliances do not have monitoring and evaluation frameworks for human resource. There is no one-stop shop for trends and patterns in human resources for health in eastern and southern Africa leading to disjointed efforts and lack of synergy among programme activities in training and research. Some networks have weak alignment with Ministries of Health (AHLMN) and/or political representation (ECSA-HC).

3.4.3 Opportunities

The one most important opportunity is recognition among networks that Human resources for Health is a key component of the health system. The human resources for health crisis, coupled with the high brain drain in some countries and institutions not only weakens institutional memory but also affects sustainability of network initiatives. The urgency to move the agenda forward because the regional and global interests on revitalization of PHC provides a conducive political and economic environment to address the human resources for health issues in Africa.

The next most important opportunity is the timing of the integration of EAC and other regional bodies as opportunity for member countries to harmonize and develop regional protocols for integrated activities. This is in part due to the recognition of high mobility and migration at national, regional and international levels as well as similarities in economic and health challenges such as environmental disasters and re-emerging infectious diseases. Projects such as the East Africa Infectious Disease Survillance Network (EAIDSNet) under the EAC aim to establish and monitor infectious disease patterns at the regional level but activities of the AHWO which would monitor patterns in HRH are attractive but still at the infancy stage.

3.4.4 THREATS

Poverty and conflict in most parts of sub-Saharan Africa are considered major threats to the conducive environment mentioned above. Not only do these factors threaten external funding, but they also make financial contributions from member countries unstable and unpredictable. It is noted by the most recently established network (AHLMN) that there are too many networks already and fundraising through paid membership may be a threat to successful attraction of member institutions. Similarly, ECSA-HC notes that such crowding of networks and regional bodies forces members to select which network to be part of and therefore restricts involvement in some theme areas not covered by the selected network.

Politics and slow institutional reforms also threaten effectiveness of the programmes under regional bodies due to delays in funding as well as approval and implementation of polices.

3.5 CHALLENGES

Among the key challenges that networks in Africa face include structural and operational challenges. The operational include inadequacy in leadership and management, time-bound or inadequate financial and human resources, weak evidence base because of poor access to data, and skills for packaging and presenting evidence to stakeholders at strategic and operational levels. The structural issues cover inappropriate technology, software, weak infrastructure, and monitoring systems, weak or none-existing legal instruments and organizational frameworks to readily improve representation.

<u>Structural challenges</u>

- Legal instruments and organizational structures to improve representation was reported by the IUCEA. These weak structures also fail to link member institutions of higher learning in public health and research to those at the middle level. Most networks specified the membership requirement so as to bring together like minded institutions. However, few described the organizational structures and legal instruments, which serve as a platform to translate research into policy and practice and thereby close the implementation, gap within countries and within the region and to reach out to broader stakeholders. Currently most networks rarely involve parliamentarians and civil society except through workshops

- MIS and ICT and no comprehensive monitoring and evaluation framework for networks to assess their performance. Such a framework should be modelled on principles of networking.
- Efforts to strengthen capacity for leadership and management in the health sector is weakened by too many players and actors within the region whose overlap is, unfortunately, rarely complimentary. Attempts should be made to create synergies between regional development bodies such as – EAC, SADC and NEPAD, their implementing institutions and sponsors such as USAID, WHO and JICA.

Operational Challenges

- The linkages between vision, mission and outputs is weak as most networks focus on activities such as capacity building at different levels which are easy to justify by holding several workshops, seminars or short-courses in a year. Rarely are these training programs monitored and evaluated and information fed into the national or regional database to help determine the critical mass in specific areas of public health..
- Most networks do not have clear definition of the roles of the network members. This leads to a situation where the network is more-less formed by evolving into the role rather than through a strategic intent.
- Networks are supposed to facilitate the sharing of available resources and best practices. However, most of them have newsletters, websites and even journal, which are not within easy reach or are not well distributed to district level health managers or administrators. While most may not have access to ICT services, for those who do, it is still a challenge for a health manager to have to read, for example, eleven (11) newsletters on health management to figure out the best community financing model. A few networks have journals, which are not available to the target audience.
- Declining donor funding, donor fatigue and competing priorities make integration and harmonization of training difficult. For example, Sida support to HEPNet is ending 2010 without an option for renewal.

4.0 DISCUSSION OF FINDINGS

In this section, we describe the achievements of the networks and alliances and suggest three options (high, medium and low performing networks) of levels of support from which JICA can select options. Secondly, an attempt is made to identify the gaps in the functioning of the networks based on the general profiles and capacity assessment as well as SWOT analysis of the networks.

4.1 WHAT HAVE THE NETWORKS AND ALLIANCES ACHIEVED?

In this section, we group the networks based on their achievements of the networks, alliances and consortiums. Networking is about sharing and engagement based on shared core values and principles. The eleven networks are divided into high, medium and low performing networks.

High performing networks (3)

This group includes HEPnet, ECSA-HC and EQUINET. The reasons for placing them among the high performing networks include:

- Clear strategic direction - Vision, mission and strategic plan for HEPNet and ECSA-HC
  - Mission and purpose (EQUINET)
- Cover Eastern and Southern - ECSA-HC (10), EQUINET (8), HEPNET (7)
- Established over 10 years ago –ECSA-HC (over 20 years), EQUINET and HEPNet (10 years)
- Membership by institution - Research, Academic, Government, NGOs, Civil Society
- Overall Capacity assessment - HEAPNet and ECSA-HC top level in all attributes. EQUINET was not assessed in-depth)
- Governance structures - structures devolved for HEAPNet and EQUINET to Country-level institutions,
- Achievements - *HEPNet* – Training - 7 PhDs, 180 Senior Managers (dip), Sponsorship to 3 annual conference attendance (10–17 people), establish professional associations (3), research publications – health insurance/financing and equity, good website and newsletter; planning for journal
  EQUINET – 3 annual regional conferences on equity and HRH regional research skills and policy analysis workshops, research reports and publications on health workforce retention – multi-disciplinary, good website newsletter
  ECSA-HC- Training (TOTs) regional, curricula for midwives, FP, HIV; several Health Ministers Conferences and workshops on health worker retention, health policies and program guidelines for member countries, good website. Hosts association of professional bodies for surgeons and nurses. ECSA-HC is only inter- governmental regional body as IUCEA and REACH are EAC based.

Medium performing networks (3)

The networks include AHWO, AHLMN and IUCEA. The reasons for their average performance are:

- Clear strategic direction – IUCEA and AHLMN (both) and AHWO (Mission only)
- Geographical Coverage - IUCEA (5), AHWO(33), AHLMN (6/33)
- Establishment - IUCEA (over 20 years), AHWO (5 years), AHLMN (2 years),
- Membership by institution - Research, Academic, NGOs, Government
- Overall capacity assessment - AHLMN (potential), AHWO and IUCEA (medium)
- Governance structures - structures for all three are not devolved – centralized. IUCEA is only inter-governmental body for regulating educational standards and harmonizing curricula and works with all (public and private) universities in EAC.
- Achievements - Joint *IUCEA* and EAC Health-desk activities, Universities – development of REACH programme, partner with AMREF/EALP on research on HIV/AIDS with 18 Universities in EA; Gender and HIV Mainstreaming in all University Curricula in region, Quality assurance capacity building for

25 Universities coordinators on region; institutional strengthening on ICT for Universities

AHWO- 2nd regional conference, launched HR shortage tracking programme, developing tools for measuring HRH inequalities, monitoring and scaling up guidelines in collaboration with GHWA, developing directory for health training HRH institutions, fellowship programme evaluated, reports on website

AHLMN – Business plan, constitution, limited fundraising

Only network that charges membership fees (Full, corporate, individual), interim secretariat, website, planning situation analysis , to obtain legal mandate in may 2010

Low performing networks (5)

Half the networks, HEALTH Alliance, REACH –Policy Initiative, SEAPREN, GEGA and GREHS are in these groups because of the following reasons.

- Clear strategic direction - Neither vision nor mission – Health Alliance, GEGA, SEAPREN,
  -Mission only – REACH Policy Initiative and CREHS
- Geographical coverage - SEAPREN (8), REACH (5), GEGA (8), CREHS (7), HEALTH Alliance (7)
- Establishment - SEAPREN (10 years), REACH and GEGA (5 years), HEALTH Alliance (3)
- Membership by institution - most work with Research & Academic; Government (REACH)
- Overall Capacity - HEALTH Alliance (low) The rest were not assessed
- Governance structures - devolved to institutions (SEAPREN, GEGA, HEALTH Alliance)
- Achievements - *REACH Policy Initiative*

  Strong government involvement and support, prospectus 2006, signed memorandum of Understanding, co-host 4th ECA community and health scientific conference April 2010 on evidence for Action

  - *Health Alliance*

  Evolved from Association of schools of Public Health to HEALTH Alliance covering more countries beyond East Africa; Established Journal of Public Health in East Africa and annual scientific meetings, still developing strategy, established website and newsletter, established country level nodes for LIPHEA project and training of district level staff in disaster preparedness and management (developed harmonized curricula); annual meetings of Directors and Deans but not institutionalized seems to rely on individual/PI effort

  - *SEAPREN*

  Workshop on NEPAD and civil society in 2003, research protocols since 2003/2004, partners with leading policy oriented research institutions and research and academic institutions outside Africa; examines poverty and other macro-level issues in health policy; several publications and reports on website; has newsletter

  - *GEGA*

  Successful involvement and empowering of legislators at national and provincial levels, workshops on budgetary process run by provincial committees (developed curricula), field visits for legislators to district hospitals to empower with information for

policy-making. 12 gauges (some national others regional) linked to research and academic institutions in member countries

- *CREHS*

Capacity building for Research in health sector reforms and especially healthcare financing, health workforce retention and productivity in Africa, Asia and Latin America, several publications in journals and conference presentations, CREHS newsletter and brochure, policy briefs. Secretariat and coordination based in UK.

The above analysis suggests five main factors contribute to the effective functioning of networks. These include clear strategic direction, devolved organizational structures, broad membership covering at least two region (not countries) and at least a range of institutions, specifically research, academic, NGOs and Government Ministries and/or departments. This broad institutional membership enables the network to draw on a broad range of expertise and resources to support and sustain the network. Equally important is an effective monitoring and evaluation framework to determine effect and impact. Two additional but essential ingredients are adequate funding and a committed and trusted leadership as suggested by AHLMN and HEPNet. That is why inter-governmental agencies such as ECSA, IUCEA and REACH have more permanence and suitable for JICA's modalities of working with governments. While adequate involvement and representation of parliamentarians and civil society is important, this study does not have adequate information to compare the effect of this variable across the networks.

4.2 WHAT ARE THE GAPS IN CAPACITIES OF NETWORKS FOR HUMAN RESOURCE FOR HEALTH FOR HEALTH SYSTEM STRENGTHENING?

The idea of establishing an independent watchdog for health in Africa was discussed at the 8th International Congress of the World Federation of Public Health Associations held in Arusha, Tanzania from the 14- 16 October 1997. In part, this was a response to the view that WHO was failing in its role in Africa. In 1998, the Independent Group for Health in Africa (IGHA) was established as a watchdog for health in Africa with its secretariat based in Zimbabwe at the centre for international health and policy. The group aim was to monitor health problems, policies, strategies and programmes including research and advocate for improved health policy in Africa. The primary objective was to audit international organizations (such as WHO, UNICEF, WORLD Bank) and NGOs involved in health work in Africa and advocate for action on audited issues. Perhaps the most important was to promote networking among the institutions, agencies and experts and advocate for relevant institutional capacity building for local health systems and institutions. The members included representatives from COHRED, WHO/HSR, the commonwealth regional secretariat (now ECSA-HC), Blair research institute, Rockefeller Foundation, AMREF and World Bank among others. At the moment, these functions are not being performed hence the many networks in capacity building for training and research.

USAID through AED led the effort to draft a strategy for Africa's Health in 2010 titled 'Capacity Strengthening of African Institutions and Networks: A Strategy'. The purpose of the strategy was to strengthen local and regional capacity of adopting effective policies and innovations for improving the health of Africans. The HEALTH Alliance movement started with the Support for Analysis and

Research in Africa (SARA) project by USAID between 1992 and 2005 whose aim was to collaboratively build capacity of select institutions and networks in Africa and improve African ownership of the initiatives. The project collaborated with WHO Afro and ESCA-HC. Afri-Health project found that there were inadequate personnel, few linkages among institutions and between south-south institutions. The major achievements included adoption of new approaches and tools for strategy development and implementation as well as information sharing and advocacy.

4.2.1 COVERAGE AND MEMBERSHIP

The first gap is that none of the networks targeted health managers and administrators to form an association, which serves as a watchdog. Such an association would provide a mechanism for regulating and setting standards for formation of networks. It would also monitor activities of the networks using a standardized performance assessment tool whose indicators include measurement of impact on strengthening the health system. To develop appropriate curricula it is important to have a body that will formally represent the target group- health managers and administrators.

The second gap refers to limited or guarded geographical coverage within and across regions by the sampled networks. Besides the WHO based network, IUCEA and AHLMN, most other networks were rather selective on the geographical coverage. For example, the variations in composition among networks covering eastern Africa, where countries such as Burundi were excluded when Rwanda was included, Eritrea was excluded when Ethiopia was included as well as selectively including Sudan and Democratic Republic of Congo. The same applies to southern Africa where South Africa was included in all networks covering the region but countries such as Lesotho, Swaziland or Angola were rarely included. While conflict may explain in part, the omission of some countries, diverse contexts provide opportunities for more comprehensive understanding of practices and lessons. Only two networks have expanded the membership since inceptions: HEPNet (from 5 to 8 countries) and HEALTH Alliance (from 2 to 7 countries). The only exception ot this analysis it that ECSA-HC has so far covered more smaller countries in southern Africa – Mauritius and Seychelles, for example, and excluded the giant – South Africa.

4.2.2 STRATEGIC DIRECTION

The fact that only four out of eleven networks had strategic plans suggests a gap and weakness among the networks in determining strategic direction. The core element of success functioning of a network is trust and communication. Yet, most of the networks did not state the core elements or set of values and beliefs that would attract member institutions. This gap, the lack of a unifying set of values and envisioning may in part explain why some networks complained that the members were very passive. There is need for a clear strategic direction to avoid too many networks operating at cross-purpose and with little impact on health systems. In addition, a clear regional monitoring and evaluation framework would ensure monitor the effectiveness of training and the impact on the health system.

4.2.3 NETWORK CAPACITY

The in-depth analysis of the six networks showed that most were lacking on two dimensions beside the strategic direction: the physical environment – weak or overburdened secretariat, limited ICT technology, poor linkages. For example, two-thirds of the networks had either regular newsletters (HEPNet, SEAPREN, CREHS, IUCEA, EQUINET, GEGA), policy briefs (HEPNet, EQUINET), and journals (HEALTH Alliance) but few had horizontal communication across networks. While the HEALTH Alliance strategies suggest that it was set up to become a one-stop shop for evidence on best practices among others, this has not happened.

There is poor coordination among networks as there are far too many networks and some countries are involved in too many activities to be effective across the board. All the networks expect two have a newsletter and/or policy brief yet there is no coordination as to how stakeholders use this information and none targets health managers or administrators. The mapping of networks shows few are linked to similar networks on their websites. This is also manifest in the many conferences held every year and at times no link to previous and similar conferences held be different networks (EQUINET, HEPNet, Health System Trust, EAC-HEALTH Alliance, SEAPREN among others).

Another gap is the weak sustainability of networks and vulnerability to external (from Africa) as revealed through interviews with coordinators of HEPNet, REACH Policy Initiative and HEALTH Alliance suggesting that these networks and alliances initiated as projects have had some difficulty securing additional funding at the end of the initial funding cycle. Having links to networks with strong governmental support – ECSA-HC and IUCEA, as intergovernmental bodies improves sustainability of initiatives. Institutionalization mechanisms are not clear and those that have reminded as projects tend to suffer the wear and tear in terms of sustained interest from member countries – hence the passive or inactive membership.

5.0 CONCLUSIONS

This final section outlines key conclusions and recommendations of the survey guided by the four objectives. The study recommendations are attached as a separate page to this report at JICA's request.

Objective 1: To identify higher educational and research networks in Eastern and Southern Africa which pose strategic implications for sustainable development of human resource for health (HRH) in the region.

There are too many health networks (over 50) but about one third are not based in Africa and another one-fifth not very active (about half responded to the email interviews). As a result, there is some duplication of activities as evidenced from the purpose and mission statement. Of the twenty-three (23) sampled, this study profiled eleven (11) based on the study objectives.

Objective 2: To profile networks offering training and research programs in the general areas of health systems management

Nine of the eleven networks were established in the last ten years with WHO (AHPSR, GHWA) taking the lead or playing a significant role in their establishment (HEPNet, AHWO, GEGA, HEALTH Alliance, AHLMN). This suggests good will (global) as well as great opportunities for regional integration.

It is noteworthy that all networks (except one) had legal mandate to operate regionally; however, they tended to be selective on the membership. For example, countries in East African had membership to eight to ten networks and alliances! Without focus, this can be overwhelming and not yield synergy in the efforts to strengthen health systems.

Networks that appear successful had clear strategic direction, covered more than one region, included a broad range of institutions (academic, research, NGOs, Government, civil society and legislators, had devolved governance structures anchored or institutionalized as national nodes and a high performing organizational, physical and social environments. The global and regional networks involving multiple institutions within countries tended to be more successful because of the element of competition. Networks with linkages to community level or district level training and programme implementation appear to be more active and relevant: HEPNEt (training district-level staff and conducting collaborative research in health insurance), HEALTH Alliance (training district-level managers in disaster preparedness and emergency) and CREHS working with legislators and civil society to create macro-level linkages to regional bodies such as NEPAD.

Objective 3: To analyse the Strengths, Weaknesses, Opportunities and Threats (SWOT) to identify gaps and unique selling points for each network

The major strength of the networks and alliances are embedded in devolved governance systems and goodwill at national, regional and global levels. Others include competencies and technical expertise in select health management areas, strategic directions and effectiveness for a few such as HEPNet. The main weakness was inadequate funding which could be addressed in various ways membership. While membership does appear to affect the sustainability of a network, with a higher sample, it should be possible to determine a threshold level for membership to ensure financial stability of the network. The key reason for the weakness is that most networks started as projects (some have principle investigators e.g., HEPNet, HEALTH Alliance and REACH Policy Initiative) and institutionalization process may not be completed by the end of phase one.

The self-assessment tool revealed that networks perceived themselves to be doing well on internal operations due to accountability and some transparency as well as effort to network with like-minded stakeholders and partners. However, most were not strong on dimensions measuring equitable resource allocation and performance-based practices.

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STUDY APPENDICES

Appendix A: General Profile of Regional Networks for Human Resource in Health (HRH) in Health Systems Management / Public Policy and Administration in Eastern and Southern Africa

Completed by Director, Coordinator or other Representative of the Network, Alliance or Consortium.

Objectives of the situation analysis specific to networks

i. To identify higher educational and research networks in Eastern and Southern Africa which pose strategic implications for sustainable development of human resource for health (HRH) in the region
ii. To profile networks offering training programs in the general areas of health systems management
iii. To analyse the Strengths, Weaknesses, Opportunities and Threats (SWOT) to identify gaps and unique selling points of each network
iv. To recommend strategies for strengthening existing networks for health systems management as well as potential areas of collaboration for possible partnership with JICA

Name of Network, Alliance, Consortium or Regulatory body	The name network, alliance, consortium or regulatory body need not appear in the 'name'		
Country (*where based):*	This refers to the Country where the secretariat is based		
Hosting Institution:	The name of the department, school, faculty, university or research centre, organization hosting the secretariat of the network (where applicable)		
Member Countries/ geographical coverage	Membership for network, alliance or consortium listed above which could be by country, institutions, or individuals. The information given here is the regional representation of the network (what are the countries represented by the member institutions) or geographical coverage.		
Type, Legal status, date established:	Type: Public – private – FBOs - NGOs Accrediting body and date:		
Physical location of network	Physical address of the network, alliance, consortium secretariat or HQ		
Contact Information:	Name of institution/network Director URL	Telephone	Fax:
	Name of contact person Email	Telephone	Fax:
Brief Historical background	Summary of how network has evolved and notable events		
Purpose / Goal of network	Purpose or goal of the network as stated on website or documents availed		
Vision	As stated on website, documents e.g., strategic plan or interview		
Mission	Core business as stated on website, documents available, or interview		
Core values	As stated on website, documents e.g., strategic plan or interview		
Strategies	Approaches and unique methods applied by network to implement activities or carry out functions		
Main Activities	Key or major activities carried out by the network, alliance, consortium		
Implementing institutions/ Partners	Who does the network work with to implement its activities? These may include collaborating institutions, member partners, regional nodes.		
Sponsors/Donors	Who are the funding organizations for the network, alliance or consortium		
Capacity of network	This refers to the organizational capacity of the network, alliance or consortium including the Physical and Human resources as well as organizational structure		
Lessons in human resource for health	What unique things can we learn from the network regarding development of human resources for health (approach, process etc)		
Challenges	What are the major challenges facing the network, alliance or consortium		
Documentation secured by consultants (through visit or email, or available from website)	Policy documents Constitution/Memoranda	Strategic plans Baseline /evaluation survey	Human resource plans Regular/annual reports

Appendix A1: African Heath and Leadership Management Network (AHLMN)

Name of Network / Consortium /regulatory body	**African Health and Leadership Management Network (AHLMN)**
Country (*where based):*	Kenya
Institution Hosting Network:	AMREF International Training Centre
Member countries/ geographical coverage:	33 interested institutions but only 16 institutions and individuals representing about 6 countries in Africa have paid up their membership – Kenya, Senegal, Ghana, Botswana, Mozambique, South Africa.
Type, Legal status & date established:	**Type:** Not for Profit international NGO **Accrediting body:** At a meeting held in Nairobi, Kenya between December 3 and 5, 2008, Thirty-Three African and international institutions agreed on and ratified a constitution to formally establish a network on Health leadership and Management for health systems strengthening in Africa. However, the full legal status and mandate will be determined at the next Assembly meeting to be held in April/May 2010. This means it will be registered as an international NGO in Kenya but with international and regional memberships and operations. **Date:** December 2008
Physical location	**AHLM**N Coordinator , c/o AMREF HQ P. O. Box 26791 00506, Nairobi, Kenya
Contact Information:	**Director** Dr. Peter Ngatia URL www.ahlmn.org Tel: +254-2-699/3220 Fax: +254-2-609518
	Name of contact person: Dr. Peter Ngatia **Email** : ahlmn@amref.org **Tel:** +254 2 699 3208/9 ; **Fax** : +254 2 609518
Brief Historical background	The Network is a not for profit membership organization made up of both African Leadership and Management Institutions and International Organizations involved in leadership and Management capacity building, research and technical support services in Africa. The first meeting held in Accra Ghana in January 2007 challenged most institutions and individuals to re-examine ways of networking in Africa in order to build leadership and management capacity for health systems strengthening. These institutions requested that WHO help them to establish a network. They also requested that the work of the network focus on all the aspects of the WHO Management and Leadership Framework. At a subsequent meeting held in Nairobi, Kenya between December 3 and 5, 2008, Thirty-Three African and international institutions agreed on and ratified a constitution to formally establish a network on Health leadership and Management for health systems strengthening in Africa. At the meeting an interim secretariat was set up headed by Dr. Ngatia of AMREF. Since then, the executive committee has only met once with some support by WHO-AFRO at AMREF HQ. The network is young and needs commitment from members & support. The legal status and location of the Network is yet to be established.
Purpose / Goal	Improving health systems through leadership and management in low and middle income countries
Vision	Towards Better Health Leadership and Management in Africa
Mission	To build capacity through organizational strengthening, institutional development, innovative training, applied research and technical support to health leadership and management institutions and individuals in Africa towards supporting the country health systems programs to meet their MDGs.
Core values/principles	Not stated on website nor in the business plan
Strategies	The strategic objectives of the network include: • To expand technical assistance resources available to support requesting countries in the area of health management and human resources development by pooling human and technical resources to create greater synergy and impact • To facilitate intra-regional integration and exchange of knowledge, services and expertise on health systems development • To set benchmarks and standards for improving the performance of its members • To serve as a forum for collective advocacy for resources to support health service delivery and efforts by African countries to attain MDG targets through better management
Main Activities	• Capacity building through member institutions • Benchmarking and peer reviews to meet international quality standards • Policy advocacy at regional and international level for improved education and training of health workers

	• Exchange of health-sector leadership and management expertise and services across Africa • Collaborative resource mobilisation for technical support to countries • Research to contribute to the available knowledge and evidence of what works in health leadership and management strengthening in Africa • Collaborative grant writing for technical support • To promote the highest ethical and legal standards of accountability in the conduct and operation of leadership and management strengthening activities • Undertake Technical Assistance assignments at National and Regional levels to strengthen leadership and management in low and middle income countries towards MDGs • To raise and manage funds in order to conduct activities appropriate to achieving the overall objective.
Implementing Institutions/ Partners	Full member: institutions with headquarters in an African country (defined as WHO AFRO member country) whose work contributes to the strengthening of management in one or more African health sectors Full .($1,000) Corporate: Any company or organization that is involved in health systems leadership and management strengthening capacity building or an end user of trained health leaders and managers based anywhere. ($500) Associate: entities with headquarters based elsewhere or who are in other fields of endeavour and whose work contributes to the strengthening of management in one or more African health sectors ($500) Individual: People based anywhere whose work contributes to strengthening health leadership and management in Africa.($250) Benefits to members • A forum for generation and exchange of skills, knowledge, and good practice. • Opportunity to access national, regional and international leadership and management knowledge resources and tools. • An opportunity for institutional and organizational development through a common resource base and collaborative resource mobilisation • An opportunity for broader national, regional and international recognition of potential and actual capabilities, products and services for a more sustainable future. • A forum for a robust quality peer review of products and services • An opportunity to participate in a broader scope of capacity building, research and technical support initiatives in collaboration with other professionals at regional and international level. • A membership certificate is issued on registration **Paid up list of partners (10):** Institute of Development management, Dept of Community Health (Maputo), Ghana Institute of Management and Public Administration (GIMPA), Health Systems Trust (SA), AMREF, KEMU, CDC, KIT, Global Health Broadreach, Johnson & Johnson
Sponsors/Donors	WHO/AFRO, African Medical and Research Foundation (AMREF) and Centre Africain d'Etudes Supérieures en Gestion(CESAG) for 2009. Is planning to approached other potential partners WHO- Africa platform for GHWA, USAID, MSH, and JICA among others
Links to other networks	WHO, Regional AIDs Training Network (RATN), ECSA-HC
Organizational Capacity of network	**Physical, structure and Human resources (where** secretariat located **and staff, board** Secretariat is located at AMREF HQ with the Chair supported by one technical staff. The network elected AMREF[1] (Dr Peter Ngatia - Director for Capacity Building) as its chairperson and CESAG[2] (Prof Mady Koanda, Director General) as its vice chairperson, and an interim executive comprising of representatives from Africa's geographical and linguistic sub-regions. The interim executive shall run the affairs of the network for the next 12 months and oversee the evolution and implementation of its strategy. The proposed organizational structure is as follows: 1. The Assembly of Members ("the Assembly"), 2. The Council of the Assembly ("the Council"), and 3. The Bureau of Officers ("the Officers").
Achievements to date	1. Network constitution and business plan developed; 2. Established the Network's interim office, hosted by AMREF in Nairobi; 3. AHLMN Mednet online communication and discussion forum is established 4. An electronic listserve and website have just been set up. 5. A mapping exercise of institutions and programmes training in leadership and management will be commissioned once funding is secured
Lessons in HRH	Successful and active networks depend on committed leadership

Challenges	Limited funding to undertake activities, expected to raise funds through membership fees but it seems that not many institutions are keen to pay the amount proposed (from interview) Will not work directly with Governments but indirectly through the member institutions
Documentation secured by consultants (through visit or email)	• Network Brochure (also available on website); • Paper presented by Dr. Ngatia to Members of the ECSA-HC met in Arusha, Tanzania, on September14-19, 2009 to discuss 'Improving Access to Quality Health Care to Achieve the Millennium Development Goals'. AMREF presented a discussion paper on strengthening leadership and management for effective results - website. • Business plan for the Network (emailed on 25th January 2010 – same day of interview)

NB: Data was compiled from AHLMN Website and interview on 25 January 2010 and Business Plan

Appendix A2: *Africa Heath Workforce Observatory (AHWO)*

Name of Network / Consortium	**Africa Health Workforce Observatory (AHWO)**
Country (*where network based):*	Congo Rep
Hosting Institution:	WHO Regional Office for Africa
Member Countries/ geographical coverage	*Defined by WHO member countries in Africa - 33*
Legal status of each network:	**Type:** Public regional **Accrediting body and date:** WHO, 2006
Physical location of network	WHO, Regional for Africa, Cité Djoué, Po Box 06 Brazzaville, Congo
Contact Information:	**Name of institution/network Director** Dr Adam Ahmat **URL** www.afro.who.int/hrh-observatory **Telephone :** +47241391 69 **Fax:**
	Name of contact person – same as above **Email observatory@afro.who.int Tel Fax:**
Brief Historical background	The call for action issued during the High Level Forum on the Health-Related Millennium Development Goals, in December 2004, cast new light on the long-recognized deficiencies of health workforce information in Africa, a continent whose heavy burden of disease is exacerbated by its health workforce crisis. It recognized that drastic improvement of the HRH evidence base was fundamental to resolving this crisis. In a consultation in March 2005, WHO Regional Office for Africa, further developed a concept document on the Africa HRH observatory. The concept was presented to an HRH meeting held in April 2005 by the West African Health Organisation (WAHO/ECOWAS), which welcomed the idea and expressed willingness to participate in the work of the observatory. The draft document prepared in March 2005 was shared during the regional consultation in Brazzaville in July 2005. This consultation was hosted by WHO, the New Partnership for Africa's Development (NEPAD) and the African Council for Sustainable Health Development (ACOSHED. The Africa Health Workforce observatory was endorsed by this consultation,
Purpose / Goal of network	The purpose of the observatory is to contribute to HRH development in the African region in order to strengthen national health systems to provide more effective and efficient service delivery.
Vision	Not stated
Mission	The mission of the observatory is to support actions that address HRH challenges urgently through promoting, developing and sustaining a firm knowledge base for HRH information that is founded on solid and updated HRH information, reliable analysis and effective use at subnational, national and regional levels.
Core values	1. As the health workforce field involves multiple sectors (education, labour, civil service, etc.) and legitimate stakeholders (ministries of health, academia, professional associations, NGOs, regional institutions, etc.), the observatory acknowledge the relative importance and role of these stakeholders and promote their participation to ensure common understanding of issues and consensus on priorities and cooperation for effective implementation. 2. The observatory is also guided by the recognition that the development of health workforce policies is a dynamic and continuous process based on a continuously renewed understanding between stakeholders. Therefore, the development of human resources policies and the negotiation process implies and should be based on the best available evidence, the production of relevant information and promotion of transparency and trust. 3. As many forces that affect human resources in a national system are common to other countries or are international in nature, the HRH observatory recognize the impact of globalization and the economic and social integration process on the HRH development in order to inform itself and influence the international initiatives and experience.
Strategies	1. COUNTRY MONITORING AND INFORMATION: **OVERALL, EVIDENCE-BASED DECISION-MAKING TO BE FACILITATED BY BETTER USE OF HRH DATA SOURCES. NATIONAL OBSERVATORIES TO BE SUPPORTED TO COLLECT, ANALYSE AND USE DATA FOR MONITORING THEIR HEALTH WORKFORCE POLICIES AND STRATEGIES.** 2. HARMONIZATION OF DATA COLLECTION METHODS AND TOOLS **IN ORDER TO ENHANCE CROSS-NATIONAL AND TIME-TREND COMPARABILITY, USING INTERNATIONALLY RECOGNIZED STANDARD CLASSIFICATIONS OF OCCUPATIONS, INDUSTRIES AND EDUCATION** 3. DEVELOPMENT OF HRH INFORMATION SYSTEMS: OBSERVATORIES HELP

	TO DEVELOP OR STRENGTHEN HRH INFORMATION SYSTEMS AT COUNTRY AND REGIONAL LEVEL. 4. RESEARCH AND ANALYSIS: **THE RESEARCH AND ANALYSIS WILL HAVE BOTH NATIONAL AND REGIONAL COMPONENTS.** 5. SHARING AND DISSEMINATION, ENGAGING WITH POLICY-MAKER: **VARIOUS MEANS WILL BE USED TO COMMUNICATE THE RESEARCH AND ANALYSIS OF THE HRH OBSERVATORIES TO POLICY-MAKERS,** 6. NATIONAL AND INTER-COUNTRY NETWORKING: **THE HRH OBSERVATORY WOULD ENSURE NETWORKING AND COMMUNICATION BETWEEN NATIONAL STAKEHOLDERS AS WELL AS WITH MULTILATERAL AND BILATERAL AGENCIES. THESE NETWORKS SHOULD NOT BE PERCEIVED AS ADMINISTRATIVE STRUCTURES BUT AS BASED ON LINKAGES.** 7. CAPACITY BUILDING FOR HRH 8. CONTRIBUTION TO HEALTH SYSTEMS STRENGTHENING: **THE OBSERVATORY WILL PARTICIPATE IN AND CONTRIBUTE TO THE HEALTH SYSTEMS REVIEWS, WITH A STRONG FOCUS ON HUMAN RESOURCES.**
Main Activities	• develop national capacity for evaluation and monitoring of HRH situation and trends; • provide information and evidence for the formulation of HRH development policies, strategies, plans and their implementation; • provide a forum for partnership, sharing of experience and advocacy in HRH development; • facilitate networking of expertise in HRH and health systems in order to strengthen regional health workforce capacity; • serve as an early warning system and whistle blower on HRH situations.
Implementing Institutions/ partners	The Africa Health Workforce Observatory is envisaged as a network comprising national observatories – which bring together stakeholders at country level – a steering group, and a regional secretariat. The institutional arrangements are envisaged as a partnership based on networking. A partnership will be developed involving national institutions and multilateral and bilateral agencies. The Africa Health Workforce Observatory implies functions at national and regional levels: NATIONAL LEVEL : The efforts will build on existing partnerships and involve other constituencies, such as academia, NGOs, professional associations, other sectors and other stakeholders. National observatories will be motivated to promote the HRH agenda through varirous means of communication. A national focal point will facilitate planning and coordinating the work of the national network. The national focal point can be based in the ministry of health or in one of the member institutions of the network. The focal point will facilitate the work of the national observatory by identifying activity areas and responsible group members; ensuring dissemination of the results; organizing the national meetings and training activities; undertaking advocacy activities; and linking with the regional secretariat. The links among the national training institutions will be strengthened and their active involvement in the observatory activities will be ensured. WHO country offices will facilitate the linkage with the regional secretariat and support the national observatories. REGIONAL LEVEL The regional secretariat is to facilitate: • the formation of national observatories; • development of common guidelines and tools; • communication with national observatories; • inter-country studies, dissemination of inter-country studies, sharing of national studies, management of the web site; • linkages with other health system interventions and disease-based activities; • resource mobilization and fund-raising efforts. The Steering Group comprise representatives from national observatories and other partners to provide advice and oversee the work of the observatory. The Steering Group can: • monitor the work of the observatory; • identify policy directions and agree/advise on the priorities, annual plans and regional allocations; • determine the inter-country work, studies and capacity-building activities; • oversee the work of the secretariat; • participate in and support fundraising. **<u>Addition from website</u>** **WHO Collaborating Centres** 1. University of Botswana: Development of community nursing and midwifery care

	2. University of Natal, South Africa : Educating Nurses and Midwives in community problem solving 3. University of South Africa (UNISA): Postgraduate Distance education and research in nursing and midwifery development 4. University of Ilorin (Nigeria) Research in human resources development/community based medical education 5. University of the Western Cape, School of public health: research and training in HRH development **WHO supported Regional Training Centres** 1. Institut régional de Santé publique (IRSP) Benin : training in public health 2. Centre de Formation en Santé Publique (CFSP) Togo : training for mid level cadres 3. Instituto Superior de Enfermagem (ISE) Angola: Midwifery training /distance edcuation 4. Centre Regional de Desenvolvimento Sanitario (CRDS) Mozambique: training in Public health 5. Centre d'Etudes supérieures en Gestion (CESAG) Senegal: training in management **Subregional Forums** 1. NEPAD - The new Partnership for Africa's Development 2. ACOSHED - African Council for Sustainable Health Development
Sponsors/Donors	WHO Regional Office, Global Health Workforce Alliance, Commission European, GTZ
Links to other Networks	**From Website** GHWA, Commission for European Community, NEPAD, ECSA-HC, Capacity project (USAID), WAHO, African Council for Sustainable Health Development (ACSHD), OCEAC, WHO • World Health Organization http://www.who.int/en/ • International Centre for Human Resources in Nursing http://www.ichrn.org • HRH Global Resource Centre http://www.hrhresourcecenter.org • Human Resources for Health - World Health Organization http://www.who.int/hrh/en/ • PAHO Observatory of Human Resources http://www.observatoriorh.org/eng/index.html • European Observatory on Health Systems and Policies http://www.euro.who.int/observatory • Global Health Workforce Alliance http://www.ghwa.org/ • NEPAD - The new Partnership for Africa's Development http://www.nepad.org/ • ACOSHED - African Council for Sustainable Health Development http://www.acoshed.net/ • Human Resources for Health Online Journal http://www.human-resources-health.com/home/
Organizational Capacity of network	**Physical and Human resources** Secretariat with Technical Officer, one Assistant, secretariat and working group Steering Group comprise a Chair and Vice Chair and partners 7 Functional National Observatories with at least one focal point and working group and 10 other under development
Achievements	• 2nd Regional Conference of the Africa Health Workforce Observatory 6-9 October 2009, Marina Hotel, Cotonou, Benin. The Division of Health Systems and Services Development of WHO/AFRO in collaboration with the European Union and Global Health Workforce Alliance (GHWA) are planning to hold the mentioned meeting at Marina Hotel in Cotonou, Benin from 06-09 October 2009. About 90 participants from thirty seven African countries, health training institutions and interested partners are expected to attend this meeting. • Launch of programme on strengthening Health Workforce development and tackling the critical shortage of health workers. The World Health Organization, the Commission of European Community and the Global health Workforce Alliance launched a programme for strengthening Health Workforce development and tackling the critical shortage of health workers. The implementation of the programme started in 1st January 2009 for a period of 3 years. • Orientation & Capacity Building meeting on use of tools & Guidelines to scale up

	service delivery, Nairobi, Kenya 20-24th April 2009. WHO and Global Health Workforce Alliance (GHWA) are planning to hold an Orientation & Capacity Building meeting on use of tools & Guidelines to scale up service delivery in the context of PHC renewal in Nairobi, Kenya from 20-24 April 2009. • Human Resources for Health Results (HR)2 Africa Health Labor Markets and Pre-service Training Conference Addis Ababa, May 11-14, 2009. The World Bank Africa Health Workforce Program in collaboration with the World Health Organization and the Global Health Workforce Alliance is hosting a "Human Resources for Health Results (HR2) Research Symposium" 11-14 May 2009 in Addis Ababa, Ethiopia. • 57th Session of the International Statistical Institute (ISI) : our past, present and future" with special topic meeting on Measuring health workforce inequalities: methods and applications 16-22 August 2009 Durban, South Africa On 16-22 August 2009, Durban will play host to the 57th Session of the International Statistical Institute, the first in Sub-Saharan Africa. An ISI Session, held biennially, provides a platform for the gathering of over 5000 of the world's statisticians from public, private, research and educational institutions to share experience in a diverse • A new directory for health training institutions is currently being developed. This directory will be a web-based database with comprehensive information on health training institutions, including schools of medicine, dentistry, nursing, midwifery, public health, pharmacy and rehabilitation. • Evaluation Report Fellowship Programme [Français] - More information on Fellowship Programmes soon available		
Lessons in human resource for health	• Working together • Sustainability Strategy • Sharing HRH practices		
Challenges	✓ Maintain of the network for working together ✓ The linkages between Health Observatory and HRH Observatory ✓ Lack of resources for implementation activities at national and regional levels ✓ Weak capacities of the HR departments on M&E and analysis ✓ Lack of HRH research activities ✓ Mobility of the Policy Makers		
Documentation secured by consultants			

NB: The form was filled and emailed by AWHO Director on January 15, 2010. Additional data compiled from Website

Appendix A3: Consortium for Research into Equitable Health Systems (CREHS)

Name (s) of Network/ Consortium/regulatory	**Consortium for Research into Equitable Health Systems (CREHS)**
Country where based	United Kingdom (UK)
Hosting institution	Health Economics and Financing Programme, London School of Hygiene & Tropical Medicine,
Member Countries/ geographical coverage	CREHS is a partnership of eight organisations based in seven (7) countries **Kenya**, India, Nigeria, **South Africa**, **Tanzania**, Thailand and the United Kingdom.
Type, Legal status and date established:	Type: International NGO Accrediting body and date: 2004
Physical location: P.O	Health Economics and Financing Programme, London School of Hygiene & Tropical Medicine, Keppel Street, London, WC1E 7HT. UK
Contact Information:	Name: Director, Kara Hanson, based at the London School of Hygiene and Tropical Medicine, UK. URL: www.crehs.lshtm.ac.uk / www.cohorto8.blogspot.com TEL:
	Name of: Nicola Lord - manager Email: nicolalord@Ishtm.ac.uk Tel: Fax:
Historical background	In low and middle income countries health systems which comprise (organizations, institutions and resources needed to deliver health care) are failing to address the needs of all people. Those who are marginalised face particular constraints in accessing health services and many are not protected against the catastrophic costs of care. The HEU is part of CREHS of research groups in various countries. Weak Health systems can therefore exacerbate ill-health, inequalities and poverty and are undermining progress towards the MDGs. Three Research objectives: healthcare delivery systems that are responsive to the poorest; better protection of the poorest from the financial risks associated with illnesses; an overall policy context and process which favours policies that benefit the poorest
Purpose / Goal	Aims to increase knowledge on how to strengthen health systems in ways that preferentially benefit the poorest and to strengthen the capacity to support policy development
Vision	Not given on website
Mission	To improve equity and contribute to poverty reduction
Core values/principles	Our approach The consortium will achieve this aim by: • working in partnership to develop research; • strengthening the capacity of partners to undertake relevant research and of policymakers to use research effectively; • communicating findings in a timely, accessible and appropriate manner so as to influence local and global policy development.
Strategies	**The three way approach is detailed as follows:** **Working in partnership** CREHS is a partnership of eight organisations based in Kenya, India, Nigeria, South Africa, Tanzania, Thailand and the United Kingdom. Many of these organisations have developed close relationships with national policymakers and practitioners providing direct pathways of influence. By working in collaboration, we are able to bring together the ideas, experiences and expertise of individuals from a range of backgrounds including economics, public health, anthropology and epidemiology. **Capacity development** An important objective of CREHS is to strengthen the capacity of partners at the individual and organisational levels. In particular, we support researchers to identify research needs, define questions, undertake research and communicate findings effectively. The consortium also works to strengthen the capacity of policymakers and others to draw on research when designing or implementing policies. The provision of medium-term financial and technical support to our partner organisations will enable them to educate and train the future generation of researchers and evidence-aware policymakers and managers. **Communication** We have devoted significant efforts towards effectively communicating with our stakeholders throughout the research process. Through this we have ensured that research is relevant to local contexts and responsive to changing circumstances. We use a variety of approaches to ensure that our findings are communicated effectively.

	These include the dissemination of print publications (journal articles, briefing notes, posters); face to face interaction with users of research; and innovative approaches such as contributing to television drama series.
Main Activities	1. Capacity building 2. Research specific themes • health sector reform – Identify economic, political and institutional factors that enable and constrain implementation of health policies that promote equity • financial risk protection – Examine how financing mechanism can be combined and implemented to strengthen allocation of resources to benefit the poorest. • health workforce performance -Identify strategies to improve health workforce, recruitment, retention, productivity and responsiveness (motivation and retention; accountability and effective functioning of CHW programmes • Scaling up- How strategies for scaling up coverage of interventions can be sustained to reach poorest. Other activities • Mobile health units in India in Orissa and Tamil Nadu States • Direct facility funding in Kenya – coast province • Retention of health workers in Thailand and South Africa and Kenya – attitudes, values, preferences and career choices for cohorts
Implementing Institutions. Partners	CREHS – Consortium for Research into Equitable Health Systems operates in 7 countries (South Africa, Nigeria, Kenya, Tanzania, India and Thailand) with leadership from London School of Hygiene and Tropical Medicine. The eight (8) specific institutions in each country are: Indian Institute of Technology, Madras (IITM); KEMRI-Wellcome Trust Research Programme, Kenya Medical Research Institute, Kenya; Health Policy Research Group (HPRG), University of Nigeria, Enugu, Nigeria; Health Economics Unit, UCT South Africa; Centre for Health Policy, University of Witwatersrand, South Africa; Ifakara Health Institute IIHI) Tanzania; International Health Policy Programme (IHPP), Thailand; Health Economics and Financing Programme, London School of Hygiene and Tropical Medical (LSHTM), UK
Linkages to other networks	EQUINET – Regional Network for Equity in Health in East and Southern Africa SHIELD – Strategies for Health Insurance for Equity in less developed Countries (Europe and Africa – Ghana, Tanzania, South Africa); HEPNet, WHO, AHPSR, INDEPTH, IHEA, HESG, Agency for Healthcare Research and Policy (AHRQ), African Networks for Health Research & Development' (AFRO-NETS), Health Systems Action Network (HSAN). HEPNet – network mentioned by Coordinator of HEPNet during interview
Sponsors/Donors	1. Department for International Developmental (DFID) and 2. Bill and Melinda Gates Foundation 3. ESRC 4. European Commission 5. Ford Foundation 6. MRC 7. Rockefeller Foundation 8. Wellcome Trust 9. WHO Special Programme 10. for Research and Training in 11. Tropical Diseases (TDR)
Capacity of network	UK based with persons responsible named on the website but no response to email
Lessons / success	**Achievements so far** CREHS has made good progress in the research programme. Research and analysis on health sector reform has been completed and the results will be published soon. CREHS studies on financial risk protection have begun in four countries, and the programme of research around health workforce performance has been developed. Although it is too early to see specific impacts of CREHS research, there are a number of instances where CREHS-related findings have been applied to policy and practice and also evidence that policymaker attitudes are being influenced. In Thailand, the government has taken the decision to include renal replacement therapy in the Universal Coverage insurance benefit package as a consequence of research demonstrating the catastrophic impact on the poor of treatment seeking associated with end-stage renal failure. Evidence from the evaluation of the Tanzania National Insecticide Treated Net (ITN) Voucher Scheme showing the persistent socioeconomic and urban-rural differentials in ITN ownership and use, has helped influence the geographic targeting of the national under-five catch-up campaign. Free distribution of nets to all children under five will start

	with the poorest and most isolated parts of the country.		
Challenges	No response to email sent to consortium		
Documentation available on the website	CREHS - Brochure CREHS Newsletter Publications – full copies of our research reports and policy briefs are available to download Blog – documents current research on health workers in Kenya, South Africa and Thailand	• Journal articles and systematic reviews • Working papers • Presentations • Posters	Regular/annual reports CREHS - Policy Brief Nov 2009

NB. Form completed on basis on information from the website – no response to email sent to fill out the form and provide contacts in Africa.

Appendix A4: Eastern, Central and Southern Africa – Health Community (ECSA-HC)

Country (*where based):*	Intergovernmental Organisation with Secretariat based in Arusha, Tanzania
Hosting Institution:	-
Name of Network /	Eastern, Central and Southern Africa – Health Community (ECSA-HC)
Member institution(s)	Ten member states (Kenya, Lesotho, Malawi, Mauritius, Seychelles, Uganda, Tanzania, Zimbabwe, Zambia, and Swaziland. Website: www.ecsa.or.tz
Legal status of each network:	Type: Public – private – FBOs - NGOs Accrediting body and date: Intergovernmental Organisation ECSA-HC is established by the *Convention of the Commonwealth Regional Health Community for East, Central and Southern Africa* duly executed on 13th November 1985 with retrospective effect from 1st July 1980. The Convention has since been amended once by Resolution of the Conference of Health Ministers Meeting in Entebbe, Uganda, in November 2002. The approval of the Convention Amendment was given by the Conference of Health Ministers Meeting in Livingstone, Zambia, in November 2003. The Convention amendment became effective in 2007 following the ratification of the Convention by the requisite two-thirds of the Member States. As a Regional Organization, ECSA-HC has, in the territories of the Member States, legal status; the right to enter into legal contracts and purchase, possess and dispose of property; and immunities and privileges for itself, its property and its staff similar to those Gra granted by Convention on Privileges and Immunities of the United Nations.
Physical location of network	East, Central and Southern Africa- Health Community Plot 157 Oloirien, Njiro Road P.O. Box 1009 Arusha, Tanzania Tel: Off: +255-27-254 8362/3; 2549392/6 Mobile: +255-754-694692 Fax: +255-27-254 9324;9392 E-mail: regsec@ecsa.or.tz Website: www.ecsa.or.tz
Contact Information:	Name of institution/network Director Dr.Helen Lugina URL : www.ecsa.or.tz ,Telephone +254 +254 9362/5/6 Fax: +254 9392/9324
	Name of contact person: Dr. Helen Lugina Email: dg@ecsa.or.tz or helugina@ecsa.or.tz Telephone+254 9362/5/6 , Fax: +254 9392/9324
Brief Historical background	The East, Central and Southern Africa Health Community (ECSA) was formerly known as the Commonwealth Regional Health Community for East, Central and Southern Africa (CRHC-ECSA), established in 1974 under the auspices of the Commonwealth Secretariat in London. Since 1980, ECSA has functioned under the direct control of Member State governments, who see ECSA as a permanent mechanism for promoting cooperation in health in the region ECSA originally consisted of nine countries at its founding in 1974, later growing to fourteen member countries namely Botswana, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. Currently ECSA has ten active member states. In November 2002, The Conference of Health Ministers held in Entebbe, Uganda resolved that the Community be renamed *"The East, Central and Southern African Health Community (ECSA)"* as part of the institutional reforms undertaken by the Community to reflect ownership. The new name is now used and reflected in all documents of the organization including the convention. Over the last three decades the ECSA Health community has undergone a series of phases of development that underpin its continued existence namely, Foundation years under Commonwealth Secretariat (1974-1980), Regional organisation-expansion of activities (1980-1985), Consolidation of regional organisation-challenging times (1985-1994), Maturing organization and the strategic approach (1995-present) The ECSA Health Community continues to enjoy strong support from the member states and partners in the region and beyond and this dynamism is reflected in the

	continuing portfolio of technical programmes. In 2007 ECSA built and officially launched a new and modern headquarters building in Njiro Area, Arusha, Tanzania further signifying the level of commitment of member states to the continued existence of the organization.
Purpose / Goal of network	To contribute to the improved health status of the people in the Region The mandate of ECSA is to foster and encourage regional cooperation in health and to strengthen capacity to address the health needs of its member states so as to attain the highest standard of health for the people of the region. The organization aims to impact health in the region through a public health perspective and using a four prong approach: regional resource for technical support in health; regional platform for all stakeholders to promote cooperation, networking, collaboration and joint /cross border actions in health; regional centre for learning and excellence and information brokerage; regional voice for member states in all health matters at international forums.
Vision	*A healthy population in the ECSA region*
Mission	To promote the highest standards of health in the region through research, advocacy, capacity building, and provision of technical advice to Member States and institutions
Core values	ECSA-HC recognizes health as a fundamental human right. The Health Community values the uniqueness of each Member State, and respects every State's right to an equal voice in matters of the Community. The core values and principles include: • Human rights • Accountability/transparency • Partnership • Efficiency • Flexibility and respect of rights of member states • Leadership • Gender equity • Client focus
Strategies	i) Promoting increased use of evidence-based information for health policy formulation, programme planning and management ii) Providing sustained policy advice and technical support to State and Non-State health service providers iii) Developing and strengthening partnerships and alliances with national stakeholders, regional, and international organisations whose objectives are similar to those of ECSA HC The organization aims to impact health in the region through a public health perspective and using a four prong approach: 1. A resource for health related technical support to member states 2. A regional platform for governments, professional organizations and the scientific community to promote cooperation, networking, collaboration and joint /cross border actions in health; 3. Regional centre for learning and excellence and information brokerage, documenting and promoting exchange of ideas, experiences, best practices, knowledge and information in health; 4. A regional voice for member states in all matters of health at regional and international decision-making forums. <u>Detailed strategies</u> **1.** Capacity building -ECSA will concentrate capacity building efforts on Human Resource Development and Strengthening of Health Systems and Processes. **2.** Policy and advocacy **3.** Information Collection, Repackaging and Dissemination **4.** Collaboration and Networking ECSA will also actively strengthen its collaboration and linkages with member states, professional networks and other agencies, in order to streamline and co-ordinate inputs and activities at the regional and national levels. The secretariat has developed an exemplary collaborative agreement with USAID/REDSO that will serve as a model for future alliances **5.** Programme delivery – member states develop priority action plans, ECSA supports member states to implement action plans, regional activities are implemented by the secretariat., use participatory approaches Institution strengthening
Main Activities	i) Enhancing Human Resources for Health and Capacity Building; ii) Improving Health Systems and Services Development; iii) Improving nutrition and health status, disease prevention, control and management;

	iv) Strengthening Policy, Research and Information Dissemination; and v) Institutional Development The activities of the Secretariat are organised around six programme areas that lend themselves to regional implementation These programmes are: 1. Human Resources for Health and Capacity Building Work with member countries in building the capacity. Also have 2 colleges 'without walls' – COSECSA (surgeons) and ECSACON (nurses); Infectious Disease Control and Prevention, TOTs, develop regional curricula (midwifery, FP, HIV, etc) plans to establish "College of Health" 2. Health Systems Strengthening and Service Development previous examples include NHA, regional laboratory service strengthening programme; have policy guidelines and monitoring and evaluation frameworks 3. Family and Reproductive Health 4. HIV/AIDS and infectious diseases 5. Research, Information and advocacy 6. Health Sector Monitoring and Evaluation
Implementing Partners	One of the health Community's unique characteristics is the networks that link it up with the member states making it possible for each programme to remain abreast of the concerns of the member states. The organization does not have country- Among the networks implementing partners are: • The Directors Joint Consultative Committee that regularly brings together Deans of Medical Schools, Directors of Health Services and Directors of Health Research Institutions to review and discuss Programme activities • Expert Committees in Nursing and Nutrition, which meet regularly to deliberate on issues and guide Programme development, implementation and effectiveness • Programme Steering Committee under the Family and Reproductive Health and Research Programme, which reviews and guides the activities of the Programme. • Dissemination Centres in each member country, which provide a two-way channel of communication that links up the Secretariat with institutions and Programme activities in each country. Colleges without walls - The East, Central and Southern Africa College of Nurses (ECSACON) and COSECSA for Surgeons
Sponsors/Donors	**USAID, TIDES**, AH2010 ,FHI, HPI, WHO, UNICEF, UNFPA, UNDP, COMMONWEALTH SECRETARIAT, MEMBER STATES, British Council and AED
Links to other networks	Collaborates with WHO (current DG chairs one of the technical committees of GHWA), EQUINET, SADC, NEPAD, (see comments on appendix B) EAC (weak link with EAC-health desk)
Organizational Capacity of network	**structures, Physical and Human resources** Structures **ECSA Governing Bodies** The governance bodies of ECSA include: **ECSA Conference of Health Ministers** which is the highest governing body and which meets annually to review policy matters, national health strategies and to define regional health priorities; **The Advisory Committee** which is composed of Permanent Secretaries of the Ministries of Health of Member States and which functions as the Board of Management of the Secretariat and **The Directors' Joint Consultative Committee** which is the highest technical committee and which is composed of Permanent Secretaries, Directors of Health Services, Deans of Medical Schools and other health institutions and heads of Health research institutions. **Programme Experts' Committees** which are technical committees that draw on expertise from member states programme managers, external advisors, professional associates and consultants from the region. Have discussion forum also on website: Discussion Forums • ECSACAIDS • Food and Nutritional Health • Family and Reproductive Health • Health Systems Development • Human Resource Development • ICT

	• Institutional Strengthening **The ECSA Secretariat** headed by the Director-General is located in Arusha, United Republic of Tanzania and is responsible for implementation of the ECSA Health Community's programmes. **ECSA Institutions and Programmes** The ECSA Health Community currently has two autonomous institutions: **The College of Surgeons for East, Central and Southern Africa (COSECSA)** **COSECSA** is a specialised agency of the ECSA Health Community based at the ECSA Secretariat. The mission of the College of Surgeons is to promote excellence in Surgical Care, Training and Research. The College has members in Ethiopia, Kenya, Malawi, Mozambique, Tanzania, Uganda, Zambia, Zimbabwe and Rwanda. **The East, Central and Southern Africa College of Nurses (ECSACON)** Human Secretariat has got Head quarters in Arusha.The Head quarter building has got space for cooperate and programme level offices and facilities. The secretariat has total number 30 personnel including 15 technical staff and 15 support staff. There are 6 technical programmes that work in close collaboration with programmes at country level. ECSA-HC has the capacity to implement activities through its technical programmes; • **Family and Reproductive Health Programme** which facilitates the development and implementation of family and reproductive health policies, programmes and strategies to improve family and reproductive health • **Food and Nutrition Security Programme** - contribute to improved nutritional status of the people of the ECSA region • **Health Systems and Services Development Programme** - aims to strengthen health systems reforms in order to improve efficiency of the health services delivery in the region. • **HIV/AIDS and other Infectious Diseases Programme** - advocate for effective policies, strategies and programmes for HIV/AIDS prevention, treatment and care. • **Human Resources for Health & Capacity Building Programme** - aims to strengthen human capacity development in the health sector in the region. • **Research, Information and Advocacy Programme** - promotes and supports activities at regional and country levels that will facilitate sharing and utilization of health research and policy information among the member states • **Monitoring and Evaluation Programme** - aims to strengthen performance and accountability by continuously monitoring and reviewing programmes and activities to ensure that they remain relevant, have impact and add value to the work of member states. **Physical** ECSA-HC has purchased land and are sourcing for a more permanent home – sponsor for construction of the regional offices in Arusha. No country-level offices
Achievements /recent events	• Planned Health Minister's Conference Feb 15 – 19 2010 in Kampala and Round Table discussions, Discussion Forums are held annually • The EQUINET –ECSA HC regional meeting on health worker retention in East and Southern Africa (ESA) was held in Windhoek, Namibia February 25-27 2008 and involved 32 delegates from government, academic and research institutions, health worker organisations, parliament and civil society from 10 ESA countries and from regional organisations including SADC and WHO. • Curricula in various areas – midwifery, FP, HIV; TOTs • Policies, guidelines and monitoring and evaluation frameworks • Demonstrated experience in transitioning from policy to programming to implementation (eg., use of injectable contraceptive to reduce postpartum bleeding)
Lessons in human resource for health	• Retention of health workers is a complex issue that involves both financial and non financial incentives • Health workforce issues need to be allocated adequate resources • Scaling up health workforce needs careful planning including training and deployment • HR information system and HR intelligence in general are key in HR planning and decision making • Good leadership and management are key in health workforce development • Safe practice environment is essential for the health and safety of both health worker and client • Investing in pre service education is sustainable

	• Member countries must actively participate in all phases of programming		
Challenges	• Insufficient human resource, institutional capacity and poor infrastructure within Member State governments which carry the primary responsibility for policy making and overall health initiatives • High incidence of poverty among Member States • Budgetary pressures affecting Member States capacity to meet their financial obligations in a timely manner – reason why some members are passive (not contribute – of the potential 33 countries only 10 have been active) • Changing donor priorities and donor conditionality that affect some Member States • Increased competition from other regional and international bodies focusing on health and targeting the same Member States and donors • Member States' multiple membership to other regional political and economic organizations • Changing population dynamics and migration patterns • Emerging and re-emerging epidemics (non-communicable diseases), which are changing disease patterns and threatening to undermine		
Documentation secured by consultants (through visit or email) **Brochure given during meeting in Nairobi** **most reports available on website but also emailed on Feb 3, 2010** **strategic plan emails ECSACON**	**Policy documents** **√Constitution /Memoranda**	**Strategic plans** **√ Baseline /evaluation survey (retention and migration studies)** • ECSA-HC brochure • Strategic plans 2002 - 2006; 2008- 2012 • HIV/AIDS Workplace policy • ECSACON Newsletter Second Regional Forum on Best Practices in Health Care & 18th Directors' Joint Consultative Committee Meeting (DJCC 2008)	**√ Human resource plans** **√Regular/annual reports** **Have discussion forums on the 6 core programme areas on the website**

NB: This form was filled and emailed by Ag. Director on Febuary 3, 2010. Additional data compiled from earlier meeting in Nairobi at JICA on January 25, 2010 and from the website.

Appendix A5: The Regional Network on Equity in Health in Southern Africa - EQUINET

Name of Network/ Consortium/regulatory	**The Regional Network on Equity in Health in Southern Africa - EQUINET**
Country where located	Zimbabwe
Hosting institution	Harare – Zimbabwe as secretariat head quarters based at the Training and Research Support Centre - TARSC
Member Countries/ geographical coverage	Works with academic, government and civic institutions from 8 countries: Namibia, Botswana, Malawi, Mozambique, **South Africa, Tanzania**, Zambia, Zimbabwe
Type, Network's Legal status; date established:	Type: not-for-profit International NGO Accrediting body and date: SADC Health Sector formally recognised EQUINET in 1999
Physical location: P.O	EQUINET Secretariat Training and Research Support Centre (TARSC) Box CY2720, Causeway, Harare, Zimbabwe
Contact Information:	Name: Web: http://www.equinetafrica.org/ Tel + 263 4 705108/708835 Fax + 263 4 737220
	Name: Rene Loewenson, EQUINET Programme Manager Email: admin@equinetafrica.org Tel Fax:
Historical background	EQUINET is a network of research, civil society and health sector organisations. EQUINET seeks to develop and widen the conceptual understanding of equity in health. EQUINET is governed by a steering committee involving academic, government and civic institutions from Botswana, Malawi, Mozambique, South Africa, Tanzania, Zambia, Zimbabwe and from SADC and international level. EQUINET activities are co-ordinated and managed through Training and Research Support Centre, a non profit institution headquartered in Zimbabwe that carries out health and social policy work at national, regional and international level. The SADC Health Sector formally recognised EQUINET in 1999 and at its Health Ministers' meeting in April 2002 recommended collaboration with EQUINET. Health Sector Officials were encouraged to work with EQUINET and to use its resources. EQUINET has co-operated with in its activities with the SADC Health Sector, the SADC Directorate of Social Development and Special Programmes, the SADC HIV/AIDS Programme and the SADC Parliamentary Forum, as well as with a number of southern African regional organisations. EQUINET identifies critical areas of work and policy issues and makes visible existing unfair and avoidable inequalities in health.
Purpose / Goal	EQUINET, the Regional Network on Equity in Health in Southern Africa, is a network of professionals, civil society members, policy makers, state officials and others within the region who have come together as an equity catalyst, to promote and realise shared values of equity and social justice in health. EQUINET's main aim is to build alliances leading to positive policies on health both the local and regional levels.
Vision	Not stated on website
Mission	EQUINET is building a forum for dialogue, learning, sharing of information and experience and critical analysis. We do this to build knowledge and perspectives, shape effective strategies, strengthen our voice nationally, regionally and globally and our strategic alliances to influence policy, politics and practice towards health equity and social justice.
Core values/principles	The network promotes and realises shared values of equity and social justice in health in East and Southern Africa.
Strategies	The Mission is achieved by disseminating information and stimulating an informed debate on equity in health in southern Africa. EQUINET gathers people to overcome isolation, give voice and promote networking using bottom-up approaches built on shared values. We have come together in a spirit of self-determination and collective self-reliance working through existing government, civil society, research and other mechanisms and institutions in the Southern African Development Community (SADC) region and in southern and East Africa.

Main Activities	As a network we mobilize and disburse resources and provide technical, institutional and other forms of support to work on health equity, including through Training, mentoring, student grants, skills workshops and formal courses Research grants and programmes Capacity support for policy analysis Publication, Information outreach and information resources Providing information and policy resources to governments, parliaments and civil society Supporting alliances with parliament and civil society for health equity Networking activities across countries, disciplines and communities EQUINET's work covers a wide range of areas identified as priorities for health equity, within the political economy of health, health services and inputs to health, covered in the theme areas shown on this site - Research and dissemination, Conferences. Theme areas for EQUINET • Equity in health • Values, policies and rights • Health equity in economic and trade policies • Poverty and health • Equitable health services • Human resources for health • Public-private mix • Resource allocation and health financing • Equity and HIV/AIDS • Governance and participation in health • Monitoring equity and research to policy
Implementing Institutions/ Partners	*Works with academic, government and civic institutions from 8 countries and other SADC countries and global institutions* • The HEU, University of CT in SA co-ordinates work on Resource Allocation & health equity • CHESSORE, Zambia & TARSC, Zimbabwe co-ordinate - Governance, equity and health • The CHP, Wits University, South Africa co-ordinates work on Policy analysis • SEATINI, Zimbabwe co-ordinates the work on Trade and health • HST, South Africa co-ordinates the work on Human Resources for Health • The Malawi Health Equity Network co-ordinates the work with parliamentarians and the student grants programme • CHESSORE Zambia co-ordinates the work on cross border disease surveillance • UCT, School of Family and Public Health co-ordinates the work on Health Rights • TARSC, Zimbabwe co-ordinates - on Equity in HIV/AIDS in a co-operation with Oxfam GB • Fahamu (UK/SA) manages the EQUINET website and newsletter • University of Zimbabwe Medical school, co-ordinates the Monitoring equity These theme area programmes collectively network institutions across all SADC countries • EQUINET co-operates with Peoples Health Movement, Community Working Group on Health and International People's Health Council in its work on civil society and health, with the Municipal Services Project in its work on essential services • Global Equity Gauge Alliance (GEGA) in its work with parliamentarians. • EQUINET is co-operating with University of New South Wales (UNSW), Australia to strengthen writing skills for peer reviewed journals and with Medact (UK), UNSW, University of Saskatchewan Canada in its work on trade and on health personnel. • EQUINET co-operates on within the African Health Research Forum in strengthening health research networking, • EQUINET in co-operation with ECSA-HC have, with government and researchers in five countries, carried out review and field studies on the implementation of incentives for health worker retention and of their impact on the adequacy and distribution of health workers. A regional meeting was held in February 2009 to review this work and other work on health worker migration and distribution in EQUINET
Sponsors/Donors	1. IDRC (Canada) 2. SDC (Switzerland) 3. SIDA (Sweden)

	4. Rockefeller Foundation 5. Oxfam (GB) 6. DfID 7. Dag Hammerskold Foundation 8. UNAIDS 9. WHO-Afro 10. WHO-EIP 11. Global Equity Gauge Alliance 12. SADC 13. Partners in Population and Development, Africa Regional Office (PPD ARO); 14. Council on Health Research for Development (COHRED), 15. The International Society for Equity in Health (ISEH), 16. and other international partners on specific areas of work.
Linkages to other networks	HEPNet at HEU, HEU contributes to equity work around equitable financing of health systems and equitable allocation of healthcare resource in countries such as Namibia, Tanzania, Zambia, Zimbabwe and Mozambique. ECSA-HC conference on human resource retention and also collaborates with EQUINET through University of Namibia, University of Limpopo and TARSC, in co-operation with the ECSA-HC, is implementing in east and southern Africa research, capacity building and programme support for the retention of health workers and for management of out-migration of health personnel. Global Equity Gauge Alliance (GEGA) in its work with parliamentarians. SADC - The SADC Health Sector formally recognised EQUINET in 1999 and at its Health Ministers' meeting in April 2002 recommended collaboration with EQUINET. Health Sector Officials were encouraged to work with EQUINET and to use its resources EQUINET has co-operated with in its activities with the SADC Health Sector, the SADC Directorate of Social Development and Special Programmes, the SADC HIV/AIDS Programme and the SADC Parliamentary Forum, as well as with a number of southern African regional organisations. EQUINET co-operates on within the African Health Research Forum in strengthening health research networking, African Networks for Health Research & Development' (AFRO-NETS) Fahamu; Learning for change: Fahamu uses information and communication technologies to serve the needs of organisations and social movements that aspire to progressive social change and that promote and protect human rights Include all implementing partners are listed on website
Capacity of network	EQUINET is governed by a steering committee with representatives from fourteen institutions in southern Africa and is co-ordinated at the Training and Research Support Centre Zimbabwe. Broad in all health systems areas but operations mainly SADC.
Achievements/recent events	• Research on equitable financing of the health systems • Equitable allocation of resources in healthcare towards the Abuja goal of 15% • EQUINET CONFERENCE was successfully held September 23-25 2009 • The 3rd EQUINET Regional conference on equity in health in east and southern Africa was held in Munyonyo Uganda September 23-25 2009. The theme was "Reclaiming the Resources for Health" and the conference involved delegates from government, non state organisations, academic and research institutions, civil society, parliaments, regional and international organisations and other institutions promoting and working on equity in health in east and southern Africa. Regional Meeting of Parliamentary Committees on Health in Eastern and Southern Africa: Munyonyo, Kampala, Uganda, September 21 2009 • A regional meeting was held in February 2009 to review this work and other work on health worker migration and distribution in EQUINET in Windhoek Namibia, locally hosted by the University of Namibia • The EQUINET –ECSA HC regional meeting on health worker retention in east and southern Africa (ESA) was held in Windhoek, Namibia February 25-27 2008 and involved 32 delegates from government, academic and research institutions, health worker organisations, parliament and civil society from 10 ESA countries and from regional organisations including SADC and WHO • 1st conferences on HRH eg. Bagamoyo, Tanzania in 2007 • Regional Workshop Report: Fair financing for health: mobilising domestic resources and managing commercialisation of health systems Health Economics Unit University of Cape Town; HealthNet Consult; EQUINET (2009) • Themes: Resource allocation and health financing Country: East and southern Africa region

	• Health policy analysis: Regional skills workshop report University of Cape Town; Centre for Health Policy; EQUINET (2009) Themes: Monitoring equity and research to policy • Policies and incentives for health worker retention in east and southern Africa: Learning from country research Iipinge, S; Dambisya, YM; Loewenson, R; Chimbari, M; Ndetei, D; Munga, M; Sibandze, S; Lugina H (2009) • In 2003-5 we are also as a network promoting equity in health sector responses to HIV and AIDS and in access to Anteretroviral treatment.		
Lessons for HRH	Did not interview – no response to emails sent		
Challenges	Network still limited to SADC (comment made by coordinator of HEPNet and Health Systems Trust (HST) during interview)		
Documentation	Has list of research collaborations and many publications on health policy and human resources for health	List of conferences and workshop reports EQUINET Newsletter	Good website describes most activities and reports available

NB. No response to email sent to secretariat in Zimbabwe. Data compiled from website and mention of network by Coordinator of HEPNet.

Appendix A6: Global Equity Gauge Alliance (GEGA)

Name of Network / Consortium	**Global Equity Gauge Alliance (GEGA)**
Country (*where based):*	South Africa
Hosting Institution:	Health Systems Trust (HST)
Member Countries / geographical coverage	The Alliance currently includes 13 member-teams, called Equity Gauges, located in **12 countries** in the Africa (6), Americas (3) and Asia (4): Burkina Faso, Kenya, South Africa, Zambia , Zimbabwe; Chile, Ecuador, Peru; Bangladesh, China, India and Thailand.
Type, Legal status of each network/ date established:	**Type:** Global Alliance – International organization **Accrediting body and date:** 1999
Physical location	Secretariat based at the Health Systems Trust in, Durban South Africa PO Box 808, 34 Essex Terrance, Westville, 3630, Durban 4000, South Africa
Contact Information:	**Name of institution/network Director** Deputy Coordinator: Thando Ford-Ngomane **URL** **Telephone** **Fax:**
	Name of contact person Assistant Coordinator: Qamar Mahmood **Email** secretariat@gega.org.za **Tel.** **Fax:**
Brief Historical background	GEGA has come about as the result of several years of the combined work of several dozen scholars and specialists working in the areas of international health and development, population health metrics, health inequalities and ethics. The organization's structure and function evolved in the course of discussions of several international meetings, and according to the efforts of a few key people who took forward recommendations and ideas from those gatherings. In 1999, the Rockefeller Foundation's Global Health Equity Initiative was assembled to discuss the problem of health inequalities between and within countries, evidenced by increasing documentation of inequalities, and to consider what the ethical mandates in responding to that evidence might be. Previous meetings have been held in Manila (1997); USA (1999); South Africa (2000); Uganda (2009) Twelve Gauges have taken up the task of implementing the Equity Gauge Strategy. In February of this year, GEGA held a meeting to support these Gauges clarify and shape the structure, form, and activities of both individual gauges and of GEGA as an active international organization. It became clear that a strong enthusiasm to continue and expand the work was driving GEGA members. The conference accomplished much conceptually and practically, including identifying next steps for continuing and strengthening the impact of Gauges and for securing the future success of the Alliance. GEGA's work is informed by a perspective that places health squarely within a larger framework of **social justice.** While some health variations between people are inevitable, e.g. the fact that the elderly generally have worse health than younger populations, many health inequalities are avoidable and associated with unjust social constructs. Furthermore, empirical evidence in both rich and poor countries demonstrates that such inequalities cut across all societies, and that health is closely associated with underlying political, economic and cultural influences and with social position. It is these inequalities with which Equity Gauges are concerned. The Alliance currently includes 13 member-teams, called Equity Gauges, located in 12 countries in the Americas (3), Africa (6) and Asia (4) **What is an Equity Gauge?** An Equity Gauge is a health development project that uses an active approach to monitoring and addressing inequity in health and health care. It moves beyond a mere description or passive monitoring of equity indicators to a set of concrete actions designed to effect real and sustained change in reducing unfair disparities in health and health care. This entails an on-going set of strategically planned and coordinated actions that involves a range of different actors who cut across a number of different disciplines and sectors. It is not a typical health research project, or even limited to actions in the public health domain. The Gauges choose indicators according to the particular needs of the country as well as of the stakeholders. However, emphasis is placed upon generating trend data within all Gauges to enable understanding of progress over time. Indicators are measured across a variety of dimensions of health as well as determinants of health, or PROGRESS variables.
Purpose / Goal	The Global Equity Gauge Alliance was created to participate in and support an active approach to monitoring health inequalities and promoting equity within and between societies. In addition to supporting and promoting the activities and goals of the 12 Gauges, GEGA is committed to supporting a Global Equity Agenda by creating a voice for the global advocacy arm of the alliance. Several activities are contributing to this goal: creation of a Global Gauge, a Global Network and Development of a Capacity Development Tool.

Vision	- Not stated on website
Mission	- Not stated on website
Core values	Social justice principle
Strategies	The Equity Gauge Strategy is explicitly based on 3 "pillars of action", each considered to be equally important and essential to a successful outcome. The three pillars are: • Research and monitoring to measure and describe inequities • Advocacy and public participation to promote the use of information to effect change involving a broad range of stakeholders from civil society working together in a movement for equity • Community involvement to involve the poor and marginalized as active participants rather than passive recipients Therefore, the Equity Gauge Strategy consists of a set of interconnected and overlapping actions, and is not, as the name might suggest, just a set of measurements. For example, the selection of equity indicators to measure and monitor should be informed by the views of community groups and by a consideration of what would be useful from an advocacy perspective. In turn, the advocacy pillar relies reliable indicators developed by the measurement pillar and may involve community members or public figures. Another important feature of the three-pillar design of the Equity Gauge Strategy is that the integration of the pillars into the project does not necessarily follow a temporal sequence. Often research projects tend to collect information, disseminate it and then undertake advocacy activities in that order. This linear approach to changing policy or affecting change has often been found to be ineffective. In an Equity Gauge, the actions of all three of its pillars should be happening concurrently.
Main Activities	In addition to promoting the 2015 Goal, GEGA is: • making information available on health and distributions of health-affecting resources within the public domain; • supporting political commitment in both the developing and the developed world to address health inequities; • amplifying the voice of those who have been economically, politically or socially marginalized; • promoting the Equity Gauge Strategy; • an initiative that emphasizes action to reduce inequity through advocacy, community involvement and public participation; • helping others around the world to effectively link research with concrete action for policy and social changes. ***Gauge Activities*** The current Equity Gauges are tackling equity monitoring in a variety of innovative ways. In the sphere of measurement, activities include analysis of secondary data sets including household surveys and budget data, undertaking primary research using focus groups and participatory research appraisal as well as quantitative research methods, and incorporating new equity-relevant measures into existing surveys. The Gauges then translate those findings into action for advocacy and community participation, making specific policy recommendations and creating strategic health interventions. **Some Gauges incorporate a training component for health personnel.** Others are developing more transparent, accountable health resource allocation formulas. Still others are developing national health reports that highlight equity issues. Information dissemination activities, designed to promote crucial stakeholder empowerment as well as contribute to advocacy, include workshops, community meetings, site visits, publications, newsletters, official reports, posters and the media.
Implementing Institutions/ Partners	Stakeholder partnerships represent the diversity of local context. The range of partnerships includes Parliamentarians and Councillors, the media, Ministries and Departments of Health, academic institutions, churches, traditional leaders, women's organisations, community based and non-governmental organisations, local authority organisations, and civic groups. Such a diversity of stakeholders not only encourages wide social and political investment in Gauge goals, but also supports capacity development within Gauge countries. **The Gauges** Each Gauge has representatives with whom GEGA maintains regular contact, spanning a variety of technical areas and stakeholder interests. Primary responsibilities of the Gauges are to carry out their project goals and communicate support needs to the GEGA Coordinator. Additionally, Gauges will be expected to provide information regularly to the Secretariat regarding progress and accomplishments, and to proactively communicate with

	other Gauges to share information, exchange strategies, and lend technical support when appropriate and feasible. The Gauges are The Centre for Health and Population Research in Bangladesh (ICDDR,B); HealthLink in South Africa; Health Systems Trust;
Link to other networks	EQUINET, Health System Trust, University of Western Cape (SFHPH), African Population and Health Research Centre
Sponsors/Donors	GEGA is currently supported by funding through the Rockefeller Foundation, the Swedish International Development Agency. The Henry J. Kaiser Family Foundation (USA) in SA
Organizational Capacity of network	GEGA's structure includes the three major organisational components that are mutually interdependent: the Secretariat, the Coordinating Committee, and the Gauges themselves. In the future, GEGA is likely to include an Advisory Board and Network Partners. **The Secretariat** The Secretariat, located in Health Systems Trust, Durban, South Africa, includes: GEGA's Deputy Coordinator: Thando Ford-Ngomane, Assistant Coordinator: Qamar Mahmood and Admin Assistant: Farana Khan. Part-time staff include: David McCoy, Paula Braveman and Abhay Shukla. The responsibilities of the Coordinator fall into two categories: facilitating the work of the country Gauges and the effectiveness of our work as an alliance, and directing GEGA's global activities for capacity development and advocacy. **The Coordinating Committee** The Coordinating Committee includes representatives from the country Gauges as well as technical specialists, who provide strategic leadership skills and advise GEGA, as well as Gauge members. Collectively, the Coordinating Committee is responsible for guiding the direction of the organisation, supporting the Gauges, liasing with global partners with whom GEGA works, and ensuring the long-term financial stability, integrity, and effectiveness of GEGA. Current members of the Coordinating Committee include: Antoinette Ntuli, Chair; David Acurio, Banza Baya,Mushtaque Chowdhurry, Yuanli Liu, Siriwan Grisurapong;;Jeanette Vega, David Owuor, TJ Ngulube, David Sanders **Equity Guages** The current Gauges encompass different approaches to geographic scope. Some Equity Gauges operate at a countrywide level, some monitor a subset of districts or provinces in a country, a few operate at a regional level and others focus specifically on equity within a city or municipality. Of the twelve Equity Gauges, nine have a national focus, and three (Cape Town, Ecuador, and Nairobi) focus at the municipal level.
Achievements / current info	The whole-hearted involvement on the part of national and provincial legislators indicates that the project has identified a real need and is contributing to meeting that need. Although a formal evaluation of the project is only due to commence at the beginning of 2000 the range of activities undertaken by the project demonstrate that some objectives are already being met. ***Workshops*** During the developmental phase of the project, an issue that was continually highlighted by legislators was their need for support to enable them to participate effectively in the budget process. One of the first tasks of the project was to develop the curriculum and materials for a workshop to meet this need. To date workshops on the budget process have been organised and run for five of the provincial committees. ***Site Visits*** A key strategy of the project in empowering legislators to understand the realities of service provision is the arranging of visits for legislators to health districts. Two site visits have already taken place in which national and provincial legislators have been exposed to the impact of inequity on health care provision. Visits are accompanied by a workshop in which legislators have the opportunity to explore possible solutions to problems encountered as well as address policy implications of the findings from the visit. Feedback from participants has indicated that they have made use of the information gleaned on site visits during Parliamentary and Committee discussions.
Lessons	
Challenges	Legislators are extremely busy. Many provincial legislators sit on more than one committee, and most committee cover more than one area. For example, most provincial standing committees on health also have welfare as part of their remit. In addition, although the legislative agenda is now beginning to level off, until recently the agenda has been extremely full. These factors limit the time available to legislators to participate in training and site visits. South Africa for example, still has limited data available with which to measure and monitor equity. For example the first ever South African demographic health survey was undertaken

	in 1998. Much of the data that is available does not enable analysis of equity according to different racial groups or according to gender. While some data allows for comparisons between rural and urban areas, rarely is there information to analyse the situation in peri-urban areas. Additionally the slow process of establishing health districts is inhibiting the development of effective monitoring of resources at the district level. A major challenge for the project is to develop tools and indicators for monitoring equity in the context of the HIV/AIDS epidemic in South Africa.	
Documentation (all information is from the Website)	Only website with icon for parliamentary alliances Presentations by GEGA and Gauges at external meetings • The Global Equity Gauge Alliance, An Introduction to the work, Presented at the WHO Meeting on Sub-National Health Systems Performance Assessement by Lexi Bambas & Hilary Brown, 24-26 April 2002 [powerpoint] • GEGA Newsletter since 2002 – 4 @yr Equity Guage websites • **Chile's Equity Gauge** http://www.equidadchile.cl/ • **Uganda's Equity Gauge** http://www.hegauuganda.com/ • **South African Equity Gauge** **http://www.hst.org.za/hlink/equitysa.htm**	Presentations at GEGA Meetings • The Equity Gauge: An approach to Monitoring Equity in Health and Health Care in Developing Countries - by Tim Evans [powerpoint presentation] • Issues in Monitoring Equity in Resource Allocation. Kwa-Maritane Meeting, 17-20 August 2000 [powerpoint presentation] • "Equity Gauge" - A Tool for Monitoring Equity in Health and Health Care in South Africa [powerpoint presentation] • Developing City Wide Equity Gauges: Rationale and Pitfalls. by Pierre Ngom [powerpoint presentation] • Making Household Surveys Equity-Relevant - Davidson R. Gwatkin [word doc] • Integrating Gender issues in Monitoring Health Equity - Elsa Gomez, Pan American Health Organisation [word doc] • Community Orientated - Bottom-up Approaches - A framework for action and assessment - Dan C.O. Kaseje [word doc]

NB: Data compiled from website and interview with Research Director, Health Systems Trust

Appendix A7: Higher Education Alliance for Leadership Through Health (HEALTH), HEALTH Alliance

Name (s) of Network/ Consortium/regulatory body	**Higher Education Alliance for Leadership Through Health (HEALTH). HEALTH Alliance** Started as association of schools of public health with LIPHEA project but now transitioning to Network of the HEALTH Alliance
Country	Uganda
Hosting Institution	School of Public Health - Makerere University
Member Countries/ Geographical coverage	6 countries in East Africa – Uganda, Tanzania, Kenya, Rwanda, DRC, Ethiopia
Network's Legal status and date established:	**Type: Regional Alliance** **Accrediting body** _has legal identity in Uganda**:** 2008
Physical location: P.O	SPH – Makerere University, Next to Mulago Hospital, Kampala, Uganda. P.O Box 7072, Kampala
Contact Information:	**Name of Director / CEO** Dr. William Bazeyo, Dean, SPH URL: http://halliance.org/groups/liphea; webmaster@halliance.org **Tel256-41-543872** **Fax:** 256-41-531807
	Name of contact person – Dr. Chris Orach - LIPHEA **Email** www.liphea.org **Telephone** **Fax:**
Historical background	Project Launch **2004**-*Leadership Initiative for Public Health Conference*, Johannesburg to involve 17 Schools of Public Health from sub-Saharan Africa. In October 2006 in Nairobi workshop to share vision on health problems in EA Started with SARA and then Health Emergency Management Project (HEMP) in 2 countries as founding partners with JHU, Tulane and GWU, LIPHEA in two then expanded to 7. To strengthen MUIPH and MUCHS capacity to provide effective Public Health Leadership not only for Uganda and Tanzania, but to catalyze the training of Public Health leaders in the whole region. The objectives were 3-fold • Establishing long term partnership between academic institutions in the United States and East Africa • curriculum revision, development of in-service short term training of Public Health Practitioners and development of faculty in order to prepare the next generation of Public Health professionals • reduce the "brain drain" by improving professional development opportunities for Public Health Leaders • **Create a Public Health Network that links Schools of Public Health, Ministries of Health with other stakeholders and Public Health practitioners.** HEALTH Alliance -improves access to human and financial resources by serving as a platform to turn research into policy and facilitate cross-border learning. The Alliance has legal identity in Uganda; it can receive funds and implement programs throughout the region. Projects spawn from HEALTH include the *Health Emergency Management Project (HEMP) and LIPHEA.*
Purpose / Goal	• Build public health leadership capacity in E.A. through strategic training and networking approaches • Strengthen and incorporate leadership skills in teaching and education programs of the two institutions. • Create a Public Health Network that links Schools of Public Health, Ministries of Health with other stakeholders and Public Health practitioners • Establish a faculty development program • Create an enabling environment for Public Health activities • Improve teaching infrastructure
Vision	None given on the website nor interview (needed copy of constitution used to register it)
Mission	Not stated on website nor interview
Core values/ principles	Not stated on website
Strategies	• Review and Incorporate Leadership training in Schools of Public health (undergraduate and graduate) Strengthen Communication and Leadership skills through short courses for in-

	service health personnel Build capacity of young faculty through sabbaticals, short courses, PhD training with JHU and Tulane Application and sharing of technology in teaching materials–locally & US partner developed Establish a network of schools of PH in the region • Harmonise curricula • ◦Exchange students and faculty • ◦Develop faculty data and maintain database • ◦Address regional PH concerns through collaborative research
Main Activities	In creating the association of schools of PH in EA the specific activities were • Hold annual meeting of Deans and Directors of Public Health Schools to establish a network of Public Health Faculty. • This includes supporting the East African Public Health Association, • Publication of East African Journal of Public Health and sharing of faculty • Establish an internet based academic network (website) • The HEALTH Alliance has been implementing Disaster Management training for operational levels in regions of Uganda by training multi-sectoral teams from districts in emergency operations planning. Since October 2009, an Epi-zoonosis component has been added to the district disaster management training. • Masters programs in leadership developed at Makarere and Muhumbili Universities initial focus of LIPHEA most MPH Curricula reviewed or developed •
Implementing Institutions/ Partners	7 Schools of Public Health in 6 countries – SPH, Makerere University, CHS Muhimbili University, SPH Moi University, Dept. Community Health, University of Nairobi, SPH, University of Rwanda, Public Health, Jimma University, SPH at University of Kinshasha
Sponsors/Donors	• African Medical and Research Foundation (AMREF) • Higher Education for Development (HED) • Jimma University Faculty of Public Health (JUFPH) • Johns Hopkins Bloomberg School of Public Health • Makerere University Institute of Public Health • Management Sciences for Health (MSH): • Center for Leadership and Management (CLM) • Muhimbili University College of Health Sciences • National University of Rwanda, School of Public Health • The Payson Center for International Development and Technology Transfer • Tulane University School of Public Health and Tropical Medicine (TUSPHTM) • Université de Kinshasa Ecole de Santé Publique (UKESP) • University of Nairobi, College of Community Health • US Agency for International Development (USAID) • The World Bank
Organizational Capacity of network	Physical and Human resources PI and coordinator, need administrators to manage the website for the Alliance and there are plans to train the systems administrators.
Achievements and updates	• Formalized the association of Public Health Schools under new name – HEALTH Alliance is now a legal entity in 2008 • Under a USAID/HED funded project, Tulane and Makerere have successfully completed a joint effort to establish a flexible web hosting environment at MUSPH and relocated the HEALTH Alliance and LIPHEA websites to Kampala. Updates with support from Tulane University • Still developing the strategic plan for the HEALTH Alliance • Have successfully launched the East African Journal of Public Health – Annual Journal • Working on Monthly HEALTH Alliance Newsletter through internship program • Have successfully launched and established country-level nodes for LIPHEA project who are undertaking training of district level health managers in disaster preparedness using the standardized curriculum under the Alliance • Next Deans and Directors meeting is scheduled to take place February 8th - 10th, 2010. • HEALTH Alliance now on the LinkedIn Professional Networking site & Twitter

	Training 1 week short courses for mid & senior health managers: 148 trained in Strategic Leadership in TZ and UG; 30 trained in Communication skills • ALLIANCE Members: 35 faculty trained in Strategic Leadership, 26 trained in Quality Improvement and 34 Ugandan religious leaders trained in strategic leadership and financial management • 15 faculty trained in use of STATA statistical package • Three faculty members; MUCHS(2) and MUIPH (1) were supported to attend a short course in Leadership at Heidelberg University, Germany. • 40 MPs in Uganda exposed to Leadership Development session • 4 faculty trained at Tulane in Learning 2 Learn w/ Technology: -24 additional faculty trained Photo: Dissemination • Regular publication of the East Africa Journal of Public Health a peer reviewed journal 8 issues published w/ 9th forthcoming LIPHEA the First East Africa Public Health Association/ Tanzania Public Health Association Scientific Conference. Held in Arusha, Tanzania in November 2007. Theme "Improving Health in East Africa through Improved Public Health Leadership "(attendance 250) Attendance by all ALLIANCE Deans HED Executive Director gave keynote address Representation of USAID • Infrastructure – improved access to internet and faster connectivity; e-learning courses and communication – skype; database and list serve.
Lessons	• Keeping the project free-form and able to take advantage of new streams of funding to reach new objectives •Regular meetings to keep parties motivated and allow for open exchange of information on progress, setbacks and successes •All involved –U.S. and African partners have high levels of inspiration and a strong belief and commitment to this project •Minimal reporting and bureaucratic requirements
Challenges	• Coordinating between:–7 schools of public health, schools of veterinary medicine, ministries of health, ministries of agriculture, wildlife management, ministries of planning and finance, the press, civil society, and the public •Lack of forward funding -majority of funding has come from USAID Washington •Minimal Mission involvement •Working with numerous partners in the United States and Africa • Created demand for Short courses --- • HEMP pilot not done for the HEALTH Alliance (Only Uganda and Tanzania) • Policy makers exposure is inadequate (only MPs) • ICT findings not implemented (needs) • HEMP training not yet implemented in PH curricula • Infrastructure (teaching and program space remains the greatest challenge-
Documentation secured by consultants –	Strategic plan for MU_SPH Website for HEALTH Alliance/LIPHEA Monthly newsletter HEALTH Alliance East African Journal of Public Health Volume 6 latest

NB: Data compiled from Website and interview with Dr. Tabu Simiyu December 16, 2009, and phone call to Dean dept. CH, UON.

Appendix A8: Health Economics and Policy Network in Africa (HEPNet)

Name (s) of Network/ Consortium/regulatory body	**Health Economics and Policy Network in Africa (HEPNet)**
Country	South Africa
Hosting institution	Health Economics Unit, School of Public Health and Family Medicine, FHS, UCT
Member countries / geographical coverage	South Africa, Tanzania, Uganda, Zambia, Zimbabwe, Nigeria, Ghana and Kenya (8)
Type, Network's Legal status and date established:	Type: Network of public institutions Accrediting body and date: University : Initiated in **2000**
Physical location: P.O	School of Public Health and Family Medicine, Faculty of Health Sciences, University of Cape Town, South Africa
Contact Information:	Name: Dr. Olufunke A. Alaba (HEPNet Coordinator) URLhttp://www.HEPNET.INFO or www.heu-uct.org.za or www.publichealth.uct.ac.za/students for training programs TEL: +27 21 406 6576 Fax: +27 21 448 815
	Name of contact person Dr. Olufunke A. Alaba (HEPNet Coordinator) Email: olufunke.alaba@uct.ac.za Tel +27 21 406 6576 Fax: +27 21 448 815
Historical background	Health Economics Unit (HEU) was established early 1990 within the SPH and FM at the UCT. In 1994, the department of Community Health become the School of Public Health and Family Medicine. This was prompted by the need to transform health systems by redefining new roles for health managers and administrators. This was in recognition of the limited opportunities for postgraduate study in specific disciplines such as health economics within Africa and the importance of capacity development within the discipline. The HEU offers a number of training programmes. **HEPNet** was created in response to the urgent need for health economics and policy analyses of the strategic options for designing and implementing health sector restructuring in African countries, in order to achieve greater efficiency and equity. Currently, there is limited capacity to undertake such analyses and there is a perceived need to develop and sustain a critical mass of people with relevant expertise in the African region. An exploratory workshop was held in Zambia in August 1999 with the objective of discussing health economics and policy analysis capacity and requirements and identifying ways in which this capacity could be strengthened. The workshop was attended by representatives of the Ministries of Health (MoH) and research institutions from South Africa, Tanzania, Uganda, Zambia and Zimbabwe, as well as representatives from SIDA and the Alliance for Health Policy and Systems Research. The workshop identified capacity constraints and capacity building needs in three main areas. 1. Academic/research institutions – capacity to conduct research that informs policy and skills to provide training for health 2. Ministries of Health – capacity to formulate, implement, monitor and evaluate policies 3. Managers at district and other decentralised levels – capacity to understand health economics research outputs and basic tools of health economics analysis. HEPNet is a network of institutions aiming to improve capacity in health economics, policy and systems in SSA. There were initially 5 member countries later expanded to 8 (Kenya, Ghana and Nigeria). Stakeholders (MoH, academic institutions and Sida and the Alliance of health policy and systems research) held workshop in 1999 and drew framework.
Purpose / Goal	To improve the performance of health systems through informing health policy and enhancing technical and managerial capacity in SSA
Vision	Not stated in document nor at interview
Mission	Lead in publishing innovative research, which addresses priority conceptual and methodological issues in low- and middle- income countries. It will play a key role in global post-graduate training in health economics and offer expert policy advice on relevant issues in SSA. It will pursue a balance of mainstream and developmental health economics drawing on the strong human resource base with a full range of relevant skills and a diversity of nationalities and backgrounds
Core values/principles	• Academic excellence in health economics and management • Excellence and independence • Fairness and independence • Respect for its collaborators and stakeholders • Innovative thinking, to ensure its work remains ground-breaking

Strategies	HEPNet's main strategies • Promote networking activities between member institutions and with international organizations active in the region • Strengthen, promote and increase the scope of capacity building in health economics and policy • Strengthen, promote and increase the scope of health economics and policy research The following specific strategies are currently used to develop capacity: 1. Disseminating Information (research findings, policy development and implementation experiences; courses, conferences and other relevant events 2. Interacting with international organisations active within the region (including promoting the use of regional expertise for providing technical assistance to Ministries of Health and other organisations) 3. Holding regular workshops, where ideas can be shared about research and key policy development and implementation issues 4. Supporting the presence of members at the International Health Economics Association conferences 5. Promoting and developing formal training programs, including short-courses and postgraduate education 6. Increasing opportunities for in-service training 7. Sharing resources for training, particularly training materials and expertise 8. Supporting research activities which address country policy priorities
Main Activities	The network's activities include support for international conference attendance (International Health Economics Association (IHEA)), • convening regular workshops and seminars, • notifying members about health economics related information through the website, bi-annual newsletter and online blog;, • the exchange of policy and research reports between members.; • promoting and developing formal training programmes (including short-courses an d pos-graduate education); • supporting research activities which address country policy priorities; • sharing resources for training, particularly training materials and expertise; and • interacting with international organizations active in the region Training programmes (1) online PG Diploma in Health Economics; (2) Masters in Public Health specializing in Health Economics; (3) Masters in Health Economics (collaborates with Business school); (4) PhD programme; (5) Postgraduate Diploma in health Management
Implementing Institutions/ Partners	Members of HEPNet Membership of HEPNet is primarily through institutions – recognising the importance of institutions and institutional memory in sustaining capacity-building initiatives. On some occasions, country members have chosen to offer individual membership, usually to people who have ties to one of the institutional members. An outline of the structure of HEPNet membership is presented below **37 Member institutions in 8 countries**: *South Africa* (4)– HEU, CHP, National dept of health, dept Health Economics- Univ of Free State; *Zambia (3); Zimbabwe(3); Kenya (4)*: KEMRI, MoH, UON – dept. of Economics and Dept of Community Health; *Uganda (5)* – Makerere- SPH, MoH, Clinical epidemiology unit, Uganda Martyrs University, African Centre for Global Health and Social Transformation; *Tanzania (4)- MoH, Muhimbili CHS, National Institute of Medical Research, Ifakara Health Research and Development; Ghana (7); Nigeria (8)*;
Linkages to other networks	EQUINET – Regional Network for Equity in Health in East and Southern Africa CREHS – Consortium for Research into Equitable Health Systems SHIELD – Strategies for Health Insurance for Equity in less developed Countries
Sponsors/Donors	HEPNet is funded through a grant from the Swedish International Development Cooperation Agency (SIDA). Sida (ending 2010)
Organizational Capacity of network	Physical - has own office block at School of Public Health Human resources – skills in Health economics, management and public health; also PG and honorary academics – research, Postdoctoral fellows, associates and support Staffing: Research (7)- Susan Cleary – Director ; Di McIntyre; Okore Okorfor; Edina Sinonvic; Veloshnee Govender; John Ataguba; Sheetal Silal; Academic (4) Gilson, Mooney, Birch,: Support (4) Allison Stevens -communication; Sue Machutchon (OT Fellowship programme); Vanessa Daries, Adams adn Boyes

	Limited to 15 masters and 3 PhD per year	
Achievements & updates	• 7 PhD and 90 MPH and 180 senior managers have graduated diploma • Financial support for conference presentations 10 (2005) to 17 (2009) • Networking initiatives – workshops on health insurance (cape town 2007); eliciting preferences (Johannesburg, 2007), donor funding (Zambia, 2008), global Economic crisis and health in Africa (Uganda, 2009) • Strengthening of capacity development- expanded membership and institutions 13 – 17; formed and inaugurated the African Health Economics and Policy Association (AfHEA) in 2009, regional (WA) and country (Nigeria); members receive Sida bursaries for MPH in economics in South Africa • Research impact on policy – national health insurance in SA; vitamins to children (Ghana) and controlling malaria (Kenya) • Bi-annual Newsletter • Research publications in equity, healthcare financing, health insurance • Planned an "African Journal of Health Economics" in 2010	
Lessons	• Start small and then expand the network – started with 5 countries and later added 3 recently (Nigeria, Ghana, Kenya) to make 8 which increased number of institutions from 13 to 37.	
Challenges (from interview)	• Sida Funding coming to an end in 2010. Coordinator has put in a proposal but not sure, it will be funded. JICA could consider sponsoring network activities especially support for students to conferences • HEPNet not involved in any research at the moment but through students and EQUINET • Weak networking within countries mainly been limited to the focal point and participating institutions. JICA could strengthen networking within countries • Network potential but limited to donor activities- institutionalization is weak. • JICA can help to identify health systems research priorities and promote research through the network.	
Documentation secured by consultants	• HEU policy information sheets on HCF • Public sector healthcare spending in SA • The public–Private health sector mix • Medical Schemes' spending in SA • Who pays for Healthcare in SA	• Brochure of HEPNet • BI-annual HEPNet Newsletter • Evaluation survey- 2005

NB: Data compiled from interview with coordinator Dr. Alaba and Alison (Communications) on 7th December 2009 at HEI, UCT medical campus.

Appendix A9: Inter-University Council for East Africa (IUCEA)

Name of Network/Regulatory body	**Inter-University Council for East Africa (IUCEA)**
Country Host	Uganda
Hosting institution	EAC
Member Countries/ geographical coverage	**5** countries in East Africa: Tanzania, Uganda, Kenya, Rwanda, Burundi
Networks Legal status:	Type: Regional inter-governmental organization Accrediting body and date: Established in 1980 under EAC but revived in 2000
Physical location: P.O	Plot 4 Nile Avenue, African Development Bank Building 3rd floor, P.O Box 7110, Kampala, Uganda
Contact Information:	Name of Executive Director Prof. Chacha Nyaigotti-Chacha URL iucea.org Telephone+256414256251/2 Fax:
	Name of contact person Benedict Mtasiwa (filled tool) Email bnmtasiwa@hotmail.com, bmtasiwa@iucea.org Telephone 006712069142 Fax:
Historical background	Originated from the University of East Africa with the Universities –Nairobi, Dar es Salaam and Makerere constituting colleges. In the 1970s, a committee called IUC(Inter-university Committee) was formed. In 1980, a memorandum of understanding (MOU) for the Inter-University Council for East Africa (IUCEA) was signed. Following the signing of the EAC protocol in 1999, the IUCEA identified as a surviving institution of the EAC, underwent a revitalization process in 2000. The Inter-University Council for East Africa (IUCEA) is a regional inter-governmental organization established in 1980 by the three East African Partner States (Kenya, Tanzania, and Uganda) with the aim of facilitating contact between the universities of East Africa, providing a forum for discussion on a wide range of academic and other matters relating to higher education, and helping maintain high and comparable academic standards. The IUCEA exists to facilitate, coordinate and promote sustainable and competitive development of universities in the region by responding to the challenges facing higher education, and helping universities to contribute to meeting national and regional development needs through its various activities. Currently, it is in the 3 year of implementation of its 2006 -2011 Strategic Plan. The Theme of the IUCEA Five Year Rolling Strategic Plan is: Strategic Inter-University Cooperation for East Africa's Prosperity and Unity.
Purpose / Goal	Coordination and Facilitation of stakeholders so as to promote strategic, sustainable and competitive development of the higher education sector in East Africa. Overall Goal is that IUCEA is transformed into a strong, competitive and responsive regional body in higher education
Partners	Universities, Ministries Responsible for Higher Education, Research, national science and technology agencies, private sector and development partners of the countries – Burundi, Kenya, Tanzania, Rwanda and Uganda
Vision	IUCEA becomes an effective regional advocate and catalyst for the strategic development and management of higher education in East Africa.
Mission	IUCEA shall coordinate; facilitate stakeholders so as to promote strategic, sustainable and competitive development of the higher education sector in East Africa.
Core values	In fulfilling its Mission and achieving its vision, IUCEA will promote and be guided by the following core values: • Tolerance of a diversity of ideas amongst its key stakeholders; • Active participation in national, regional and international events and networks related to higher education; • Application of modern technology (e.g. ICT) in the enhancement of the delivery of IUCEA activities ; • Good governance, integrity and accountability to all key stakeholders by ensuring transparent decision-making and operation, allowing full participation of member universities both in the contribution of efforts and sharing of the benefits; • Equity, inclusiveness and social justice: by ensuring equal opportunity in all aspects to member universities without discrimination due to their affiliation, i.e. public or private, religion, country or location;

	• Receptivity and responsiveness to relevant and strategic needs of member universities and partner states; • The pursuit of national, regional and international norms of quality assurance and control in higher education; • Internationalization of the higher education in East Africa.
Strategies	IUCEA will implement its Rolling Strategic Plan for the period 2006/07 – 2010/11 through addressing the following thirteen strategic objectives: 1. The legal and management framework consolidated. 2. Human resources capacity and management strengthened. 3. IUCEA physical infrastructure improved. 4. IUCEA publicity and marketing strengthened. 5. Financial capacity and sustainability strengthened. 6. Planning, monitoring and evaluation capacity strengthened. 7. Leadership and management capacity of member universities developed. 8. Strategic regional training and research programmes promoted. 9. Inter-University cooperation promoted. 10. Application of ICT and networking of member universities promoted. 11. Regional higher education quality control and assurance institutionalised. 12. Internationalisation of higher education and research in East Africa increased. 13. Gender balance and mainstreaming promoted.
Main Activities	CORE FUNCTIONS OF THE IUCEA <u>(a) Coordination of Inter-university Cooperation</u> • To promote the development of mutually beneficial collaboration between member Universities, and between them and governments and other organizations, both public and private; • To strengthen regional communications through electronic networks which link Member Universities together and to relevant sites in East Africa and the world; • To encourage collaboration in regional research and thereby assist universities to develop centres of advanced study and research on a rationalized basis; • To encourage the exchange of staff and students between Member Universities; • To promote through relevant activities in the Member Universities the meaning and value of East African unity. <u>(b) Facilitation of The Strategic Development of Member Universities</u> • To assist and encourage the development of East African higher institutions of learning; • To assist Member Universities with academic staff development activities; • To assist Member Universities identify and implement good practices in the management of institutions and the use of resources; • To keep abreast of international developments in higher education and to inform Member Universities accordingly; • To solicit for funds from local and international sources for strategic inter-institution interventions in higher education; • To collect, classify and disseminate information on higher education and research, particularly in East Africa. <u>(C) Promotion of The Quality of Higher Education for Common Regional Development</u> • To promote the development and application of harmonized higher education quality assurance framework in order to ensure that teaching and research achieve and maintain international standards; • To advocate for and assist governments and other appropriate bodies and authorities with the development of strategies for rational development of higher education in East Africa
Implementing institutions/ partners	Institutions of the EAC - Council of Ministers, the Summit Member institutions – all public and private universities in East Africa
Links to other networks	EAC-HC
Sponsors/Donors	EAC, Sida, EU,
Capacity	Physical and human resources • Awaiting to acquire own premises • Has a lean secretariat
Achievements	- Joint activities with the EAC-Health desk have been as follows (both feed into the Council of Ministers); 1) Consultations and participation in the joint (National dental and medical councils, commissions for Higher Education, IUCEA and the health unit at the EAC secretariat) development of guidelines for accreditation and inspection of dental and medical schools in East Africa). These were approved by the Health Sector Council meeting and the Council of

	Ministers meeting So far, medical and dental schools were inspected in Tanzania mid- 2009, followed by Kenya around October. The next inspections will be held in Uganda sometime in January 2010, and later to be followed by Rwanda and Burundi. 2) The IUCEA has participated in Development, Consultation and co-sponsoring of the Regional East African Community Health Research Initiative (REACH) forums. The forum seeks to establish a framework for development of health policies backed by research evidence. The REACH secretariat is in the EAC secretariat and has so far been in place for about 3 Years. 3) On HIV and AIDS, the IUCEA is a partner in a programme - East African Community/AMREF Lake Victoria Partnership (EALP) to implement coordination strategies for Higher Education institutions. The other sectors are fisheries and plantation workers/ the target area is the Lake Victoria basin. • Phased plan to train quality assurance coordinators from 25 universities in the 5 Partner States (Burundi, Kenya, Tanzania, Rwanda and Uganda), underwent the Quality Training in Germany in September 2008 and in East Africa, • It can be noted that the IUCEA has had significant engagement with the Health Unit in all aspects of Higher Education functions of Teaching, Research and Services. Also, the IUCEA has identified areas in each of the 7 objectives of the EAC HIV and AIDS Strategic Plan for effective participation. Implementation of activities for those objectives will imply even more areas of cooperation. • The Lake Victoria Research Initiative (VicRes) received a total of Sek 100 Million equivalent to 12.5 Million US Dollars for Phase III (2009- 2012). • Meeting of the Task Force on ICT Policy and Information Resource Center 18th-21st May 2009, Kigali Rwanda		
Lessons	Several programmes – EAC-LVP HIV and AIDS; gender mainstreaming; quality control Strategic plan 2006/2011		
challenges	• Need to review the legal instruments and organizational structure. • The Protocol does not spell out and rationalize IUCEA strategic partners' roles and relationships. • Inadequate representation of IUCEA at member countries and institutions level • Inadequate IUCEA programme management cycle. • Need to create the right number of job positions for effective delivery of the mission • Need to develop capacity of governing organs. • Need to upgrade management systems, including management information and financial management systems and operational policies and procedures. • Need to enhancement of the application of ICT to the activities of IUCEA. • Lack a comprehensive monitoring and evaluation plan for Quality control for training and research programmes at university		
Documentation secured by consultants	Newsletter copy	Copy of IUCEA Corporate Strategic plan 2006 – 2011 was emailed	

NB: Tool was filled and emailed by Dr. Mtasiwa on 14 December, 2009. Additional information is compiled from strategic plan (2006-2011) and initial interview on 3rd December 2009 and website.

Appendix A10: The Regional East African Community Health (REACH) Policy Initiative

Name (s) of Network/ Consortium	**The Regional East African Community Health (REACH) Policy Initiative**
Country	Arusha
Hosting institution	The East African Health Research Council (EAHRC) - EAST AFRICAN COMMUNITY
Member Countries / geographical coverage	The five **(5)** East African Countries – Tanzania, Uganda, Kenya, Rwanda, Burundi – the country nodes of the REACH –policy alliance are located in MoH in each country
Network's Legal status:	**Type:** Inter-governmental Public – Policy making/regulatory on research **Accrediting body and date:** EAC in Arusha REACH (2007) The East African Community (Article 118, on Health- Items B, E and F), provides the legal framework for establishing the East African Health Research Council. The objectives of REACH-Policy Initiative are embedded within the legal protocol of EAHRC. It is therefore logical and appropriate that REACH-Policy Initiative be set up within the already existing East African Treaty that makes provision for the formulation of such regional institutes.
Physical location: P.O	East African Community Secretariat office: Arusha International Conference Centre, Kilimanjaro wing 5th floor, P.O Box 1096, Arusha, Tanzania
Contact Information:	**Name of Coordinator** Tel: 255-27-2504253/8 Fax: +255-27-2504255 **URL** Weblink: www.eac.int
	Name of contact person Dr. Sonoiya **Email:** eac@eachq.org or health@eachq.org **Tel:** **Fax:** +255-27-2504481
Historical background	The Health desk in the EAC secretariat is supposed to coordinate programmes and projects in the health sector as envisioned in the treaty, and revolves around harmonized policies and efforts to contain burdens of communicable diseases(Malaria, tuberculosis and .....) and non-communicable diseases. Recognizing the "need" and "desire" to improve the health of the people of our countries, 3 countries joined together to propose the establishment of an institutional mechanism within the newly formed East African Health Research Council in the East African Community (EAC) to bridge the gap between evidence and health policy and practice. We see numerous advantages through this initiative to greatly improve the information available to our respective policy makers and policy making bodies to establish evidence-informed health policy. Weak health systems have been identified as the major bottleneck in progress. There has been increasing momentum towards evidence-informed health systems since the early 1990's. The International Development Research Centre, Canada, joined in partnership with the Tanzania Ministry of Health to explore how evidence could play a larger role in reforming health systems. As one legacy of this partnership, IDRC and the Ministry of Health have sponsored a series of consultations. The first was held in Arusha (Duluti) Tanzania in December 4-5, 2001, which concluded that a formal institutional mechanism should be explored. The initial field assessment consultancy commissioned by the Tanzania National Institute for Medical Research revealed much information in the form of research reports, consultancy reports, scientific publications that were found on the shelves of key policy and decision makers. Many of these reports and publications dealt with issues relevant and pertinent to the office where they were found. These were mostly un-utilized. Very few were found to be easily applicable to improve the policy/decision makers' work performance in the health sector. A major observation made at that time, and repeated during subsequent country-level consultations, was a problem of getting research results into policy or decision-making processes and practices.
Purpose / Goal	Overall Goal: To improve people's health and health equity in East Africa through more effective use and application of knowledge to strengthen health policy and practice
Vision	Not stated on website
Mission	To access, synthesise, package and communicate evidence required for policy and practice and for influencing policy relevant research agendas for improved population health and health equity.
Core values	Not stated on website
Strategies	This mission will be approached through the following 1. Managing for involving policy makers and researchers 2. Facilitating access to research 3. Commissioning syntheses of research of high policy relevance

	4. Packaging research syntheses for high policy impact 5. Communicating and advocating to inform policy and research agendas 6. Strengthening regional capacity for knowledge translation **7.** Monitoring and evaluation of REACH-Policy Initiative and the impact on policy change and trends of key indicators The broad strategies include: • Planning and coordination and Resource • Mobilization • Surveillance • Capacity Building • Laboratory • Information , Education and public awareness • Review of policies and legislation • Research of AI in the EAC Partner States • Prevention and containment • Establishment of Emergency preparedness fund
Main Activities	• Convene priority-setting meetings involving policymakers to build consensus on high priority policy issues that could be informed by research • Convene 'safe harbour' meetings involving policymakers, stakeholders affected by policy issues under discussion, and researchers to discuss take home messages from research and their implications for high priority policy issues • Develop and maintain a clearinghouse for one-stop shopping for research syntheses, • Develop and maintain a website and network to provide the same type of one-stop shopping for documents and research contacts • Develop and maintain a rapid- response unit to search for syntheses, conduct assessments of their quality and • Strengthen regional capacity on knowledge translation by providing training for policy makers in how to acquire, assess, adapt and apply research and training for researchers in the policy context for health systems research and management
Implementing Institutions/ Partners	Ministries of Health and schools of Medicine and of Public health in Universities; Ministries of, Finance, Planning and Local Government of the EAC Countries; research institutions in Kenya, Uganda, Tanzania, Rwanda, Burundi; Council of Ministers, the Sectoral Committee on Health **Nodes in each country will:** • support country ministries in making policy decisions. • to communicate and sell the findings and recommendations of the REACH-Policy Initiative team, work closely with Parliament and Parliamentary committees that are interested in REACH-Policy Initiative findings, as well as with parts of civil society, notably health professional organizations for example of doctors and nurses as well as Universities and research institutions. • responsible for communicating and publicizing approved findings with the general public and the media. • act as a clear "knowledge broker" - translating the needs of ministries, parliament and "civil society" into questions that the REACH-Policy Initiative may answer, drawing on research evidence – and working with ministries, parliament and "civil society" into leveraging those answers into actionable policy recommendations.
Sponsors/Donors	IDRC and the Tanzania Ministry of Health
Links to other networks in the region	The East African Integrated Disease Surveillance Network (**EAIDSNet**) is a collaborative effort of the Ministries of Health of Kenya, Tanzania, and Uganda as well as national health research, and academic institutions set up in 2003. An important aspect of the Network is to improve the quality of data on communicable diseases and the flow and sharing of information to improve the health of the East African population. **IUCEA** has participated in forums to develop and harmonize the REACH activities, EQUINET, GEGA and other WHO initiatives,
Capacity of network	**Physical and Human resources** • Executive Director • Senior Policy Analyst • Senior Research Analyst

	• IT Specialist/Librarian • Writer • Finance and Administration Manager • Office manager • Office clerk • Messenger/driver		
Achievements to date/ recent events	• The fact that the REACH-Policy Initiative has come up from country-level efforts, has strong high-level political support, and has been several years in preparation is an asset in terms of a thoroughly considered initiative. • Developed prospectus in 2006 signed by Directors of respective Ministries of Health in 3 countries. • 4th Annual East African Community Health and Scientific Conference– March 31– April 2, 2010 in Kigali, Rwanda Theme: "EAC AT 10 YEARS: Regional Health Priorities and Opportunities: 'Evidence for Action in Changing Global Financial Situation"		
Lessons	Unlike previous efforts, the proposed REACH-Policy initiative addresses the entire spectrum of activities and products needed for the effective translation of knowledge for better health policy and practice. Importantly, it is based on real experiences, is driven by developing Countries, has the potential to benefit the East African region, and has high-level political support. WHO congratulates the community for its vision and commitment and looks forward to working with the initiative to extend their work to other parts of the developing world."		
Challenges	**Not stated on website**		
Documentation secured by consultants (website)	**Prospectus document on website**		

NB. Data compiled from EAC Website as there was no response to email communications.

Appendix A11: Southern and Eastern Africa Policy Research Network (SEAPREN)

Country hosting	Namibia
Name (s) of Network/ Consortium/regulatory	**Southern and Eastern Africa Policy Research Network (SEAPREN)**
Hosting/Implementing institution(s)	Namibian Economic Policy Research Unit (NEPRU) Windhoek, Namibia as head quarters
Member Countries/ Geographical coverage	(7) Botswana, South Africa, Zambia, Namibia, Tanzania, Uganda, Kenya
Network's Legal status:	Type: International network of research and policy institutions Accrediting body and date: 1999 (but started operations in 2002)
Physical location: P.O	Secretariat: Namibian Economic Policy Research Unit (NEPRU) P.O. Box 40710, Windhoek, Namibia
Contact Information:	Name: SEAPREN Coordinator: Dirk Hansohm (DirkH@nepru.org.na) URL http://www.seapren.org/ Tel: +264 61 277500 Fax: +264 61 277501
	Name: Assistant Coordinator: Rosa Endjala Email: RosaE@nepru.org.na or SeaprenSecretariat@esrf.or.tz Tel: +264 61 277500 Fax: +264 61 277501
Historical background	The network of six research institutions who are engaged in strengthening policy analysis in their home countries. The network was established in Gaborone, Botswana November 1999. The network is driven by a Secretariat, which is currently housed at the Economic and Social Research Foundation (ESRF). The responsibility of the Secretariat is to ensure that the network is managed effectively and efficiently, and is properly resourced at all times. The network took off in 2002 with the seed funding provided by the International Development Research Centre (IDRC). The IDRC has generously funded several meetings of the network and thus has been instrumental in its creation. On 24 Janaury 2003, Dr. Dirk Hansohm (Director of NEPRU and Coordinator of SEAPREN) signed the Grant Agreement to the value of US$ 250,000 for a period of 18 months. These core funds will allow the network to start its activities in the fields of collaborative research, training and dissemination. The Governance and Capacity Building Unit was established in 2000 (then Capacity Building Unit) and was developed to ensure Tanzania is a country with economic and social policies that are delivering development needs of a society and that the government, CSOs, NGO community, academic institutions, private sector and donors are effectively participating in shaping, implementing and evaluating those policies. ESRF's approach to achieve this is through enhancing both the strength of institutions and that of human capacity. The Unit coordinates efforts that involve training, information/ knowledge dissemination seminars/ workshops, networking and facilitation of field/ work attachments. The main objective of this is to equip policy analysts and decision makers with analytical tools that allow them to advise senior policy makers on the formulation, implementation and evaluation of policy packages and to effectively communicate with other stakeholders. To further economic and social policy analysis, initiatives and approaches under the Unit include: joint research and short-term assignments pursued together with public servants and the private sector; work attachments provided for both junior and senior researchers; hosting visiting local and international scholars; and running short courses, trainings and seminars.
Purpose / Goal	The aim of the Network is to collaborate on national and regional research projects and capacity building; exchange best practices and mutual learning in research as well as institutional management; and monitor international developments and new approaches within the field of policy analysis to ensure that network members use best practices and techniques.
Vision	Not stated on website
Mission	Southern and Eastern Africa Policy Research Network (SEAPREN) is a network of six research institutions who are engaged in strengthening policy analysis in their home countries. The network was established in Gaborone, Botswana November 1999.
Objectives	Regional trade, governance, poverty, economic growth and industry, institute management, capacity building, connectivity,
Core values/principles	Not stated on website
Strategies	Research, Capacity building, Exchange best practices The CBU Strategy • Use of collaboration, partnerships and networks local, regional and international to deliver our programmes, • Consolidation • Reaching out by offering out of Dar es Salaam workshops, conferences, briefings, and

	short courses with various sets of stakeholders in the national and international policy community.
Main Activities	Training and Capacity building; Research; Exchange best practices Governance and Capacity Building Activities (i) Policy Dialogue Seminars These seminars provide a forum for policy actors to influence development policy in Tanzania. They are conducted atleast twice a month. Discussed topics are based on research findings from the Foundation, emerging development issues and themes as suggested by stakeholders. (ii) Training Programme The main objectives of this programme is to Impart targeted policy actors with knowledge on contemporary features of government and donor policies for them to understand consequences of these policies to their organizations and or activities. It also aims at providing opportunities for targeted policy actors to discuss and make recommendations to policy makers in Tanzania, within the African region and international whose decision have a bearing on different aspects of the livelihoods of Tanzanians. The Programme employs an approach in which individual training activities are designed in response to training needs assessments. Past trainees have been exposed to new policy concepts such as Sector Wide Approaches; Public Expenditure Reviews and Medium Term Expenditure Frameworks Enable policy actors. In perspective, ESRF will cover not only Tanzanian issues, but create a comparative framework for the whole area of the Eastern and Southern Africa, where the need for such activities obviously exists. (iii) Mentoring This is done through visiting fellowship and attachment programmes to allow individuals to familiarize with research techniques relevant to economic and social policy analysis. Postgraduate and undergraduate students from reputable international and local universities and institutions have benefited from this programme. The Programme offers visiting fellowships, senior officials from government, private sector and non governmental organizations with tools and techniques for effective economic and social policy analysis. Beneficiaries of the Mentoring Programme include those from the Ministry of Planning, Economy and Empowerment, Ministry of Finance and other Government Departments. (iv) Technical and Consultancy Services The Technical and Consultancy Services involves providing direct inputs to policy formulation, implementation and review, via task forces and through sector and project based consultancies. Such work has been carried out for several Government Ministries and donors in Tanzania; the World Bank; Secretariat of the East African Community, and a considerable number of International and local non governmental organizations as well as private sector organizations inside and outside Tanzania.
Implementing Institutions/ Partners	Six now 7 research institutions in 4 in Southern Botswana, South Africa, Zambia, Namibia and 3 in Eastern - Tanzania, Uganda, Kenya (latest) • Botswana Institute for Development Policy Analysis (BIDPA), **Botswana** • Development Policy Research, Unit (DPRU), **South Africa** • Economic and Social Research Foundation (ESRF),**Tanzania** • Economic Policy Research Centre (EPRC), **Uganda** • Institute of Economic and Social Research (INESOR), **Zambia** • Institute of Policy Analysis and Research (IPAR), **Kenya** • Namibian Economic Policy Research Unit (NEPRU), **Namibia**
Linkages to other networks	NEPAD, AU, African Economic Research consortium (AERC) through Economic Policy Research Centre (EPRC) in Uganda,
Sponsors/Donors	World Bank, Hanns Seidel Foundation, EU, Christian Michelsen Institute - Norway (CMI), NORAD.
Capacity of network	Large but focus on policy and evidence gaps but less on implementation gap
Achievements	• Workshop on NEPAD and Civil Society in November 2003 - The 3 day event attracted representatives from Governments, the civil society and Development partners of NEPAD. Represented were the 9 African countries, Germany, the G8, the EU. The workshop also emphasised the need to strengthen African institutions such as the AU and Regional Economic Communities as they are very instrumental for the smooth operation of NEPAD. • In 2004 SEAPREN kicked off with the initiation of a fresh round of project proposals for 2004. Meanwhile five projects began in 2003. The "Budgetary processes and economic governance in Southern and Eastern Africa" and the "Comparative Analysis of Poverty

	Policies in Southern and Eastern Africa" projects led by NEPRU and ESRF respectively are in their second phase while the other three are expected to enter the second phase around April 2004. • EPRC has developed a reputation as one of the leading policy oriented research institutions in the East African region, developing linkages with several reputable institutions worldwide. Collaborative linkages have been established with Oxford University, African Economic Research consortium (AERC), University of Manchester, and various ACBF funded policy research centres in Sub-Saharan Africa. EPRC has participated in regional related work including the following. (i) Derosa A. Dean, Marios Obwona and Vernon O. Roningen, The new EAC customs union: Implications forUganda Trade, Industry, Competitiveness and Economics Welfare, (ii) Obwona M. and S. Wangwe, East African Community Development Strategy: 2001-2005 (iii) Obwona M. and S. Wangwe, Final draft of the evaluation report of the implementation of the East African Cooperation Development Strategy 1997-2000. This offers an ideal opportunity for the Center to develop valuable linkages with key policy making and policy research oriented organs. • Conference held in South Africa (Cape Town) 13-15 October 2004 "African Development and Poverty Reduction: The Macro-Micro Linkage". • Monitoring progress in regional integration in Southern Africa under SADC. • Governance and capacity building unit (GCBU) Achievements at Economic and Social Research Foundation (ESRF) member institution in Tanzania · We may not be able to measure major impact or changes in the existing policies but based on Evaluations forms that are filled at any training or seminar dialogue, many of the stakeholders have appreciated being given a common ground for development partners, policy makers, private sector, researchers, civil society, policy analysts, academicians and other stakeholders to discuss on key policy and development issues. · A database of Reports from Policy dialogue seminars and other workshops which are shared with relevant stakeholders, · Publications of various Policy Analysis Training Manuals, · Policy briefs based on Policy dialogues, · Various Policy Position Papers and Research reports of Visiting Fellows, · Database of trainees on various trainings.		
Lessons	Not on website and not interviewed		
Challenges	Limited to research institutions thus implementation gap (researcher's view) Include training component for parliamentary members in order to close implementation gap. The network is among the few networks that has direct links to SADC, EAC and NEPAD and approach is developmental rather than sector based.		
Documentation secured by consultants – website based	List of publications on key research from member institutions	SEAPREN Newsletter	

NB: Data compiled from website only as no response to email sent to secretariat at HQ in Namibia.

Appendix A12: List of Networks

Networks	Member institutions/states
(1) AHLMN **African Health and Leadership Management Network** (membership is by individual and institution)	23 institutions: *Kenya: AMREF, Kenya Methodist Univ., AMHF , Strathmore Business School *South Africa: Health System Trust, Univ. Of Pretoria (School of Health Systems and Public Health), Univ. of Witswatersrand (School of Public Health) *Tanzania: Eastern and Southern African Management Institute, ECSA-HC *Uganda: Uganda Management Institute *Togo: Centre for African Family Studies Programme en Management Leadership et Renforcement Institutionnel *Benin: Institute Regional de Sante Publique Afred Comlan Quenum de Quidah *Botswana: Institute of Development Management , Audrey and Associates *Ghana: School of Public Health , Ghana Institute of Management and Public Administration *Mozambique: Universidad Eduardo Modlane (School of Public Health) *Nigeria: Health Reform Foundation of Nigeria, *Senegal: ISED, Centre African d'Etudes Superieures en Gestion *Burkina Faso: Ecole NAtionale de Sante Publique *Cote D'ivoire:Institute Natonal de Sante Publique *Democratique du Congo: Ecole de Sante Publique de Kinshara 10 International partner organizations: *USA: The Capacity Project , Management Sciences of Health, Centre for Leadership and Management, INTRAHEALTH International, Centre for Disease Control and Prevention *South Africa: Broad Reach Healthcare *Portugal: Instituto de Higiene Medecina Tropical, Universidare Nova de Lisboa *Netherlands: Royal Tropical Institute, *Congo: WHO *Switzerland: WHOHQ (Dept. of Health System Governance and Service Delivery, Department of Human Resource of Health)
(2) AHWO **Africa Health Workforce Observatory** (membership by Country)	**WHO Collaborating Centres** 1. University of Botswana: Development of community nursing and midwifery care 2. University of Natal, South Africa : Educating Nurses and Midwives in community problem solving 3. University of South Africa (UNISA): Postgraduate Distance education and research in nursing and midwifery development 4. University of Ilorin (Nigeria) Research in human resources development/community based medical education 5. University of the Western Cape, School of public health: research and training in HRH development **WHO supported Regional Training Centres** 1. Institut régional de Santé publique (IRSP) Benin : training in public health 2. Centre de Formation en Santé Publique (CFSP) Togo : training for mid level cadres 3. Instituto Superior de Enfermagem (ISE) Angola: Midwifery training /distance edcuation 4. Centre Regional de Desenvolvimento Sanitario (CRDS) Mozambique: training in Public health 5. Centre d'Etudes supérieures en Gestion (CESAG) Senegal: training in management **Subregional Forums** 1. NEPAD - The new Partnership for Africa's Development 2. ACOSHED - African Council for Sustainable Health Development
(3) CREHS **Consortium for Research into Equitable Health Systems** (Membership	The eight (8) specific institutions in seven (7) country are: • Indian Institute of Technology, Madras (IITM); • Kenya: KEMRI-Wellcome Trust Research Programme, Kenya Health Policy Research Group (HPRG), • Nigeria: University of Nigeria, Enugu, Nigeria; • South Africa: Health Economics Unit, UCT -SA; Centre for Health Policy, University of Witwatersrand, SA • Tanzania: Ifakara Health Institute IIHI) Tanzania; • Thailand: International Health Policy Programme (IHPP), Thailand;

by institution)	• UK: Health Economics and Financing Programme, London School of Hygiene and Tropical Medicine (LSHTM)
(4) ECSA-HC **Eastern, Central and Southern Africa – Health Community** (membership is by Country)	10 states: Kenya, Tanzania, Uganda, Malawi, Lesotho, Mauritius, Seychelles, Swaziland, Zambia and Zimbabwe
(5) EQUINET **The Regional Network on Equity in Health in Southern Africa** (Membership by institution)	Institutions in 8 countries Namibia, Botswana, Malawi, Mozambique, South Africa, Tanzania, Zambia, Zimbabwe: South Africa: • The HEU, University of CT in SA co-ordinates work on Resource Allocation & health equity; • UCT, School of Family and Public Health co-ordinates the work on Health Rights • The CHP, Wits University, South Africa co-ordinates work on Policy analysis; • HST, South Africa co-ordinates the work on Human Resources for Health • University of Limpopo • Fahamu (UK/SA) manages the EQUINET website and newsletter Zambia • CHESSORE, Zambia (governance and work on cross border disease surveillance Zimbabwe • TARSC (Training and Research Support Centre), co-ordinate - Governance, equity and health and Equity in HIV/AIDS in a co-operation with Oxfam GB • SEATINI, Zimbabwe co-ordinates the work on Trade and health • University of Zimbabwe Medical school, co-ordinates the Monitoring equity Malawi • Health Equity Network co-ordinates the work with parliamentarians and the student grants programme Mozambique • Botswana • Namibia • University of Namibia, Tanzania • IFAKARA - Theme co-ordination work on district health systems • East, Central and Southern African Health Community (ECSA-HC) Uganda Partners in Population and Development, Africa Regional Office (PPD ARO)
(6) GEGA **Global Equity Gauge Alliance** (Membership is by Institution)	12 Equity Gauges in 12 Countries: Burkina Faso, Kenya, South Africa, Zambia , Zimbabwe; Chile, Ecuador, Peru; Bangladesh, China, India and Thailand 1. South Africa: Health System Trust (HST), University of Western Cape (SFHPH), HealthLink**,** Health Science Research Council, South Africa, - South African Equity Gauge - http://www.hst.org.za/hlink/equitysa.htm 2. Kenya: African Population and Health Research Centre 3. Uganda - HEPS-Uganda is a Health Consumers' Organization; Uganda's Equity Gauge - http://www.hegauuganda.com/ 4. Zambia 5. Zimbabwe 6. Bukina Faso 7. Bangladesh - The Centre for Health and Population Research in Bangladesh (ICDDR, B)- http://www.icddrb.org/ 8. China: 9. India:

	10. Chile - **Chile's Equity Gauge-** http://www.equidadchile.cl/ 11. Ecuador 12. Peru External EQUINET is co-operating with University of New South Wales (UNSW), Australia to strengthen writing skills for peer reviewed journals and with MEDAct (UK), UNSW, and the University of Saskatchewan Canada in its work on trade and on health personnel.
(7) HEALTH Alliance **Higher Education Alliance for Leadership Through Health** (Membership is by Country and institution)	LIPHEA Partners Sponsors/Donors: ・Higher Education for Development (HED)(as sponsor) ・African Medical and Research Foundation (AMREF) (as sponsor) ・USAID (as donor) ・World Bank (as donor) Partners in Africa: ・Tanzania: Muhimbili University College of Health Science (as founding partner) ・Uganda: Makerere University Institute of Public Health (as founding partner) ・Kenya: University of Nairobi, College of Community Health ・ Moi University School of Public Health ・Rwanda: National University of Rwanda, School of Public Health ・Ethiopia: Jimma University Faculty of Public Health ・ DRC: Unicersite de Kinshasa Ecole de Sante Publique US Partners: ・ Johns Hopkins Bloomberg School of Public Health ・ Tulane University School of Public Health and Tropical Medicine ・ George Washington School of Public Policy and Administration
(8) HEPNet **Health Economics & Policy Network in Africa** (Membership is by Country and institution)	37 Institutions in 8 countries *Kenya: Ministry of Health, KEMRI/Welcome Trust, University of Nairobi (School of Economics, Department of Community Health) *South Africa: Ministry of Health, University of Cape Town（Health Economics Unit）, University of Witwatersrand (Centre for Health Policy) *Tanzania: Ministry of Health, National Institute of Medical Research, Muhimbill University College of Health Sciences, Ifakara Health Research and Development *Uganda: Ministry of Health, Makerere University (Institute of Public Health, Clinical Epidemiology Unit), Uganda Martyrs University *Zambia: University of Zambia (Department of Economics) *Zimbabwe: Ministry of Health, Biair Research Institute, University of Zambia (Department of Community Health) *Ghana: Ministry of Health, Ghana Health Service (Health Research Unit), University of Ghana (School of Public Health), Navrongo Health Research Centre , Dangbe West Health Research Centre, National Health Insurance Secretariat, Kwame Nkrumah University of Science and Technology *Nigeria: Federal Ministry of Health(Abuja, Enugu State), Ministry of Health, Enugu and Anambra Ministry of Health, Awka, University of Nigeria Enugu Campus (Health Policy Research Group, department of Health Administration and Management, University of Nigeria Nsukka (Department of Economics,), University of Ibadan (Department of Economics)
(9) IUCEA **Inter-University Council for East Africa**	5 Countries Tanzania – Uganda – Kenya – Rwanda –

(membership is by Country)	Burundi – (membership with each country open to all public and private Universities)
(10) REACH Policy Initiative **The Regional East African Community Health Policy Initiative** (Membership by Country)	5 countries in East Africa Tanzania – Uganda – Kenya – Rwanda – Burundi – (works with Ministries of Health, Finance and local government in all the member countries and select academic and research institutions – public and private)
(11) SEAPREN **Southern and Eastern Africa Policy Research Network** (Membership by institution)	7 SEAPREN MEMBERS in 7 countries 1. Botswana Institute for Development Policy Analysis- (BIDPA), Botswana 2. Development Policy Research Unit (DPRU), South Africa 3. Economic and Social Research, Foundation (ESRF), Tanzania 4. Economic Policy Research, Centre (EPRC), Uganda 5. Institute of Economic and Social Research (INESOR), Zambia 6. Institute of Policy Analysis and Research (IPAR), Kenya 7. Namibian Economic Policy, Research Unit (NEPRU), Namibia

Appendix B: Self-Assessment of Network's Organization Capacity

Situation Analysis - ***Completed for each Network, Alliance, Consortium engaged in training, research, technical support, funding activities in <u>any field</u> of health system management***

Objectives of the situation analysis specific to networks

i. To identify higher educational and research networks in Eastern and Southern Africa which pose strategic implications for sustainable development of human resource for health (HRH) in the region.
ii. To profile networks offering training and research programs in the general areas of health systems management
iii. To analyse the Strengths, Weaknesses, Opportunities and Threats (SWOT) and identify gaps and unique selling points for each network
iv. To recommend strategies for strengthening existing networks for training, research and technical support in health systems management as well as potential areas for possible collaboration with JICA

*Name of Network/Alliance/Consortium*_____ _____ *Date established:* _____

*Type: Government, Parastatal/semi-governmental, Private, NGO*_____

Country (where network HQ office or secretariat is hosted) _____

Name of Regional offices/nodes in <u>Eastern and Southern Africa</u> (if applicable)_____

Date commenced operations *in Eastern and Southern Africa region:* _____

Name and Designation of person filling questionnaire*:* _____

Characteristic of Network/Alliance/Consortium 1 = less developed, 6 = well-developed	***1***	***2***	***3***	***4***	***5***	***6***
1. Position (refers to the image and ranking of network in terms of its core business)						
Network/Consortium is known in region for distinctive competence and proven performance in development /management of human resource for health (HRH)						
Network has a positive image amongst relevant stakeholders: International/Regional/National						
Evidence on Position (Supporting documents emailed to consultant or reference to website)						
2. **Thinking and learning (networks strategic internal reactions to external change in environment)**	**1**	**2**	**3**	**4**	**5**	**6**
Has well formulated policy and strategic plan on HRH which is understood by all members						
Has commitment to equity and achieving positive outcomes for Health Systems in member countries						
Recognizes diversity and conflicting interests in HRH development/ management in member countries						
Uses internal evidence from monitoring to improve quality and performance of the network						
Its strategies and practices are driven by external evidence on best practices						
Evidence on thinking and learning (any documents emailed to consultant or reference to website)						
3. Doing (assessment of relevance, equity, effectiveness and efficiency of outputs/core business)	**1**	**2**	**3**	**4**	**5**	**6**
Its projects and activities are relevant and answer urgent and serious needs of health system needs in host countries						
Promotes equity through Training; Research; Funding; ICT Service Development; Documentation/sharing information; Coordination of networks/Alliances; (check all that apply)						
Programmes are effective programmes (i) improving capacity and retention of health providers						
(ii) improving health system performance (specify)						
Cost-effective interventions for human resource development and management in health (give example)						
Evidence provided on 'Doing' – any documents emailed to consultant or reference to website						
4. Being (the way the network/alliance/consortium operates internally in order to provide services)	**1**	**2**	**3**	**4**	**5**	**6**
Network/organization has appropriate legal status / constitution and complies with it						
Competent leadership: visionary, incorruptible, manages internal conflicts, timely decision making, result /culture-oriented, accessible / accountable to staff and external stakeholders (tick all apply)						
Competent staff: sufficient, qualified (technical and administrative), committed to quality						

Clear and sustainable financial plan and criteria on resource allocation for core business or strategies						
Uses participatory approaches in planning, implementing and managing projects in host country institutions						
Transparent structures and systems that ensure optimal use of resources and that safeguard unity yet allow for autonomy of members						
Evidence on the networks "being" any documents emailed to consultant or reference to website						
5. Relating (Extent to which the network/alliance/consortium relates to others in the health sector)	**1**	**2**	**3**	**4**	**5**	**6**
Knows other relevant actors trying to influence HRH to strengthen Africa's Health systems e.g., SADC						
Has active collaboration and exchange with other networks/organizations in the area without compromising on ideals and principles						
Initiates and actively maintains relevant relations with other stakeholders at all levels (international/ /regional/national)						
Accountable and supportive to all members /stakeholders						
Self-confident, business-like and adequate relation with donors/development partners						
Evidence by network on Relating -any documents emailed to consultant or reference to website						

6. (a) Who are the network/consortium sponsors (b) What role do WHO, SADC, NEPAD, IGAD play)? (c) What is the overall annual budget (US dollars)?

7. What are the strengths, weaknesses, opportunities, threats of your regional network/centre/organization/ consortium?

a) Strengths: _____
b) Weaknesses_____
c) Opportunities_____
d) Threats_____

8. What are your recommendations for effective networking in the area of human resource for health development and management in order to improve health system performance in sub-Saharan Africa?

9. Any other comments/ suggestions?

Appendix B1: Africa Health Leadership and Management Network (AHLMN)

Name of Network/Consortium: ***Africa Health Leadership and Management Network (AHLMN)***
Date established: ***December 2008***
Type: ***Not-for-profit international NGO***
Country (HQ office where network is hosted) ***Kenya, Nairobi*** *(temporarily at AMREF HQ)*
Name any regional offices (if any): ***None***
Date commenced operations in Eastern and Southern Africa region: ***December 2008***
*Name and Designation of person filling questionnaire****: Dr. Peter Ngatia, Chairperson***

Characteristic of Network/Alliance/Consortium 1 = less developed, 6 = well-developed	***1***	***2***	***3***	***4***	***5***	***6***
1. Position						
NETWORK IS KNOWN IN REGION FOR DISTINCTIVE COMPETENCE AND PROVEN PERFORMANCE IN DEVELOPMENT /MANAGEMENT OF HUMAN RESOURCE FOR HEALTH (HRH)			X			
Network has a positive image amongst relevant stakeholders: International/Regional/National				X		
Evidence on Position (Supporting documents – fact that Chairperson invited to present at HMC under ECSA-HC, Kamapla Feb 15 -19 2010)						
2. **Thinking and learning (internal reactions to external change)**	**1**	**2**	**3**	**4**	**5**	**6**
Has well formulated policy and strategic plan on HRH which is understood by all members						X
Has commitment to equity and achieving positive outcomes for Health Systems in member countries						X
Recognizes diversity and conflicting interests in HRH development/ management in member countries						X
Uses internal evidence from monitoring to improve quality and performance of the network					X	
Its strategies and practices are driven by external evidence on best practices					X	
Evidence on thinking and learning (Business plan emailed to consultant)						
3. Doing (output: core business)	**1**	**2**	**3**	**4**	**5**	**6**
Its projects and activities are relevant and answer urgent and serious needs of health system needs in host countries						X
Promotes equity through Training; Research; Funding; ICT Service Development; Documentation/sharing information; Coordination of networks; (check all that apply)					X	
Programmes are effective programmes (i) improving capacity and retention of health providers						
(ii) improving health system performance (specify) N/A						
Cost-effective interventions for human resource development and management in health (thro members)					**X**	
Evidence provided on 'Doing' – any documents emailed to consultant or reference to website						
4. Being (the way the network operates internally in order to provide services)	**1**	**2**	**3**	**4**	**5**	**6**
Network has appropriate legal status / constitution and complies with it						X
Competent leadership: visionary, incorruptible, manages internal conflicts, timely decision making, result /culture-oriented, accessible / accountable to staff and external stakeholders (tick all apply)					X	
Competent staff: sufficient, qualified (technical and administrative), committed to quality			X			
Clear and sustainable financial plan and criteria on resource allocation for core business or strategies	X					
Uses participatory approaches in planning, implementing and managing projects and activities in host country institutions				X		
Transparent structures and systems that ensure optimal use of resources and that safeguard unity yet allow for autonomy of members (Still being set up)			X			
Evidence on the networks "being" any documents emailed to consultant or reference to website						

5. Relating (Extent to which the network works together with others in the health sector)	**1**	**2**	**3**	**4**	**5**	**6**
Knows other relevant actors trying to influence HRH to strengthen Africa's Health systems						X
Has active collaboration and exchange with other networks/organizations in the area without compromising on ideals and principles						X
Initiates and actively maintains relevant relations with other stakeholders at all levels (international/ /regional/national)				X		
Accountable and supportive to all members /stakeholders					X	
Self-confident, business-like and adequate relation with donors/development partners (N/A)						
Evidence by network on Relating -any documents emailed to consultant or reference to website						

6. Who are the network/consortium sponsors (list or refer to website)? What is the overall annual budget (US dollars)?

2009 – used about US $ 16,000 from AMREF to run activities of the AHLMN. Budget for 2010 is about US $ 54,000

From Business plan 2009-2011: the budget is $1,365,925 (available = $334,850) shortfall $1,031,075

7. What are the strengths, weaknesses, opportunities, threats of your network, Alliance or Consortium?

a) Strengths:

- Network provides opportunity for members to share strategic as well as operational interests and concerns
- Minimizes duplication of activities in the region
- Opens opportunity for teaming up – multi-agency, multi-disciplinary work
- Has developed a business plan

b) Weaknesses:

- Requires a champion or individual commitment as members tend to be very passive
- Weak legal mandate is a challenge as some members unsure of the participation
- Limited resources as the expected membership drive has not worked – 7/33 paid
- Network has no formal relationship with the Governments

c) Opportunities:

- Ownership opportunity - The network is based in Africa
- Marketing opportunity - Invited to address the Health Ministers Conference organized by ECSA-HC in Feb 2010

d) Threats:

- There are already too many networks focusing on public health in Africa and most tend to be funded

8. What are your recommendations for effective networking in the area of human resource for health development and management in order to improve health system performance in sub-Saharan Africa?

- Need a charter to help clarify the legal mandate of the network.
- Approach Ministry of Health to facilitate member institutions
- Requires technical and financial support /gap

9. Any other comments/ suggestions?

- AMREF will use existing linkages to other training institutions – Strathmore University to expand (offers diploma (PSSP) to health practitioners and to use as model for training incorporating business approach

Appendix B2: Africa Health Workforce Observatory (AHWO)

Name of Network/Alliance/Consortium ***Africa Health Workforce Observatory (AHWO)***
Date established: ***30 June 2007***
Type: ***Consortium***
Country (where network HQ /secretariat office is hosted) ***CONGO BRAZZAVILLE***
Name Regional offices/nodes in Eastern and Southern Africa (if any) ***None***
Date commenced operations in Eastern and Southern Africa region: 2007
Name and Designation of person filling questionnaire: ***Adam AHMAT, Coordinator of the Observatory***

Characteristic of Network/Alliance/Consortium 1 = less developed, 6 = well-developed	***1***	***2***	***3***	***4***	***5***	***6***
1. Position						
NETWORK/OBSERVATORY IS KNOWN IN REGION FOR DISTINCTIVE COMPETENCE AND PROVEN PERFORMANCE IN DEVELOPMENT /MANAGEMENT OF HUMAN RESOURCE FOR HEALTH (HRH)				x		
Network has a positive image amongst relevant stakeholders: International/Regional/National						x
Evidence on Position (Supporting documents emailed to consultant or reference to website)						
2. **Thinking and learning (internal reactions to external change)**	**1**	**2**	**3**	**4**	**5**	**6**
Has well formulated policy and strategic plan on HRH which is understood by all members					x	
Has commitment to equity and achieving positive outcomes for Health Systems in member countries		x				
Recognizes diversity and conflicting interests in HRH development/ management in member countries				x		
Uses internal evidence from monitoring to improve quality and performance of the network					x	
Its strategies and practices are driven by external evidence on best practices					x	
Evidence on thinking and learning (any documents emailed to consultant or reference to website)						
3. Doing (output: core business)	**1**	**2**	**3**	**4**	**5**	**6**
Its projects and activities are relevant and answer urgent and serious needs of health system needs in host countries				x		
Promotes equity through Training; Research; Funding; ICT Service Development; Documentation/sharing information; Coordination of networks/observatory; (check all that apply)	x					
Programmes are effective programmes (i) improving capacity and retention of health providers				x		
(ii) improving health system performance (specify)				x		
Cost-effective interventions for human resource development and management in health					**x**	
Evidence provided on 'Doing' – any documents emailed to consultant or reference to website						
4. Being (the way the observatory operates internally in order to provide services)	**1**	**2**	**3**	**4**	**5**	**6**
Network/observatory has appropriate legal status / constitution and complies with it					x	
Competent leadership: visionary, incorruptible, manages internal conflicts, timely decision making, result /culture-oriented, accessible / accountable to staff and external stakeholders (tick all apply)					x	
Competent staff: sufficient, qualified (technical and administrative), committed to quality					x	
Clear and sustainable financial plan and criteria on resource allocation for core business or strategies					x	
Uses participatory approaches in planning, implementing and managing projects and activities in host country institutions						x
Transparent structures and systems that ensure optimal use of resources and that safeguard unity yet allow for autonomy of members						x

Evidence on the networks "being" any documents emailed to consultant or reference to website						
5. Relating (Extent to which the network/observatory together with others in the health sector)	**1**	**2**	**3**	**4**	**5**	**6**
Knows other relevant actors trying to influence HRH to strengthen Africa's Health systems						x
Has active collaboration and exchange with other networks/organizations in the area without compromising on ideals and principles					x	
Initiates and actively maintains relevant relations with other stakeholders at all levels (international/ /regional/national)						x
Accountable and supportive to all members /stakeholders			x			
Self-confident, business-like and adequate relation with donors/development partners					x	
Evidence by network on Relating -any documents emailed to consultant or reference to website						

6. Who are the network/consortium sponsors (list or refer to website)? What is the overall annual budget (US dollars)?

7. What are the strengths, weaknesses, opportunities, threats of your network/centre/organization/ consortium?

a) Strengths:
- Support of WHO and Partners
- Competencies of the staff of the secretariat

b) Weaknesses:
- Staff overloaded in regional level
- Low capacities in country level to undertake research in HRH
- Lack of human resources and funding to implement national plan of work
- Misunderstanding of the network in country level
- Weak the HRH information systems in country level

c) Opportunities:
- A momentum to move forward to address HRH crisis in Africa
- The Observatory is being attractive
- Willing of the stakeholders to work together

d) Threats: More expectations on the observatory

8. What are your recommendations for effective networking in the area of human resource for health development and management in order to improve health system performance in sub-Saharan Africa?

1. Strengthen the HRH information system at country level
2. Promote and support research in HRH
3. Involve stakeholders to address HRH issues in all levels
4. Promote the generation and the use of evidence for decision making
5. Sharing systematically best practices and evidence

9. Any other comments/ suggestions?

Appendix B3: Regional Eastern, Central and Southern Africa Health Community (ECSA-HC)

Name of Network/Consortium: ***The Regional Eastern, Central and Southern Africa Health Community (ECSA-HC)***

Date established: **1974**

Type: **Inter-governmental Organization**

Country (HQ office where network is hosted): **Tanzania**

Name any regional offices (if any): **None**

Date commenced operations *in Eastern and Southern Africa region:* ***1974***

Name and Designation of person filling questionnaire***: Dr. Hellen Lugina, Ag. Director General***

Characteristic of Network/Cooperation ***1 = less developed, 6 = well-developed***	***1***	***2***	***3***	***4***	***5***	***6***
1. Position						
NETWORK/OBSERVATORY IS KNOWN IN REGION FOR DISTINCTIVE COMPETENCE AND PROVEN PERFORMANCE IN DEVELOPMENT /MANAGEMENT OF HUMAN RESOURCE FOR HEALTH (HRH)						
Network has a positive image amongst relevant stakeholders: International/Regional/National						
Evidence on Position (Supporting documents emailed to consultant or reference to website)						
2. **Thinking and learning (internal reactions to external change)**	**1**	**2**	**3**	**4**	**5**	**6**
Has well formulated policy and strategic plan on HRH which is understood by all members						
Has commitment to equity and achieving positive outcomes for Health Systems in member countries						
Recognizes diversity and conflicting interests in HRH development/ management in member countries						
Uses internal evidence from monitoring to improve quality and performance of the network						
Its strategies and practices are driven by external evidence on best practices						
Evidence on thinking and learning (any documents emailed to consultant or reference to website)						
3. Doing (output: core business)	**1**	**2**	**3**	**4**	**5**	**6**
Its projects and activities are relevant and answer urgent and serious needs of health system needs in host countries						
Promotes equity through Training; Research; Funding; ICT Service Development; Documentation/sharing information; Coordination of networks/organizations; (check all that apply)						
Programmes are effective programmes (i) improving capacity and retention of health providers						
(ii) improving health system performance (specify)						
Cost-effective interventions for human resource development and management in health						
Evidence provided on 'Doing' – any documents emailed to consultant or reference to website						
***4.* Being (the way the organization operates internally in order to provide services)**	**1**	**2**	**3**	**4**	**5**	**6**
Network/organization has appropriate legal status / constitution and complies with it						
Competent leadership: visionary, incorruptible, manages internal conflicts, timely decision making, result /culture-oriented, accessible / accountable to staff and external stakeholders (tick all apply)						
Competent staff: sufficient, qualified (technical and administrative), committed to quality						
Clear and sustainable financial plan and criteria on resource allocation for core business or strategies						
Uses participatory approaches in planning, implementing and managing projects and activities in host country institutions						
Transparent structures and systems that ensure optimal use of resources and that safeguard unity yet allow for autonomy of members						

Evidence on the networks "being" any documents emailed to consultant or reference to website						
5. Relating (Extent to which the organization together with others in the health sector)	**1**	**2**	**3**	**4**	**5**	**6**
Knows other relevant actors trying to influence HRH to strengthen Africa's Health systems						
Has active collaboration and exchange with other networks/organizations in the area without compromising on ideals and principles						
Initiates and actively maintains relevant relations with other stakeholders at all levels (international/ /regional/national)						
Accountable and supportive to all members /stakeholders						
Self-confident, business-like and adequate relation with donors/development partners						
Evidence by network on Relating -any documents emailed to consultant or reference to website						

6. Who are the network/consortium sponsors (list or refer to website)? What is the overall annual budget (US dollars)?

7. What are the strengths, weaknesses, opportunities, threats of your network, Alliance or Consortium?

a) Strengths:

- Technical expert teams in each area of programme/theme
- Potential to influence policy using best practices - Streamlined process of transitioning from Policy to programming to implementation
- Competencies in many areas: health policy analysis, development and advocacy, harmonization of health policies and guidelines, capacity building of HRH, provision of technical assistance, research, dissemination and re-packing, HSS, monitoring and evaluation of impact of health policies, programmes and budgets
- Enjoys support from Member states as they are the ones who establish the ECSA –HC agenda
- Long established history and experiences since 1974 (over 35 years)

b) Weaknesses:

- Inadequate financing
- Inadequate technical capacity for the priority programme areas
- High expectations of ECSA responsibilities by the Member States
- Not all member states are active

c) Opportunities:

- Regional block to lobby for voice on international issues affecting health in Africa

d) Threats:

- Conflict in the region

8. What are your recommendations for effective networking in the area of human resource for health development and management in order to improve health system performance in sub-Saharan Africa?

9. Any other comments/ suggestions?

Appendix B4: HEALTH Alliance (houses LIPHEA project)

Name of Network/Alliance/ ***HEALTH Alliance (houses LIPHEA project)***
Date established: ***2006 under Association of schools of public health in EA***
Type: ***public universities***
Country (where Network's HQ/Secretariat office is located): **Uganda**
Regional offices/Nodes: Tanzania**, Ethiopia, Kenya (Nairobi, Eldoret), DRC, Rwanda**
Date commenced operations *in host country:* ***Initially Muhimbili & Uganda then involved other countries***
Name/Designation of person filling questionnaire***: Dr. Simiyu Tabu; Kenya Country representative***

Characteristic of Network/Alliance/Consortium 1 = less developed, 6 = well-developed	***1***	***2***	***3***	***4***	***5***	***6***
1. Position						
NETWORK/ALLIANCE/CONSORTIUM IS KNOWN IN REGION FOR DISTINCTIVE COMPETENCE AND PROVEN PERFORMANCE IN DEVELOPMENT /MANAGEMENT OF HUMAN RESOURCE FOR HEALTH			x			
Network has a positive image amongst relevant stakeholders: International/Regional/National					x	
Evidence on Position (Supporting Documents provided by network)				**x**		
2. **Thinking and learning (internal reactions to external change)**	**1**	**2**	**3**	**4**	**5**	**6**
Has well formulated policy and strategic plan on human resource which is understood by all members			x			
Has commitment to equity and achieving positive outcomes for network members				x		
Recognizes diversity and conflicting interests in human resource development among members				x		
Uses internal evidence from monitoring to improve quality and performance of the network					x	
Its strategies and practices are driven by external evidence on best practices			x			
Evidence on thinking and learning (documents provided by organization/network)					**x**	
3. Doing (output: core business)	**1**	**2**	**3**	**4**	**5**	**6**
Its projects and activities are relevant and answer urgent and serious needs of health system needs in host countries					x	
Promotes equity through Training; Research; Funding; ICT Service Development; Documentation/sharing information; Coordination of network/alliance; (check all that apply)				x		
Programmes are effective programmes (i) improving capacity and retention of health providers		x				
(ii) improving health system performance (specify)		x				
Cost-effective interventions for human resource development and management in health		**x**				
Evidence provided on 'Doing'					**x**	
4. Being (the way the network/alliance operates internally in order to provide services)	**1**	**2**	**3**	**4**	**5**	**6**
Network/Alliance has appropriate legal status / constitution and complies with it					x	
Competent leadership: visionary, incorruptible, manages internal conflicts, timely decision making, result /culture-oriented, accessible / accountable to staff and external stakeholders (tick all apply)			x			
Competent staff: sufficient, qualified (technical and administrative), committed to quality			x			
Clear and sustainable financial plan and criteria on resource allocation for core business or strategies			x			
Uses participatory approaches in planning, implementing and managing projects and activities in host country institutions				x		
Transparent structures and systems that ensure optimal use of resources and that safeguard unity yet allow for autonomy of members			x			
Evidence provided on the networks "being"						

5. Relating (Extent to which the network/alliance works together with others in the health sector)	**1**	**2**	**3**	**4**	**5**	**6**
Knows other relevant actors trying to influence HRH to strengthen Africa's Health systems	x					
Has active collaboration and exchange with other networks/organizations in the area without compromising on ideals and principles					x	
Initiates and actively maintains relevant relations with other stakeholders at all levels (international/ /regional/national)						x
Accountable and supportive to all members /stakeholders			x			
Self-confident, business-like and adequate relation with donors/development partners					x	
Evidence provided by network on Relating					x	

6. Who are the programme / project sponsors (list all since inception)? What is the overall budget (US dollars)? USAID, HED, CDC.

7. What are the strengths, weaknesses, opportunities, threats of your network/centre/organization/ institution?

a) Strengths: Brought public Health practitioners together, Regional scientific/research organisation have a forum to exchange ideas, forum for research/publishing, website, developed common material for teaching, regular meetings, workshops and international conference sponsorships
b) Weaknesses: Lack of transparency esp. financial planning and management, late invitations, lack of hands-on team, Lack of funding for planned activities
c) Opportunities:

- Disasters common in the region, and similar,
- Ready market for short courses, we already have staff with basic training

d) Threats: Competing priorities, donor fatigue. difficult integration with the mainstream government8.

8. What are your recommendations for effective networking in the area of human resource for health development and management in order to improve health system performance in sub-Saharan Africa? Development of common curriculum, short courses, Agreed standards in Public health

9. Any other comments/ suggestions?

Appendix B5: Health Economics and Policy Network (HEPNET)

Name of Network/Alliance/consortium/ **Health Economics and Policy Network**
Date established: ***2000***
Type: ***Government, Parastatal/semi-governmental, Private, NGO, Consortium***
Country (Network's HQ/secretariat office): **SOUTH AFRICA**
Regional offices/Nodes/members: **Kenya, Uganda, Tanzania, Zambia, Zimbabwe, Ghana, Nigeria**
Date commenced operations *in host country/region:* ***YEAR 2000***
Name/Designation of person filling questionnaire***:_OLUFUNKE A ALABA (COORDINATOR)***

Characteristic of Network/Alliance/Consortium 1 = less developed, 6 = well-developed	***1***	***2***	***3***	***4***	***5***	***6***
1. Position						
NETWORK/ALLIANCE/CONSORTIUM IS KNOWN IN REGION FOR DISTINCTIVE COMPETENCE AND PROVEN PERFORMANCE IN DEVELOPMENT /MANAGEMENT OF HUMAN RESOURCE FOR HEALTH						X
Network has a positive image amongst relevant stakeholders: International/Regional/National						X
Evidence on Position (Supporting Documents provided by network)						
2. **Thinking and learning (internal reactions to external change)**	**1**	**2**	**3**	**4**	**5**	**6**
Has well formulated policy and strategic plan on human resource which is understood by all members					X	
Has commitment to equity and achieving positive outcomes for network members						X
Recognizes diversity and conflicting interests in human resource development among members					X	
Uses internal evidence from monitoring to improve quality and performance of the network					X	
Its strategies and practices are driven by external evidence on best practices					X	
Evidence on thinking and learning (documents provided by organization/network)						**X**
3. Doing (output: core business)	**1**	**2**	**3**	**4**	**5**	**6**
Its projects and activities are relevant and answer urgent and serious needs of health system needs in host countries						X
Promotes equity through Training; Research; Funding; ICT Service Development; Documentation/sharing information; Coordination of networks/organizations; (check all that apply)						X
Programmes are effective programmes (i) improving capacity and retention of health providers						X
(ii) improving health system performance (specify)						
Cost-effective interventions for human resource development and management in health				**X**		
Evidence provided on 'Doing'						
***4.* Being (the way the network operates internally in order to provide services)**	**1**	**2**	**3**	**4**	**5**	**6**
Network has appropriate legal status / constitution and complies with it						X
Competent leadership: visionary, incorruptible, manages internal conflicts, timely decision making, result /culture-oriented, accessible / accountable to staff and external stakeholders (tick all apply)						X
Competent staff: sufficient, qualified (technical and administrative), committed to quality						X
Clear and sustainable financial plan and criteria on resource allocation for core business or strategies						X
Uses participatory approaches in planning, implementing and managing projects and activities in host country institutions						X
Transparent structures and systems that ensure optimal use of resources and that safeguard unity yet allow for autonomy of members						X
Evidence provided on the networks "being"						
5. Relating (Extent to which the network works together with others in the health	**1**	**2**	**3**	**4**	**5**	**6**

sector)						
Knows other relevant actors trying to influence HRH to strengthen Africa's Health systems						X
Has active collaboration and exchange with other networks/organizations in the area without compromising on ideals and principles						X
Initiates and actively maintains relevant relations with other stakeholders at all levels (international/ /regional/national)						X
Accountable and supportive to all members /stakeholders						X
Self-confident, business-like and adequate relation with donors/development partners						X
Evidence provided by network on Relating						

6. Who are the programme / project sponsors (list all since inception)? What is the overall budget (US dollars)?

The main sponsor is Swedish International Development Cooperation Agency (SIDA)

7. What are the strengths, weaknesses, opportunities, threats of your network/centre/organization/ institution?

a) Strengths: The Health Economics and Policy Network in Africa (HEPNet) is a network of institutions in a number of African countries that has contributed to health sector development in the region by:- promoting networking activities between member institutions and with international organisations active in the region; strengthening, promoting and increasing the scope of capacity building in health economics and policy research in Africa.

b) Weaknesses: The overall vision of HEPNet is to develop capacity in Health Economics and Health Policy Research in Sub-Saharan Africa. However, the current network member-countries is limited to only 8. There is need to cover more countries in Africa.

c) Opportunities: A very good and established platform to improve and increase capacity development relevant to health economics and policy research in Africa. This could be done through grants, bursaries and sponsorship to attend conferences and workshops. HEPNet provides opportunities for researcher and policy makers to be at the best in their field. HEPnet sponsored 17 participants to the World Conference of Health Economist in China in June 2009 and 23 members were supported to the Inaugural meeting of the African Health Economics and Policy Association (A*f*HEA) held in Ghana, in 2009. The sponsorship cut across both researchers and policymakers, indicating the vision for symbiotism between research and policymaking.

d) Threats: DUE TO THE TERMINATION OF SIDA FUNDING; THE MAIN FUNDERS OF HEPNET, THE CONTINUITY OF HEPNet IS VERY DOUBTFUL

8. What are your recommendations for effective networking in the area of human resource for health development and management in order to improve health system performance in sub-Saharan Africa?

9. Any other comments/ suggestions?

There is still limited human resource capacity to undertake policy analyses of the strategic options for designing and implementing health sector restructuring in African countries. Thus, the need to develop and sustain a critical mass of people with relevant expertise in the African region, preferably through established networks.

Appendix B6: Inter-University Council for East Africa (IUCEA)

Name of Consortium: ***IUCEA Thematic Clusters' Set-up in this case – Health and Health Sciences Thematic Cluster.***
Date established: **Established in 1980, Revitalized in 2000**
Type: ***Inter-Governmental (East African Community COUNTRIES)***
Country (Network's HQ/Secretariat office): **Uganda**
Regional offices/Nodes/: **None**
Date **1960s as IUC and 1980-MOU for IUCEA** commenced operations *in host country/region:* ***Uganda, Kampala***
Designation of person filling questionnaire***: Dr. Ben Mtasiwa, Programmes and Projects Officer***

Characteristic of Network/Alliance/Consortium 1 = less developed, 6 = well-developed	***1***	***2***	***3***	***4***	***5***	***6***
1. Position						
NETWORK/ALLIANCE/CONSORTIUM IS KNOWN IN REGION FOR DISTINCTIVE COMPETENCE AND PROVEN PERFORMANCE IN DEVELOPMENT /MANAGEMENT OF HUMAN RESOURCE FOR HEALTH				X		
Network has a positive image amongst relevant stakeholders: International/Regional/National				X		
Evidence on Position (Supporting Documents provided by organization)						
2. **Thinking and learning (internal reactions to external change)**	**1**	**2**	**3**	**4**	**5**	**6**
Has well formulated policy and strategic plan on human resource which is understood by all members				X		
Has commitment to equity and achieving positive outcomes for network members				X		
Recognizes diversity and conflicting interests in human resource development among members				X		
Uses internal evidence from monitoring to improve quality and performance of the network			X			
Its strategies and practices are driven by external evidence on best practices				X		
Evidence on thinking and learning (documents provided by organization/network)						
3. Doing (output: core business)	**1**	**2**	**3**	**4**	**5**	**6**
Its projects and activities are relevant and answer urgent and serious needs of health system needs in host countries			X			
Has Potential to Promote equity through Training; Research; Funding; ICT Service Development; Documentation/sharing information; Coordination of networks/organizations; (check all that apply)						
Potential for Programmes effectiveness programmes (i) improving capacity and retention of health providers (ii) improving health system performance (specify)						
Cost-effective interventions for human resource development and management in health						
Evidence provided on 'Doing'						
***4.* Being (the way the institution/network operates internally in order to provide services)**	**1**	**2**	**3**	**4**	**5**	**6**
Network/Alliance/Consortium has appropriate legal status / constitution and complies with it						X
Competent leadership: visionary, incorruptible, manages internal conflicts, timely decision making, result /culture-oriented, accessible / accountable to staff and external stakeholders (tick all apply)				X		
Competent staff: sufficient, qualified (technical and administrative), committed to quality					X	
Clear and sustainable financial plan and criteria on resource allocation for core business or strategies				X		
Uses participatory approaches in planning, implementing and managing projects and activities in host country institutions				X		
Transparent structures and systems that ensure optimal use of resources and that safeguard unity yet allow for autonomy of members				X		
Evidence provided on the networks "being"						
5. Relating (Extent to which the *Network/Alliance/Consortium works* together with	**1**	**2**	**3**	**4**	**5**	**6**

others in the health sector)						
Potentially Knows other relevant actors trying to influence HRH to strengthen Africa's Health systems						X
Has potential for active collaboration and exchange with other networks/organizations in the area without compromising on ideals and principles						X
Initiates and actively maintains relevant relations with other stakeholders at all levels (international/ /regional/national)				X		
Accountable and supportive to all members /stakeholders					X	
Self-confident, business-like and adequate relation with donors/development partners					X	
Evidence provided by network on Relating						

6. Who are the programme / project sponsors (list all since inception)? What is the overall budget (US dollars)?

- Governments of the Partner States, Member Universities through subscription fees and Development Partners
- Ford Foundation, Rockefeller foundation, European Union, East African Development Bank, SIDA Sarec, Norweigian AID, DAAD, DfID et.c.
- The budget has on average been at USD 5,000,000

7. What are the strengths, weaknesses, opportunities, threats of your network/centre/organization/ institution? Ref; The IUCEA Corporate Strategic Plan 2006 - 2011

a) Strengths:

- Governance: Effective Governing board in terms of Affiliation representing the right stakeholder community,___
- Administration: Governing Board – Management Linkage effectiver, Staff Capacity good, related to effective remuneration package structure, administrative structure strategically filled covering key areas of coordination – Public Relations, Administration, ICT, Programmes and Projects, Quality Assurance, Finance and Internal Audit
- Information sharing and flow effective by structured forums like general Staff meeting, Management committee and soon to be introduced, inter-unit committee.
- Have newsletter, brochures

b) Weaknesses:

- Resources for implementation of the strategic plan inadequate because of limited resource mobilization avenues

Inadequate strategic focus.

- Corporate culture is inadequately established, e.g. No shared values formally agreed on, inadequate teamwork.

Public image

- IUCEA is not well known.
- Newsletter is published less frequently (biannually) and poorly circulated.
- Website not attractive

c) Opportunities:

- Implementation of the EAC protocol – customs union, common market and later monetary and political integration, will require development of various instruments for harmonization which will be based on harmonization of education and especially higher education. This will be of immense opportunity for the IUCEA as an institution mandated to coordinate inter-university coordination and harmonization of the Higher Education systems. These create a conducive political and economic environment for cooperation and regional programming in education
- High Demand for Programmes under IUCEA.
- Growing numbers of member institutions.
- Growing importance of regional approaches to addressing poverty, environment, education, health and gender
- Willingness of donors to support various programmes under IUCEA.

d) Threats:

Institutional Transformation

- Governments' delays in deciding on matters which should assist in speeding up the transformation process.
- Presence of different standards of education in the different countries.

Funding

- Insufficient and unpredictable financial support from the EA Governments.

Governance

- High staff brain drain at universities.

8. What are your recommendations for effective networking in the area of human resource for health development and management in order to improve health system performance in sub-Saharan Africa?

The IUCEA based Thematic Cluster on Health and Health science should;

- Enhance networking towards curriculum development for training in Primary Health Care, in addition to various initiatives on HIV and AIDS. There are significant complementarities between these two areas
- Form research networks to take advantage of networks such as the Regional East African Community Policy initiative (REACH) which is focused on health related policy development based on research evidence

9. Any other comments/ suggestions?

The IUCEA has 13 Thematic Clusters which represent all areas of professional specialization as well as sectors in the economy and livelihoods. One of them is the Health and Health sciences. The IUCEA policy is to support interaction among scholars in these clusters at least 1 per year. They are encouraged to form networks among themselves as well as in more specialized areas which will constitute sub-theme and sub-networks. In some sub-themes, there is a possibility of networks from inter-instiututional, geographic area based et.c. It will all depend on initiatives of sub- themes or networks' members.

Appendix C: Sampling Framework for Networks and Alliances: Health Specialist B

List of Networks/Alliances engaged in HRH (HSS) training, research, practice in Eastern and Southern Africa

	Name of network/ alliance/ centre/ Trust/ Consortium	*Internet-based Broad scan*	*Selected Profiled Form A*	*In-depth interview Form B*	*Names of persons/ titles who responded to questionnaires*
	Total	***N=54***	***n=27***	***n=18***	***n=11***
1.	WHO -Alliance for Health Policy and Systems Research (AHPSR)- Geneva, Switzerland	Alliance based in Geneva	Yes	No	Information from website
2.	WHO/AFRO – Global Health Workforce Alliance (GHWA) and	Alliance based in Africa	Yes	Yes	Information from website
3.	**WHO /Afro Africa Health Workforce Observatory (AHWO)**	Observatory based in Africa	Yes	Yes	**Dr. Adam AHMAT, Coordinator of the Observatory**
4.	The Regional Network on Equity in Health in Health in Southern Africa (EQUINET)- Harare	Network based in Harare	Yes	No	Information from website
5.	**Health Economics and Policy Network (HEPNet) – University of Cape Town**	Network based at UCT	Yes	Yes	**Dr. Olufunke Alaba the HEPNet coordinator**
6.	**Higher Education Leadership through Health (HEALTH) Alliance** Leadership Initiative for Public Health in East Africa (LIPHEA) –Makerere, SPH Kampala	Alliance based at SPH-MU with LIPHEA project and RCQHC	Yes	Yes	Met the Coordinator/**Dean Dr. W. Bazeyo** – Interviewed **Dr. S. Tabu**, LIPHEA coordinator, Kenya
7.	EAC Secretariat Health Desk - Regional East African Community Health (REACH)-Policy Initiative and EAIDSNet, Arusha , Tanzania	Policy initiative of EAC-Health Desk – Arusha; EAIDSNet – disease specific	Yes Profiled REACH	Yes	Information from website
8.	**The East, Central and Southern African Health Community (ECSA-HC)**	HC covering 3 regions ECS	Yes	Yes	**Dr. Hellen Lugina, Ag. Director General**
9.	Southern and Eastern Africa Policy Research Network (SEAPREN) HQs in Namibia but networks with Tanzania	Network based in Namibia covers 2 area	Yes	No	Information from website
10.	**Health Systems Trust (HST) – Durban South Africa**	A Trust hosts GEGA and member other network	Yes	Yes	**Dr. Irwin Friedman Director Research**
11.	Global Equity Gauge Alliance – (GEGA)-	Alliance 11 countries	Yes	No	Information from website
12.	Consortium for Research into Equitable Health Systems (CREHS) (SA, Nigeria, Kenya, Tanzania, India and Thailand with leadership from London School of Hygiene &Tropical Medicine	Research Consortium based in London	Yes (A)	No	Profiled form A based on internet (sent email to London no response)
13.	Centre for Health Policy (CHP) , Witwatersrand University , Johannesburg, South Africa	Research centre member of networks, Jo'burg, SA	Yes	Yes	Despite numerous communications - No response – listed
14.	**Centre for Policy Studies (CPS) , Johannesburg, South Africa**	Policy centre in Jo'burg, SA	Yes	Yes	**Dr. Thambo Rapoo Centre Director**
15.	EA Health Research Commission (EAHRC) - Arusha , Tanzania	Research commission	No	No	-
16.	African Union – Health Desk	Continental body	Yes	No	Notes from internet
17.	**The African Health and Leadership for Health Systems Network (AHLMN)**	Network based at AMREF Nairobi	Yes	Yes	**Dr. Peter Ngatia, Director Capacity Building and Chair network**
18.	**The Consortium for National Health Research (CNHR), Nairobi Kenya**	Consortium based in Nairobi	Yes	Yes	**Prof. Gilbert Kokwaro**, **Director**
19.	Higher Education Quality Committee (HEQC), SA, Pretoria	Regulatory body for higher Education in SA	Yes	Yes	Mr. K. Legire Programme officer HEQA/ Ruth -Library
20.	SAQA South African Quality Authority) - and HESA (Higher Education South Africa)	Regulatory body for HE in SA.	Yes	Yes	Notes based on internet
21.	**Southern African Research and Innovation Management Association (SARIMA)**	Research/training association	Yes	Yes	**Ms. Corline Kriel coordinator**
22.	**Medical Research Council (MRC) of South Africa, Cape Town,**	Research council	Yes	Yes	**Dr. Muhammad Ali Dhansay (Vice-President research) and Dr. Sandile Williams (Senior Research**

					Manager
23.	New Partnership for Africa's Development (NEPAD) and Southern African Development Community (SADC) – South Africa	Developmental partnership -Africa	Yes	No	Information from website
24.	African Networks for Health Research and Development (AFRO-NETS)	Internet based network	Yes	No	Information from website
25.	**Inter-University Council for East Africa (IUCEA) – EAC, Kampala, Uganda**	EAC council for HE	Yes	Yes	**Dr. Ben Mtasiwa, programme Officer**
26.	Commission for Higher Education, Kenya	Kenya - CHE	Yes	Visited	Notes based on visit
27.	National Commission for Higher Education, Uganda	Uganda-CHE	Yes	visited	Ambassador Yeko Acato (Ass. Executive Director) and Mr. Patrick Okae (Higher Education Officer, research and inspection)
28.	**Great Lakes University , Kisumu– Secretariat for SAHARA Network, CNHR and UNISOL**	Hosts several networks	Yes	Yes	**Prof. D. Kaseje, Vice-Chancellor**
29.	New SA – Bloemfontein Centre for Health System Research and Development (CHSRD)	Research Centre for HSD, SA	Yes-new	Yes	**Dr Christo Heurus Director and Katinka de Wet**
30.	The AURUM Institute, South Africa	Research NGO, SA	Yes-new	No	Sent email -no response
31.	African Economic Research Consortium (AERC), Nairobi 00200 Kenya	Consortium includes research on financing	Yes	No	Listed as member of other network
32.	The African Network of Scientific and Technological Institutions (ANSTI) - UNESCO Nairobi Office	Network for middle-level colleges	No	No	-
33.	African Technology Policy Studies Network (ATPS), Nairobi 00100, Kenya	Network-technology policy studies	Yes	No	Profiled A-Acknowledged email
34.	Institute of Policy Analysis and Research (IPAR), Kenya	Member of SEAPREN	No	No	Listed as members of networks already profiled
35.	Kenya Institute for Public Policy Research and Analysis (KIPPRA)	Member of AERC	No	No	Listed as members of networks already profiled
36.	Health Systems Research for Reproductive Health & Health Care Reforms in the Eastern & Southern Africa Region	Specific to reproductive health agenda	No	No	Specialized networks
37.	International University of Health Sciences, Kampala	e-learning and HSS	Visited	No	**Met Vice chancellor Prof. Deirdre Carabine still trying to establish networks**

NB. As of Monday January 11, 2010 had about n=16 interviews but today January 18, 2010 had 2 more sent and 2 more promised (ECSA-HC and GHWA) making n=20 for total form 'A' and n=8 for 'B

Appendix D: Terms of Reference – Health Specialist B

Schedule for situation Analysis – Health Specialist B

Days	*Dates*	*Activity and Venue*	*Comments*
5	26 – 30 October 2009	Id and profile networks	As scheduled
5	2 – 6 November	Id and profile regional	As scheduled
5	9 – 13 November	Analysis Profiling	As scheduled
5	16 – 20 November	Analysis SWOT	As scheduled
5	23 – 27 November	Draft tools and letters	As scheduled
5	30 – 4 December	Send out questionnaires	Done in phases by Country
5	7 – 11 December	Survey Kenya	Conducted last from 16 December, 2009
5	14 – 18 December	Survey SA	
4	21 – 25 December	Survey SA	Holiday Meeting with Keiko Kita – JICA consultant on 22nd December
4	28 – 2 January 2010	Survey Kenya	Holiday-
5	4 – 8 January 2010	Analysis of data	Reminders to email questionnaires/ Kenya /WHO
5	11 – 15 January 2010	Draft report to JICA	Meeting with Ikuo and Keiko at JICA on January 2010
5	18 – 22 January 2010	Workshop	To set date after draft report ready
5	25 – 29 January 2010	Review Final report –	Hand in to JICA as planned
68 days- This contract was for 60 days , the 8 days were holiday-time taken and not worked			

JAPAN INTERNATIONAL CO-OPERATION AGENCY

REPORT ON THE NEEDS ASSESSMENT FOR STRENGTHENING HUMAN RESOURCE FOR HEALTH (HRH) SERVICES MANAGEMENT AND ADMINISTRATION

BY

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JANUARY 2010

ACRONYMS

AFENET	African Field Epidemiology Network
AHLMN	Africa Health Leadership and Management Network
AIDS	Auto Immune Deficiency Syndrome
AMREF	African Medical Research Foundation
AU	African Union
CPHR	Centre for Public Health Research
DFID	UK Department for International Agency
DRC	Democratic Republic of Congo
G8	Group of 8
GLUK	Great LakesUniversity of Kisumu
GM	General Management
HEPNet	Health Education and Promotion Network
HIV	Human Immune Deficiency Virus
HR	Human Resource
HRH	Human Resource for Health
HSM	Health Systems Management/Health Systems Manager
HSM&A	Health Systems Management & Administration
ICRC	International Committee of the Red Cross
JICA	Japan International Co-operation Agency
JLI	Joint Learning Initiative
KeMU	KenyaMethodistUniversity
KMTC	KenyaMedicalTrainingCollege
KEMRI	Kenya Medical Research Institute
MDG	Millennium Development Goals
MoH	Ministry of Health
MPH	Masters Degree in Public Health
MUHAS	MuhimbiliUniversity of Health and Allied Sciences
NASCOP	National STI AIDS Control Program
NGO	Non-governmental Organization
NUFFIC	Netherlands Organization for International Co-operation in Higher Education
PHSWOW	Public Health Schools Without Walls
SA	South Africa
SAHARA	Social Aspects of AIDS Research Alliance
SIDA	Swedish International Development Agency
TEPHINET	Training Programs in Epidemiology and Public Health Interventions Network
TICAD IV	Tokyo International Conference on African Development IV
UEAB	University of East Africa, Baraton
UKZN	University of KwaZulu Natal
UNDP	United Nations Development Program
UNESCO	United Nations Educational Scientific Cultural Organization
UNICEF	The United Nation's Children's Fund
USAID	United States Agency for International Development
VVOB	Flemish Association for Development Cooperation and Technical Assistance

EXPLANATION OF TERMS

General Management Training Program	Refers to management training programs whose curriculum or subjects taught are **not specific to health systems** or for health professionals. These are taught to professionals of any field, including health.
Exclusive Health Systems Management Training Program	Refers to a management training program **focused o**n HSM.
Comprehensive Health Systems Management Training Program	Refers to an exclusive management training program which is **dedicated** to training in health systems management, **as opposed to** programs that offer **some** HSM units or topics within other training programs e.g. MPH.
Selective Health Systems Management Training Program	Refers to an exclusive health systems management training program(s) that **do not** have dedicated training in health systems management but provides this training as a unit (topic) or two within another program e.g. MPH.

Table of Contents

1.0 Executive Summary:

This study, which was conducted as part of the study by JICA to explore the possibility to support regional programs and activities in Eastern and Southern Africa towards contributing to the sustainable development of HRH, aimed to identify higher educational and research institutions, both public and private, which pose strategic implications for sustainable development, particularly HSM&A, and make recommendations for strengthening existing programs as well as possible future JICA partnership with these institutions.

Internet search, use of Organization's data bases, review of institutional documents and administration of a questionnaire were used to collect data from institutions of higher learning in 24 East and South African target countries(six of which were excluded due to country communication languages which the investigator was unfamiliar with).

Due to JICA's prevailing administrative constraints in addition to the presence of a relatively higher concentration of candidate institutions of higher learning and existence of current assistance programs and offices in specific countries of the East and South African region, it was decided that only two countries (Kenya and South Africa) be selected for a detailed collection of information. Visits, to selected institutions within these two countries, were made during which time structured questionnaires (electronic or hard copy) were left with relevant respondents for self administration (and subsequent return to the investigator) while institutional documents were collected for review. Two additional countries, Uganda and Tanzania, were also included in this process on the investigators conviction that these countries have contributed immensely to training in the region for several decades.

Data from questionnaires were entered into computer using MS Access while that from document reviews were manually coded and all analyzed.

Findings:

It is apparent that training in HSM, as a profession for health workers, is not an established phenomenon in the East and South African region and health systems appear to be largely managed by technical health workers with little or no management and administrative skills. Even for trained health systems leaders, most have general administrative and management qualifications that are not specific to health systems.

Thirty three (44%) of the 75 institutions, whose status in leadership training is known, provide HSM training, suggesting that this is a less attractive profession particularly given that fewer of these institutions have exclusive HSM programs as is the case with Kenya Methodist University, Strathmore University, University of Cape Town, University of Witwatersrand and Makerere University among others. Other institutions do not have exclusive programs and provide their training in HSM as units in other health related programs such as MPH. As a consequence, HSM training continues to be given comparatively lesser attention by training institutions and by extension, health professionals.

Generally both comprehensive HSM and general management (GM)training institutions are largely government owned (54.7%) with most of the total having been established within the last three decades mainly in response to the expanding market needs for higher education. As such, most of the comprehensive HSM graduate and higher degree programs have been established relatively recently. Nevertheless, there exists the institutional infrastructure and expertise necessary for training in HSM in the region for short courses, certificate and diploma programs. Higher level training (degree and higher degree) programs are limited to a few institutions and therefore fewer places of training exist.

Institutions largely target, for training, a wide range of health professionals in employment who work at different levels of the public and private health systems. As such most of the institutions (such as Makerere in Uganda, AMREF, Strathmore and KeMU in Kenya, Mzumbe in Tanzania and University of the Western Cape, University of Cape Town and University of Kwa Zulu Natal in South Africa) provide short courses and certificate training programs in which participants are trained for a few days to weeks. These training programs remain the most popular in the institutions identified for this survey.

The course content of HSM training programs vary from institution to institution. While some institutions, like Strathmore University, has a comprehensive short course or certificate HSM training program, other institutions like University of the Western Cape and AMREF provide selective HSM programs that consist of one or two selected topics of health systems management and administration that are taught at any given time. Institutions with non-comprehensive HSM training programs were more likely to cover even fewer of these special HSM topics.

Institutions whose filled questionnaires were received and analyzed indicated little infrastructural training challenges. However the challenge of inadequate qualified staff, training equipment and lack of student scholarships featured prominently in both the questionnaires and during discussions. In a number of cases, the same qualified staff are used as part time or visiting trainers in a number of institutions, which is a very common feature. Most of the Kenyan universities and some South African and Ugandan institutions alluded to the existence of the practice. These arrangements of providing training services to institutions is made either at individual level (institution and the identified lecturer and to whom payment is directly made) or institutional level (where trainers provide training on behalf of their mother institutions.

Many of the institutions have memberships to existing networks and also partner with other institutions within the East and South African region. The networks to which institutions are members include AHLMN, Health Alliance and HEP Net. Membership to these networks has certain advantages to the member institutions which include exchange of resources such as scientific information, engaging in student and staff exchanges, training of staff and development of curricula among others.

2.0 Introduction:

Human Resource for Health (HRH) has been described to include all individuals engaged in the promotion, protection or improvement of population health, while Human Resource Management (HRM) has been defined as the integrated use of procedures, policies and practices to recruit maintain and develop employees in order for the organization to meet its desired goals[1]. It often includes the following components,

a) Personnel policy
b) Performance management
c) Training
d) Human resource data systems
e) Human resource strategy development
f) General leadership and management

Strategic human resource (HR) leadership and management (managing people as strategic resources), however, pose a significant challenge for most ministries of health as well as non-governmental organizations (NGOs) working in health—because there is no trained professional cadre of HR managers. HR management policies and practices are underdeveloped and if developed, these policies and practices are not universally implemented, monitored, and evaluated[2].

Ideally, a cadre of managers should be trained for the central, provincial, and district health systems levels. To make significant, sustainable improvements in HRH and in the health of populations, managers at all levels need to be able to lead and manage the health workforce, which in turn will improve performance and retention.

As a result, missing at all levels of the health systems is a critical mass of proactive, respected, and professionally trained human resource managers and specialists who have the authority and expertise to command attention, and champion a favourable response. The absence of human resource management capacity in the health sector is a key factor standing between success and failure in Africa's effort to alleviate its crushing burden of disease[2]. With just 11% of the world's population, sub-Saharan Africa is home to more than 60% of people with HIV and 90% of the world's malaria cases [3]. Africa accounts for 19 of the 20 countries world wide with the highest rates of maternal and neonatal mortality. Africa's crude birth rate is 43/1000 live births, four times the rate in Europe.

The recognition about the difficulties that weakness present in health systems will prevent achievements of the MDG has been made [5]. Difficulties with health systems performance are considered major causes for the delays in achieving key targets of the health related MDGs i.e. those related to child mortality (MDG 4)[5,6], maternal mortality (MDG 5)[7,8] and prevention of HIV/AIDS, malaria and other diseases (MDG 6). These delays are especially pronounced in countries of sub-Saharan Africa.

The dimensions of the human resource (HR) crisis in health have been reported in stark terms in publications and studies by the Joint Learning Initiative (JLI) [9]and the World Health Organization[5], among others. Despite rising attention to the general acute shortage of health care workers, little attention has been paid to the role of those who have human resource management responsibilities and whose job is to transform health workers into a productive motivated and

supported workforce capable of improving health and saving lives. There is an urgent need to professionalize this role and develop a cadre of well trained managers in health institutions both private and public. It includes expanding both the numbers of human resource managers, their role and updating their skill. These changes would enable human resource managers to be more effective in leading and implementing positive solutions that in turn will improve performance and retention of staff.

The Japanese and Italian leadership has been important in pushing the G8 to address global health issues as exemplified by the Japanese initiative at the 2000 Kyushu-Okinawa summit to propose the global fund which was endorsed by the G8 leadership at the 2001 Genoa summit.

2.0.1 Tackling the HRH Crisis:

The World Health Organization estimates that sub-Saharan African is suffering a shortage of nearly 1.5 million HRH of all kinds. In this connection, African countries, through AU resolution in the Africa Health Strategy 2007-2015, collectively regard development of human resources for health as one of the priorities in health development in the region.

Like other building blocks of the health systems, the issue of human resource for health should be addressed by individual countries reflecting needs and constraints unique to each country. However, regional networking of research and training institutions is deemed effective for the training of health administrators and managers, as the participants will benefit from exposure to experiences of other countries and from mutual learning process.

Takemi Working Group[10], an independent group organized by former Japanese parliamentarian, Mr. KeizoTakemi, with an aim of informing the policy formulation process of TICAD IV and G8 on global health, published a series of thematic papers on health systems strengthening. One of the recommendations on human resource for health was *to strengthen the international networks of higher education institutions to provide access to health and medical education in areas with limited resources*.

Consequent to the scenario described above, JICA resolved to conduct a study to explore the possibility to support regional programs and activities in Eastern and Southern Africa which can contribute to the sustainable development of HRH in the region. Among the diverse cadres included in HRH, focus was given to the training of health administrators and managers in the area of health systems management as they would benefit more from regional exchange of experiences and lessons learned.

The need therefore, to institute this study for informed decisions based on supportive data, in the mitigation of the current health worker (in particular, health systems leadership) crisis experienced by the developing world can not be over emphasized. The foregoing contributed to the genesis of this study by JICA.

2.0.2 Main Objective:

The main objective of this study was to explore the possibility to support regional programs and activities in Eastern and Southern Africa which can contribute to the sustainable development of HRH in the region through training focusing on health administrators and managers in the area of health systems management. This was intended to assist in formulation of relevant policies towards training in Health Systems Management.

2.0.2.1 Specific Objectives.

1. To identify higher educational and research institutions, both public and private, in 24 countries in Eastern and Southern Africa, which pose strategic implications for sustainable development of HRH in the region.
2. To identify existing databases of higher educational and research institutions in Sub-Sahara Africa, with focus on Eastern and Southern Africa, which can be utilized for the study.
3. To identify other readily available data sources of higher education and research institutions in Sub-Sahara Africa, with focus on Eastern and Southern Africa, which can be utilized for the study.
4. To analyze the information collected from the readily available sources, such as existing databases obtained from other organizations, web-site of each institution, and other existing materials.
5. To conduct a questionnaire survey and on-site interview survey to further verify the capacity and challenges of the identified institutions.

2.0.3 Methodology:

1. Priority institutions for data collection were those that offer training programs in the areas of health systems management (e.g., policy & planning, monitoring & evaluation, governance & leadership, health facility management, health program management, health financing, HRH management, health information management, logistics management, etc.) as well as actively receiving students from other countries in Africa.

However not only specialized institutions for health professional education (e.g., schools of public health), but also general schools (e.g., schools of public administration) which offer management training for health professionals were included as much as possible. Though the study proposed to cover 24 countries in East and Southern Africa, institutions located in countries with full-scale JICA offices, especially Kenya and South Africa, Uganda and Tanzania were given priority to be consistent as much as possible with JICA's country programs in those countries.

Information collected from these selected institutions included

- Details of the programs offered including long and short-term programs in the areas of health systems management including,

- ♦ Health policy planning
- ♦ Monitoring and evaluation of health policies and programs
- ♦ Health governance and leadership
- ♦ Health financing
- ♦ Health facility management
- ♦ Management of human resources for health
- ♦ Health information management
- ♦ Health logistics management

- Geographic coverage of the student intakes,
- Areas of specific competency covered in the teaching,
- Cooperating partners including donors,
- Membership to any networks of training institutions (e.g., network of schools of public health, etc.) shall be compiled for each of the selected institutions.

Thus for every selected institution, information collected was,

- Name of institution
- Location (Country and region in country)
- Contact information
- URL (Web-site)
- Relevant programs offered
- Geographical coverage of students/trainees and total numbers
- Specific areas of technical competency
- Administrative capability
- Membership to network organizations
- Partner organizations

2. This was done through search of databases conducted in liaison with organizations such as Commissions for Higher Education (CHE) to obtain relevant information from their available databases.

3. The other sources of information include an internet search engine, relevant documents and a hearing from certain key persons such as Prof. Jerling Johan at North West University among others.

4. Additional data was collected through self administration of structured questionnaires to key administrative personnel within the selected institutions. The selected institutions were visited for this purpose

2.0.4 Selection Strategy of Study Countries and Institutions:

The selection of the institutions for detailed study was done at two levels; 1. Country selection and, 2. Institution selection within the country.

1. In selecting the countries, the following JICA conditions and country situations were considered (in particular countries had to satisfy two or more of these),
   a) JICA's administrative constraints
   b) Existence of a relatively higher concentration of candidate institutions in the country
   c) Consistency with the current country assistance programs of JICA
   d) Country eminence in providing training to nationals of other countries within the target region.

Based on these criteria, South Africa, Kenya, Uganda and Tanzania were selected as priority countries for the survey.

2. Selection of institutions within countries was based on;
   a) The strategic location in the country (which included location within at least a key city or region of the country)
   b) Eminence of the institution in HSM in the country and beyond.

Summary of Sources of Data

Table 1: Primary and Secondary Data Sources

Sources/Respondents	Methods	Tools
Leaders of Institutions (e.g. Departmental, School heads)	questionnaires given toidentified respondents and the researchers verify for accuracy and completeness	Structured questionnaires
1. Institutional documents e.g. Strategic Plans, Annual financial and Action Reports, curricula, brochures 2. Internet	Collection of documents through visits to institutions Search	Review guides Summary forms

2.0.5 Data Management and analysis:

Data from structured questionnaires was entered using MS Access while document reviews were manually coded and analyzed.

All data were processed, and secured at the Centre for Public Health Research, Kenya Medical Research Institute.

2.0.5.1 Data Quality Management:

- Pre-testing of questionnaires was undertaken and appropriate improvements made.
- Examination of all collected data for completeness and accuracy.

2.0.5.2 Study and Data Limitations:
There were a number of constraints experienced during data collection. These included websites that were out dated, and in many cases, information was either incomplete or overtaken by more recent events. Institutional transfers or retirement of staff, complete change of physical addresses and e-mail addresses or telephone numbers that were out of service were common experiences.

Unavailability of relevant respondents to the questionnaires or interviews due to other scheduled institutional engagements greatly frustrated efforts to conduct interviews or administer questionnaires especially in South Africa. This was made worse by the very tight travel schedule which did not allow for revisits as requested by the-would-be respondents. Further, many members of staff in the institutions had proceeded on leave for the December holidays and for those still in office, they were relatively unavailable.

In addition, administration of the questionnaire could not be achieved at a single visit since most of the willing respondents preferred to take time to verify certain information that they needed to enter on to the questionnaire. As such, it became necessary to complete questionnaires by e-mail.

3.0 FINDINGS:

3.1 Overview of Health Systems Management (HSM) Training by Institutions of Higher Learning in East and South Africa.

3.1.1 Institutions with Either HSM or General Management Training:

Table 2 shows institutions of higher learning in 18of the 24 target countries selected for this assessment.78 institutions were identified and listed for collection of information (these institutions are listed by country and basic information collected in Appendix 1).The listed institutions may not be exhaustive of those existing in each of the countries, but they provide a good perception of, in particular, key institutional establishments that provide higher education training in these countries. It will be noted that certain countries, namely Angola, Burundi, DRC, Mozambique, Eritrea and Madagascar have either no information or information posted is scanty. This is attributed to the communication languages (Portuguese or French) in the respective websites which the investigator was not conversant with.

Of the identified 78 institutions, the sponsoring agency for 75 was known. Forty one (54.7%) of these are government supported while privately sponsored institutions constitute 45.3% (34), (see Table 2).Although not shown in this table, religious organizations, mostly Christian and Moslem, play a substantial role in the establishment and support of the privately owned institutions. Most of these institutions are established in the countries of Kenya, Uganda, Tanzania, Ethiopia and South Africa which together account for more than 87% of the institutions of higher learning identified (Appendix 1).

TABLE 2: Distribution of HSM and GM Training Institutions of Higher Learning By Sponsoring Agency

ALL INSTITUTIONS WITH HSM OR GM TRAINING	
Sponsoring Agency	**No. (%)**
Private	34 45.3%
Public	41 54.7%
Total	75* 100%
ALL INSTITUTIONS WITH HSM TRAINING	
Sponsoring Agency	**No. (%)**
Private	11 33.3%
Public	22 66.7%
Total	33 100%
ALL INSTITUTIONS WITH GMTRAINING	
Sponsoring Agency	**No. (%)**
Private	26 61.9%
Public	16 38.1%
Total	42** 100%

***3Status of institutions could not be established. ** 2 Status of institutions could not be established**

Table 2 also summarizes information on institutions of higher learning according to whether they provide GM training programs or training programs with HSM subjects. Generally, institutions that provide HSM training are fewer than those that provide GM training.

Of the 75 institutions with information regarding training programs, 33 (44%) provide exclusive (comprehensive or selective) training in HSM while the rest 42 (56%) provide GM training. Of the institutions with exclusive health systems management training, 33% (11) are privately owned while government owned institutions constitute 66.7% (22). Among the institutions that provide GM training, 26 (61.9%) are privately owned. Thus generally, institutions that provide exclusive HSM training are more likely to be government owned than those providing GM training.

24 (32.9%) of the institutions, whose year of establishment is shown on their website, were established before 1979; some having been in existence for well over 10 decades e.g. University of Cape Town. Institutions that were established much recently i.e. after 2005, constitute 16.4% (12) of the total (see Table 3). Proportionately, over 60% of all institutions of higher learning were established in the last three decades consistent with the drastic increase in demand for higher learning. Over 61% (19) of the institutions which offer comprehensive HSM training were established within the last 3 decades and 22 (78.6%) have had their web sites updated within 2009.

Of the institutions with GM training programs, 33 (78.6%) weree stablished in the past three decades and for those institutions whose date of last web site update could be established, over 78% (21) were up dated in 2009(see Appendix 1).

3.2 Institutions Providing HSM Training in Kenya, South Africa, Tanzania and Uganda:

In light of the selection criteria shown in 2.0.4 above, four out of 24countries in East and Southern African were selected as target for the survey: Kenya and S.Africa, Uganda and Tanzania. Among institutions for higher learning that provide HSM training in the four countries, the study focused on 19 institutions (see tables 4, 5, and 6): 10 institutions (5government supported and 5 privately sponsored) in Kenya, 5 (all public supported) in South Africa, 2 (1 private and 1 public) in Uganda and 2(both public) in Tanzania were selected and visited for further data collection. The interview survey was conducted on all 18 institutions, except Maseno University, of which only nine responded to the questionnaire (Among the 19 institutions shown in Table 4,5 and 6, those were both interviewed and responded to the questionnaire are shaded, those were only interviewed are underlined and the rest i.e. Maseno University is neither shaded nor underlined).

It would be of interest to note theyears, since inception, of these selected institutions of the four countries. Slightly less than half (9) were established within the past three decades while the rest were established before 1979(see also appendix 1). This trend holds more for Kenya, Uganda and Tanzania than South Africa where all but one of the institutions were started way before 1979(University of Cape Town for example is over a Century old). The significance of this is in

that, institutions of long standing are generally larger, reflect on administrative and professional maturity as well as experience in the handling of training at all levels.

HSM training programs and the specific areas of HSM training covered in the curricula of the various institutions tend to vary little between institutions. Most training is provided through Schools or Programs of Public Health, as with Moi University in Kenya, University of Kwa Zulu Natal in South Africa and Muhimbili University of Health and Allied Sciences (MUHAS)in Tanzania. Some institutions, like University of Cape Town share the training process between the Schools of Business and Public Health in the same university.

3.2.1 Institutions and HSM Courses offered in Kenya:

In Kenya, comprehensive HSM training is provided in roughly as many institutions under public as under private sponsorship (Table 3). Exclusive HSM programs exist within schools/departments of public health or business as in KeMU, Maseno, Moi, GLUK and Strathmore Universities. In other institutions, like the University of Nairobi, HSM is taught as units within existing programs of Public Health. It is notable that private institutions (like Kenya Methodist and Strathmore University, among others) have programs, departments or schools of business with dedicated training in HSM. Such training is provided either at degree, certificate levels or short course. Other non-universities provide leadership training either as standalone institutions (e.g. Kenya Medical Training College and Kenya Institute of Administration) or in collaboration with public universities (e.g. AMREF, Nairobi). In particular Strathmore University is one good example of a Business School which recently (2009) established a comprehensive training program in health systems leadership which targets executive managers in health.

The 10 listed institutions in Kenya cover common topics or areas of HSM in their training programs (see details Table 3).Considering the course contents or topics of the HSM training offered, Moi University, Kenya Methodist University, AMREF, Great Lakes University of Kisumu and Strathmore University have programs or units that cover most of the specific areas or topics of training in HSM.

While Baraton and Moi Universities provide leadership training at masters and degree levels only, most of the other institutions provide certificate, diploma or post graduate diploma courses. It is also notable that most institutions provide short course training programs too, most likely, in response to market needs of training in HSM within and outside the country. This is in addition to consideration of the fact that the target trainees are a wide range of health professionals, working at different levels of the public-health system, who are in full time employment and thus not in a position to spend long periods of time in full long term training. A good example of these is the innovative short course Executive Health Care Program designed and currently offered by Strathmore University. Such short training programs range, in duration of training, between a few days, weeks to months. All of the institutions in Kenya admit foreign students and continue to provide training to other nationals.

Table 3: Institutions and HSM Courses offered in Kenya.

Institution	Department/School	Course Content	Other Relevant Training & Level	Other Information
University of Eastern Africa, Baraton	School of Health Sciences School of Business	Human Resource Management in Health	Degree Higher Degree	Course provided is General Management Training Trains students from Kenya and any others from the region.
Moi University	School of Public Health	Hospital Administration, Health Services Mgt, Human Resource Management, Health Policy & Planning, Health Care Financing, Health Economics	Master of Public Health	Trains students from Kenya and any others from the region. Course is also offered in Collaboration with AMREF in Nairobi
Great Lakes University of Kisumu	Tropical Institute of Community Health	Health Informatics, Health Financing and Health Economics, Health Systems Development and Management, Health Services Planning &Mgt, Health Policy Analysis and Develop, Develop. &Mgt of Decentralized Health Systems, Mgt of Essential Drugs, Human Resource Mgt & Devel.	Certificate Diploma Higher Degree	Trains students from Kenya and any others from the region.
Strathmore University	Business School	Strategic Health Care Management, Innovation in Health Care, Health Care Law and Ethics, Talent Management in Health Care, Health Management Information System, Supply Chain Management in Health Care, Health Economics and Health Financing, Health Policy Planning & Develop.	Certificate Diploma Bachelors Masters	Training is provided in general leadership. Unique to Strathmore is the Executive Health Care Program which is short course most of the specific areas of Health management and Administration. Training is provided to Kenyan Students as well as students from many other African Countries.
Kenya Methodist University	Business School	Health Care Financing, Health Care Law & Ethics, Health Management Information Systems, Health Policy Planning & Develop., Projects Management & Evaluation, Management of District Health Services, Quality Assurance and Control in Health Care.	Diploma Higher Degree	Training is provided to Kenyans and other students from the African Region. In-service Training is also provided.
African Medical Research Foundation	Nairobi International Training Centre	Monit. and Eval., Health Serv. Organiz .& Mgt, Strateg.Mgt in Hlth and Develop. Programs, Strateg Leadership in Hlth and Develop. Progms, Health Finance Mgt, Logist. Mg for Drugs and Other Health Commodities.	Short Courses, Certificate, Diploma	Training provided to Kenyans and students from up to 40 countries within various regions of Africa.
University of Nairobi	Master of Public Health, Faculty of Medicine	Health Services Administration and Evaluation, Health Planning and Development	Masters Degree Provided as a unit in MPH	Training provided to Kenyans and students from any other nations This institution has been providing general leadership training to many persons that work in health systems over many years
Maseno University	School of Public Health, in MPH Program	Management of Health Systems, Monitoring & Evaluation, Health Service Organization &Management, Strategic Management in Health and Development Programs, Health Finance Management, Logistics Management for Drugs	Higher Degree	Training is also provided to students from neighbouring countries in the region. This is offered mainly at higher degree (Masters Degree) level.
Kenya Institute of Administration	Commerce and Business Administration Program	Hum. Res. Mgt, Mgt Inf. Syst, Operat. Mgt & Strat. Mgt and Proj. Plan. & Mgt.	Certificate Courses	Training to students from 6 Eastern and Southern African ` region
Kenya Medical Training College	College	Health Systems Management offered as unit for every student admitted in any program	Short Courses, Certificate, Diploma	Training to students from many countries in the region

3.2.2 Institutions and HSM Courses offered in South Africa:

The selected South African institutions that offer HSM training are shown in Table 4.These are also the institutions that were visited for assessment (as were those of Kenya described above). The institutions were selected based on their strategic location in the country (which included location within at least a key city or region of the country) and eminence in the area of higher learning.

TABLE 4: Institutions and HSM Courses offered in South Africa.

Institution	Department/School	Courses	Other Relevant Training & Level	Other Information
University of Cape Town	Faculty ofHealth Sciences. School of Public Health in conjunction with the Health Economics Unit.	Health Systems Management and Policy Health Economics and Policy Management of Health Resources, Financial Management, Health Management Theories, Health Information Systems	PhD MastersDegree Diploma Certificate	Diploma training is for Senior Public Health Managers (only South Africans). Health Economics Unit with the MBA program 50/50 in training. Distance learning also provided on-line for MSc in Health Economics & Policy to students of other countries Courses target managers of health at District, Provincial and National Level.
University of The Western Cape	Faculty of Community and Health Sciences, School of Public Health (SOPH)	Health Management, Human Resource Management and Development, Planning & Resource management, Budgeting Skills, Health Information Systems, Health Systems Research, Health Promotion	PhD Post graduate Certificate MastersDegree Certificate, Short Courses	Provides skills for managers with District Health Systems and managers of Health and Social Service programs at District, Provincial and higher levels.
University of KwaZulu Natal	Nelson Mandela School of Medicine, Howard College, College of Health Sciences, Department of Public Health.	Hospital Management and Medicines management, Health services management Human resource management Health Economics and Financing, Corporate Hospital Governance	MastersDegree Postgraduate Diploma Certificate and Short courses	Courses open to South Africans and Other African Countries.
University of The Free State	School of Public Health	Principles of Management, Administration/Management of Health Services, Concepts in Health Care, Health Care and Law, Health Care Planning, Health Programs and Specialized Services, Human Resource Management, Quality Assurance	MastersDegree Advanced Diploma	This institution has been involved in HSM training program for S.Africans in the years immediately after S.Africas independence. The Centre for Policy Research and Development has been involved in this.
University of The Witwatersrand, Johannesburg	Faculty of Health Sciences, School of Public Health, Centre for Health Policy	Health systems and Policy Health care Financing, Health Systems Approaches to Planning, Hospital Management, Hospital Risk Management.	Masters Degree Certificate	For Hospital Managers, and Chief Executives to effectively Manage their Institutions. Program was initiated by the Witwatersrand School of Public Health and University of KwaZulu Natal, School of Public Health and Family Medicine. Program is funded and Supported by National Department of Health of South Africa. Other nationalities also are trained here.

Under this selection criteria, a total of 5 institutions of higher learning were identified. All the 5 public supported institutions were noted to be much larger in sizes(including their constituent colleges and departments) with better established facilities than those of Kenya, Uganda or Tanzania. Training in HSM is provided mainly in schools or faculties of health sciences and public health. The course contents of the exclusive HSM programs offered by these institutions are summarized in Table 4 above.

A number of these institutions have entered into inter-institutional collaboration, where experts in HSM training of one institution provide training support in others. The Universities of Witwatersrand and Kwa Zulu Natal have collaborated in this way for a number of years now. Inter-departmental collaboration within institutions also exists where HSM experts in one department provide training support to another. A key example of this is with the University of Cape Town (Health Economics Unit) and University of the Free State (Centre for Health Policy Research and Development) which provide training support (in addition to research) in HSM to the relevant departments within their respective institutions.

Some institutions, notably University of Cape Town (Health Economics Unit) and University of the Free State (Centre for Health Policy Research and Development) have in the past, with the support of the S.African government and other donor agencies, rolled out training programs in HSM for South African health systems leaders (this training arrangement is, reportedly, coming to an end or have already come to an end due to termination of funding from the donor sources). This can be viewed as providing a source of relevant training implementation and curricula development expertise which may be tapped for the creation of relevant, similar programs in the current JICA proposal.

The Centre for Health Policy Research and Development (University of the Free State) in particular, has provided large scale short course HSM training for many South Africans in the period immediately after the country's independence. This funded program came to an end and the centre now focuses more on health systems research although the concentration of its highly qualified personnel is often utilized to support training in health systems leadership within the institution.

HSM training is generally provided by institutions at degree and diploma levels. However, as with Kenya, short courses popularly referred to as summer or winter courses, are also offered. University of the Western Cape particularly advertises a range of such courses in HSM annually. All these S. African institutions provide training to many students from countries in the East and South African region.

3.2.3 Institutions and HSM Courses offered in Uganda and Tanzania:

Two institutions of higher learning in each of the two countries (Uganda and Tanzania) were identified based on available information with respect to their eminence in training in health systems management in the respective countries.

TABLE 5:
Institutions and HSM Courses they Offer in Uganda and Tanzania.

Uganda				
Institution	**Department**	**Courses**	**Other Relevant Training & Level**	**Other Information**
Makerere University, College of Health Sciences, School of Public Health	Department of Health Policy, Planning and Management	Runs Regular Courses in public health policy, health planning and management, health economics and finance, primary health care and health systems management.	PHSWOW*. Graduate and Post Graduate. Short Courses for District and other health personnel.	Distance Learning available but for MPH students. Proposed collaboration with Western Cape University of South Africa. Intakes include from Kenya & Egypt. Intake in whole School of Public Health 2007/08 is 170 students (MPH alone is 120).
	Regional Centre for Quality of Health Care	Provides Regular training in Quality of Health Care	Post Graduate Diploma	
International Health Sciences University	Institute of Health Policy and Management	Runs Health Management Public Health (Economics & Policy) Health care Leadership and Management	MBA and BBA BSc Diploma Contact: Professor Deirdre Carabine,	Full time and Part-time courses. Admits from other countries Currently , the most successful e-learning program in Public Health in Uganda is also offered. It is 3 yrs program. Other courses 1 to 3 yrs Duration. Has 13 Lecture Theatres, 150 computers, 15 notebooks and expect another 150 computers next year (2010). This years has been operating since 2007.
Tanzania				
Mzumbe University	Faculty of Public Administration and Management	Administration & Management Human Resource management Procurement and Supply chain Management Health Systems Management	Certificate Diploma Bachelors Masters Degree	Training is provided to Hospital Administrators, Health Administrators, Hospital Secretaries and Health Planners. Duration 1 to 3 Years Students admitted from Tanzania and other countries.
Muhimbili University of Health and Allied Sciences	Department of Public Health	Health Policy and Management Financing and Financial Management of Health Systems	Certificate Masters Degree	Short courses are provided to working persons Training is to Tanzanians and students of other countries.

*Public Health Schools Without Walls Programs with Ghana, Zimbabwe & Vietnam.

The course contents of the training programs cover a number of the special areas or topics of health systems management as shown in Table 5. Like with the other countries, the institutions in Tanzania and Uganda have established programs that provide training at higher degree, bachelors degree, post graduate diploma and diploma levels in health systems leadership. However short course programs also exist as with the Kenyan and South African institutions described earlier. All these country's institutions admit and train students from other countries.

Further to the description of training provided above in all the four countries, mention must be made of e-learning and distance learning programs which are currently provided by several institutions. Such institutions include, in Uganda (International Health Sciences and Makerere Universities), South Africa (University of Cape Town and University of the Western Cape) and Kenya (Strathmore University and University of Nairobi).

4.0 HSM CURRICULA IN THE SELECTED INSTITUTIONS:

Tables 4, 5 and 6 above summarize the training programs and content that institutions of higher learning provide in HSM. This data shows that, collectively, most of the topics in HSM training programs (which JICA has included in the list of topics in HSM - see page 12) are covered. However, it is apparent that no single HSM program/course content address all the areas in the list of topics in HSM provided on page 12.

The combination of topics in the HSM programs varies from institution to institution (e.g. those of GLUK and Strathmore University, University of Kwa Zulu Natal and Makerere University).With reference to the list of program topics or areas in health systems management provided on page 12 of this report, it is evident that virtually all the institutions developed their programs with a selected few of the listed topics. While health care financing and health system (or hospital) management feature most as common topics in the programs, topics like information management and monitoring and evaluation seem to feature least in most of the course contents of institutions. In addition other program topic areas such as health care law and ethics and management of decentralized health systems which are offered by, for example, GLUK and Strathmore Universities are additional to the HSM topics that other institutions provide.

It must be emphasized that this variability in content of topics of HSM training programs between institutions is present at all training levels i.e. short courses, certificate, diploma, degree and masters. As such, there exists no basic uniformity or standard program for training in HSM. Short course programs particularly, which are taught for a few days to a week or two, often train on one or two topics at any given time, as is the case with programs of the University of the Western Cape. As such, trainees would require to attend a string of these short courses to cover several of the topics in health systems management. For this reason, there is a clear need to harmonize the basic training curricula in HSM training.

5.0 Institutions of Higher Learning Partnerships and Membership to Networks:

The institutions of higher learning were noted to have established partnerships between them as well as entering into memberships of certain networks (see Table 6) below.

These partnerships and networks have been crucial in providing different types of support to the member institutions. Although information about the type of support can not be shown in the table 6below, such support has included strengthening of institutional training capacities, support for staff training and curriculum development among others. Other partnerships have supported networking, staff and student exchange programs as well.

AMREF particularly partners with many institutions in the region. This arises from the fact that it does not have the mass of resident trainers hence relying, to a large extent, on other institutions for this support.

Table 6: Summary of Partnerships and Member Institutions of Selected Networks (AHLMN, Health Alliance, ECSA-HC and HEP Net)

Institution	Dept./School	Course Contents	HSM Training Program*			Level	Network to which the institution belongs	Collaboration with other institutions
			Exclusive		General			
			Comp.	Select.				
Moi University	School of Public Health	Hospital Administration, Health Services Mgt, Human Resource Management, Health Policy & Planning, Health Care Financing, Health Economics	✓			Masters	Health Alliance	・AMREF
Strathmore University	Business School	Strategic Health Care Management, Innovation in Health Care, Health Care Law and Ethics, Talent Management in Health Care, Health Management Information System, Supply Chain Management in Health Care, Health Economics and Health Financing, Health Policy Planning & Develop.	✓			Certificate Diploma Bachelors Masters	AHLMN	・The Association of African Business Schools ・IESE Business School, University of Navara (Madrid) ・Balanced Scorecard Institute AMREF
Kenya Methodist University	Business School	Health Care Financing, Health Care Law & Ethics, Health Management Information Systems, Health Policy Planning & Develop., Projects Management & Evaluation, Management of District Health Services, Quality Assurance and Control in Health Care.	✓			Diploma Higher Degree	AHLMN	AMREF
University of Nairobi	Department of Public Health, Faculty of Medicine	Health Services Administration and Evaluation, Health Planning and Development		✓		Provided as a unit in MPH	・HEP Net ・Health Alliance	AMREF Mzumbe University Makerere University
AMREF	International Training Centre	Training Program: Community Health course, Short specialized courses, Distance Education Program, E-learning Program		✓		Masters Diploma Short Courses	AHLMN	Moi University KeMU University of Nairobi

*Comp. = Comprehensive, Select. = Selective.

Table 6 (Continued): Summary of Partnerships and Member Institutions of 4 Selected Networks (AHLMN, Health Alliance, ECSA-HC and HEP Net)

Institution	Dept./School	Course Contents	HSM Training Program*			Level	Network to which the institution belongs	Collaboration with other institutions
			Exclusive		General			
			Comp.	Select.				
University of Cape Town	Faculty of Health Sciences. School of Public Health in conjunction with the Health Economics Unit.	Health Systems Management and Policy Health Economics and Policy Management of Health Resources, Financial Management, Health Management Theories, Health Information Systems	✓			Diploma MSc Certificate	HEP Net (Health Community Unit)	Makerere University KEMRI University of Kwa Zulu Natal
University of Witwatesrand	Faculty of Health Science, School of Public Health, Center for Health Policy	Health Systems and Policy Health Care Financing Health Systems Approaches to Planning Hospital Management, Hospital Risk Management	✓			Masters Degree Certificate	HEP Net (Center for Public Health) AHLMN	University of Kwa Zulu Natal University of Pretoria
Makerere University, College of Health Sciences, School of Public Health.	Department of Health Policy, Planning and Management	Runs Regular Courses in public health policy, health planning and management, health economics and finance, primary health care and health systems management	✓			PHSWOW*. Graduate and Post Graduate. Short Courses for District and other health personnel.	HEP Net (Institute of Public Health) Health Alliance (Institute of Public Health)	University of Cape Town, University of the Western Cape University of Dar es salaam University of Nairobi Moi University Zimbabwe University Egerton University
	Regional Centre for Quality of Health Care	Provides Regular training in Quality of Health Care	✓			Post Graduate Diploma		
Muhimbili University of Health and Allied Sciences	Department of Public Health	Health Policy and Management Financing and Financial Management of Health Systems	✓			Certificate Masters	HEP Net (College of Health Science)	Mzumbe University

*Comp. = Comprehensive, Select. = Selective.

6.0 Strengths and Challenges of Each Institution and Program:

In assessing the strengths and weaknesses of the institutions of higher learning in the four countries, a combination of data sources, i.e. filled questionnaires, institutional document reviews and information from institution's web-sites was used. Bearing in mind that not all institutions, to which questionnaires were sent, filled and returned the same to the investigator, a substantial number of institutions have missing information (see Appendix 3). Nevertheless, the available data can be used with these limitations in mind. Table 7 below, provides a summary of strengths and weaknesses based on information collected using all the data sources stated above. In writing this section reference is made to Table 7 and Appendix 3.

The following assessment areas (among others) were used for this purpose;

a) **Year of establishment of the institution** – bearing in mind that much older institutions comparatively affirm superiority in both administrative and training expertise.
b) **Lecture rooms** –This address issues of capacity in accommodating students during training.
c) **Constituent Colleges** – Constituent colleges of institutions in diverse regions of a country address issues of accessibility particularly given that training will target, to a large extent, professionals that are in employment.
d) **Qualifications of the resource persons and their numbers** has a bearing on capacity and quality of training provided.
e) **Training programs in HSM** (degrees or non degrees) offered determine the extent to which professionals in employment will find time to attend training with relative ease.
f) **Current student populations**, address institutional popularity among students from within or outside host countries as well as relevance to matters of capacity, capability and coverage.
g) **Frequency of review f curricula** is relevant to the sensitivity of institutions to the changing market needs in health systems.

Except for University of East Africa, Baraton, the University of Nairobi, Kenya Medical Training Centre (KMTC) and Kenya Institute of Administration, which train health systems leaders in other programs e.g. MPH, other institutions have dedicated (comprehensive) health systems management training programs. Most institutions provide training mainly at the levels of certificate and diploma.

AMREF and KMTC trains the most students (although this number is more likely inclusive of students in other different programs). Other institutions provide diploma and Masters degree for between 20 and 50 students in annual intakes.

Exclusive Training Programs in HSM:

Of the listed institutions in Table 7, University of Eastern Africa, Baraton (UEAB) and University of Nairobi provide HSM training as units in other existing programs. UEAB, in particular, has its HSM training program still in proposal form and health systems leaders are currently trained within the existing MBA and BBA programs.

Table: 7 Strengths and Challenges of Institutions for Training in HSM

Institution	Strengths	Challenges
Moi University	Has comprehensive HSM training, has training collaboration with AMREF, has qualified staff for training, has existing arrangements with other institutions for training staff when required, admits students from other countries in the East and South African region.	Existing program is at Masters Degree level, training duration is 2 years.
Great Lakes University of Kisumu	Has comprehensive HSM training program, has qualified staff for the training, provides short courses, certificate, and diploma training, admits from other countries of the East and South African region.	Capacity in terms of training space is still relatively low and training costs are relatively high.
Strathmore University	Has comprehensive HSM program, has facility expansion program in place, collaborates with AMREF and other institutions in sourcing training staff, has resident qualified training staff, has modern training equipment, provides short courses training level, admits students from other countries of the East African region	Capacity in terms of training space is still relatively small
Kenya Methodist University	Has comprehensive HSM program, has existing qualified staff for training, has arrangement for sourcing qualified staff from other establishments, admits students from countries of the East African region ,	The program is at Masters Degree level, training duration is 2 years, student intake capacity is relatively low, in need of additional teaching staff.
African Medical Research Foundation	Has selective HSM training, has training collaborative arrangement with other institutions like Moi and Strathmore Universities, has existing arrangements to source training staff from other establishments, training level is mainly short courses level, has the widest coverage in training of students from other countries in Eat and South African region, has existing facilities for training, training costs are relatively low, good networking and international donors	Relies heavily on training staff from other establishments, lacks accommodation hostels for student, currently lack accreditations.
University of Nairobi	Has selective HSM training, has existing qualified staff, long standing training experience, admits students from other countries of the East and South African region.	Existing program is at Masters degree level, training duration is 2 years, existing training is provided as selective HSM, i.e. as units in MPH program hence course content is less detailed., few teaching staff and teaching equipment.
Kenya Institute of Administration	Has general management training program with longstanding experience in handling short course training, has good established training facilities (expansion process is still on)/ good resource base, continues to train health systems managers, has qualified and experienced training staff, admits students from various countries of the East and South African region, has government goodwill, has e-learning capacity, newly introduced HSM courses at two levels (mid and top level professional), have good understating of the public service	Existing programs are mainly GL (comprehensive HSM is rather new, i.e. introduced in 2009), low ICT capacity, low capacity in conducting training impact assessment, low capacity on student accommodation
Kenya Medical Training College	Has selective HSM training program and is among oldest institutions with expertise and experience in diploma and short courses level of training, has qualified training staff, has good training facilities, admits students from other countries of the East and South African region, training costs are relatively low.	Does not have an comprehensive HSM program. Training in HSM consists of scattered units in short course programs.
University of Eastern Africa, Baraton	Has general management training program for health systems leaders; has qualified staff, admits students from other countries of East and South African region.	Training in comprehensive HSM still in proposal form; Existing program is atMastersdegree level; lacking in adequate training facilities, inadequate training staff.

Table 7 (Continued): Strengths and Challenges of Institutions for Training in HSM

Institution	Strengths	Challenges
University of Cape Town,	Has comprehensive HSM program, provides training at certificate and diploma levels, has long standing experience and expertise in training in HSM, has currently an existing program to train South African health systems managers, has qualified staff, has good training facilities, admits students from countries in the East and South African region.	Existing training program for South Africans is at Masters Degree level, the program is coming to end due to termination of funding by the donor agency.
University of The Western Cape	Has comprehensive HSM training programs, provides several short course training (popular as summer or winter courses), including certificate and diploma courses, has long standing training experience and expertise, has qualified training staff and relatively good training facilities, admits students from other countries within the East and South African region.	Cost of training is relatively high.
University of Kwa Zulu Natal	Has comprehensive HSM training program; provides short courses, certificate and diploma training; has qualified and experienced staff for HSM training, has good training facilities, provides short course training in HSM, admits students from other countries in the East and South African region	Cost of training is relatively high.
University of The Free State,	Has comprehensive HSM program, has long standing experience and expertise in HSM training, has previously implemented a large scale short course training program for health systems managers who are South Africans, has qualified and experienced staff in HSM, has good training facilities, provides short course and certificate training as well as Masters degree; admits students from other countries within the East and South African region.	Cost of training is relatively high; Training which was provided to South Africans came to an end.
University of The Witwatersrand, Johannesburg	Has comprehensive HSM program; long standing experience and expertise in training, has qualified staff, has existing short course program in HSM at short course, certificate, diploma and degree levels; admits students from other countries of the East and South African region,	Cost of training is relatively high.
Makerere University	Has a comprehensive HSM training program; training is provided at the levels of short courses, certificate, diploma and Masters degree levels; has existing qualified staff for training at the School of Public Health and Social Sciences; provides short course training in HSM; has training collaborative arrangement with other institutions like Moi University; provides training for students from other countries in the East and South African region.	Main training program is at Masters Degree level, training duration is 2 years, in need of more teaching staff
International Health Sciences University	Has comprehensive HSM training program, has qualified staff for the training, provides short courses, certificate, and diploma training, has good number of computers and lecture room space, provides distant learning training.	Institution is relatively new (2008) and most of the training geared mainly for the Ugandan clientele; admits few students from other countries of the East and South African region.
Muhimbili University of Health and Allied Sciences	Has comprehensive HSM program, has existing qualified staff for training, provides short course and diploma training in HSM, admits students from countries of the East African region.	The main program is at Masters Degree level, training duration is 2 years, requires more qualified training staff, low financial support from government.
Mzumbe University	Has comprehensive HSM training program, has long standing experience and expertise in HSM training, has short course training program, admits students from other countries of the East and South African region.	Is in requirement of additional qualified training staff.

Student Intakes:
Although AMREF, MUHAS and KMTC indicate high numbers of student intakes of between 250 and 800, the numbers provided most likely include students of other training disciplines. Nevertheless, these institutions still remain, strategically, providers of training to large numbers of students.

Levels of Training and Related Costs:
Strategically, institutions that provide certificate and diploma training are more suitable to meeting training needs of professionals who are in employment. The University of East Africa, Baraton, Moi University and University of Nairobi provide training at masters degree levels, as opposed to other institutions that train certificate and diploma or post-graduate diplomas. The relevance of this is in the much shorter time professionals prefer to complete their training as opposed to the two to three years of masters or undergraduate training.

Generally the training programs are expensive e.g. KeMU degree program charges Ksh. 900,000.00 (US $ 11, 689.00) while Strathmore's short course program charges Ksh. 306,600.00 (US $ 3,981.80). For its short and certificate courses, AMREF charges between Ksh. 20,000.00(US $ 260.00) and Ksh. 100,000.00 (US $ 1,300.00) while KMTC will charge Ksh. 240,000.00(US $ 3,116.90) for diploma program.

Areas of Management Training Covered:
Makerere University (through the Department of Health Policy, Planning and Management) and International Health Sciences University (through the Institute of Health Policy and Management) have programs that cover diverse special areas of training in HSM and are fairly inclusive (including policy, planning and management, economics and finance, leadership). This observation can also be said of MUHAS and Mzumbe Universities of Tanzania. In Kenya, except Kenya Medical Training College, KMTC, UEAB and University of Nairobi, other institutions also cover a wide range of the HSM special topics.

In addition to the programs offered, certain institutions (e.g. Strathmore University) reviews their curricula annually as opposed to, KeMU(every 3 years) and other institutions(every 3-5 years).This arrangement by Strathmore University provides sufficient consideration for frequent variation of course content in the HSM program in line with rapidly changing challenges faced by health systems in this region of the developing world.

Regional Student Admissions:
Among institutions that admit students from countries other than the host country, AMREF, KMTC, Strathmore, KIA and KeMU are most outstanding with student admissions from up to, or more than 10 countries of the East and Southern African region.

Training Facilities (Infrastructure and Equipment):
Facilities that are referred to here include computers, lecture rooms and other communication facilities. Institutions that returned filled questionnaires showed relatively low numbers of student populations currently under training. These students are for the various levels of training and range between 25 and 50 per institution.

With respect to computers used for training, the International Health Sciences University of Uganda has the highest computer/student ratio, which is set to increase this year (2010), while KeMU has the second highest ratio.

Number of lecture rooms used for student training range from 2 to 6 per institution. These are shared with the training of students in other programs. Against this position, some universities, e.g. Strathmore, have embarked on ambitious projects to increase this capacity through the construction of additional teaching space.

Qualifications of Staff in HSM training:
Training staff numbers and their qualifications is a critical matter for all institutions and it is particularly a problem for training of students at degree and higher levels. Training at short course, certificate and diploma levels seems to be adequately covered by trained staff with masters' degree, and lower, qualifications. For example trainers with masters degrees and above range between 5 and 10 in most institutions (KMTC and MUHAS gives numbers of 96 and 35 respectively, which is more the institution total teacher population and not specific to HSM), giving a student/teacher ratio of between 5 and 7.

7.0 REFERENCES:

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4. G8 and Strengthening of Health Systems: Follow-up to the Toyako Summit. www.lancet.com/journals/lancet/article/PII'S140-67369(08)61899-l/fulltext?-eventId=login

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8.0 APPENDICES

Appendix 1: Distribution of Institutions that Provide either HSM or GM Training by Country in the Eastern and Southern Africa

	Name of University	Public/ Private	Programs Offered and Level		HSM or GM	Physical location	Website address	Institute Established/	Last Web Update	Contacts
Country: BOTSWANA										
1	University of Botswana	Public	Business Administration	Ma/Ba/Di	GM	Gaborne,Francistown	www.ub.bw	1982	1982	holmj@mopipi.ub.bw
Country: ETHIOPIA										
2	Unity University	Private	Business Administration	Ba	GM	Addis Ababa	www.uu.edu.et	1991	2009	distanceedu@unityuniversity.net
3	US College	Private	Human Resource Mgt	Ba/SCo	GM	Shashamane	www.us-college.net	2008	2009	info@us-college.net
4	Mekelle Institute of Technology	Private	Health Service Mgt / Health Economics/Info. Tech.	Ba	HSM	A. Ababa	www.mekit.edu.et	2002		ccm@mu.edu.et
5	Wollega University	Public	Procurem & Suppl / Mgt/ Business Management	Ba	GM	Nekemte,	www.wuni.edu.et	2007	2007	wu@ethionet.et
6	Arba Minch University	Public	Business Management	Ba/Di	GM	Arba Minch	www.arbaminch-univ.com	2004	2009	webmaster@arbaminch-univ.com
7	Jimma University	Public	Health Serv. Management/ Human Resource Mgt	Ma/Ba/Di	HSM	Addis Ababa	www.ju.edu.et	1999	2009	webmaster(a)ju.edu.et or support(a)ju.edu.et
8	Africa Beza College	Private	Mgt/ Hum. Reso. Mgt/ Purch. & Suppl. Mgt	Ba/Di	GM	ShashemeneA.Ababa	www.africabezacollege.com	1999	2008	afribeza@ethionet.et
9	International Leadership Institute		Busin. Admin.,Busin. Mgt	PhD/Ma/Ba/Di	GM	Addis Ababa	www.ili.edu.et		2006	info@ili.edu.et
10	Haramaya University	Public	Public Health Management	Ma/Ba/Di	HSM	Dire Dawa	www.haramaya.edu.et	1954	2009	251 25-5530320 / Fax: 251 25-5530331
11	Hawassa University	Public	Business Management	Ba/Di	GM	Hawassa,	www.hu.edu.et	1999	2009	info@hu.edu.et
12	Infonet College	Private	Mgt, Purchase Mgt	Ba/Di	GM	Addis Ababa	www.infonetcollege.edu.et	2002	2009	
13	Addis ababa University	Public	Business Administration	Ma/Ba/Di	GM	Public	www.aau.edu.et	1950	2009	+251111233769
COUNTRY: KENYA										
14	Egerton Unversity	Public	Bus. &Mgt/ Bus. Admin/ Hum. Res. Mgt/ Int. Bus. Mgt/Hlth Serv. Mgt	Ma/Ba	HSM	Njoro	www.egerton.ac.ke	1987	2009	vc@egerton.ac.ke
15	Kabarak University	Private	Hum. Res. Mgt/Bus. Mgt/Inf. Mngt	Ba	GM	Nakuru	www.kabarak.ac.ke	2008	2008	registrar@kabarak.ac.ke
16	Kenya Methodist University	Private	Hlth. Sys. Mgt/Hum. Res. Mgt/Bus. Admin.	Ma/Ba/Di	HSM	Meru	www.kemu.ac.ke	2006	2009	bon_oirere@yahoo.com
17	Kiriri Women's University	Private	Bus. Adm./Int. Bus. Mgt/Gen. Mgt/Purch. & Sup. Mgt	Ba.	GM	Kasarani	www.kwust.ac.ke	2002	2009	info@kwust.ac.ke
18	University of Eastern Africa Baraton	Private	Hum. Res. Mgt/Bus. Admin.	Ma/Ba	HSM	Baraton	www.ueab.ac.ke	1991	2007	Dean_shs@ueab.ac.ke

COUNTRY: KENYA										
	Name of University	**Public/ Private**	**Programs Offered and Level**		**HSM or GM**	**Physical location**	**Website address**	**Institute Established/ Last Web Update**		**Contacts**
19	StrathmoreUniversity	Private	Hlth Sys. Mgt Hum. Res. Mgt/Purch. &SuppMgt/Lead. &Mgt	Ma/Ba/Di /SCo.	HSM	Nairobi,	www.strathmore.edu	2008	2008	SMukasa@strathmore.edu
20	United StatesInternationalUniversity	Private	Bus. Admin/Intern. Bus. Admin/ Mgt&Organiz. Development	Ba/Di	GM	Kasarani,	www.usiu.ac.ke	1999	2009	gkaol@usiu.ac.ke
21	DaystarUniversity	Private	Bus. Adm.&Mgt/Hum. Res.Mgt/ Strategic Mgt	Ma/Ba	GM	Nairobi	www.daystar.ac.ke	1994	2009	admissions@daystar.ac.ke
22	MoiUniversity	Public	Bus. Mgt/ Hum. Res. Mgt/Health Serv. Mgt	PhD/Ma/ Di	HSM	Eldoret	www.mu.ac.ke	1984	2009	Idemken.tabu04@gmail.com
23	Catholic University of Eastern Afric	Private	Bus. Adm. &Mgt/Plan &Mgt of Develop. Projects	Ba	GM	Nairobi	www.cuea.edu	1992	2009	vc@cuea.edu
24	AfricaNazareneUniversity	Private	Bus. Adm./Human Resource Management	Ma/Ba	GM	Nairobi	www.anu.ac.ke	2002	2009	Registrar@anu.ac.ke
25	MasenoUniversity	Public	Bus. Admin/Hlth Syst. Mgt/Project Plan &Mgt/Hum. Res. Mgt.	Ma/Ba/Di	HSM	Maseno	www.maseno.ac.ke	2001	2009	wodero@africaonline.co.ke
26	University of Nairobi	Public	Hum. Res. Mgt/Bus. Admin./Operat.&Strat. Mgt/Project Planning & Mgt.	Ma/Di	GM	Nairobi	www.uonbi.ac.ke	1970	2009	walter.mwanda@uobi.ca.ke
27	KenyattaUniversity	Public	Hum. Res. Mgt/Bus. Mgt	Ma/Di	HSM	Nairobi	www.ku.ac.ke	1985	2009	Registrar-acad@ku.ac.ke
28	Mt KenyaUniversity	Private	Bus. Admin& Mgt/Hum. Res. Mgt/Strateg. Mgt	Ma/Di	GM	Thika	www.mku.ac.ke	2008		
29	KimathiUniversityCollege of Techology	Public	Business Administration	Di	GM	Nyeri	www.kuct.ac.ke	2007		info@kuct.ac.ke
30	African Medical Research Foundation	Private	Monit. &Evalua./Hlth Serv. Organiz. &Mgt/Strategic Lead. In Hlth&Dvlp/Hlth Finance	SCo.	HSM	Nairobi	www.amref.org	1957		Info.kenya@amref.org
31	JomoKenyattaUniversity of Agriculture and Technology	Public	Human Res. Mgt/Mgt& Bus. Admin./Purchase & Supp. Mgt/Mgt Inform. Technology	Ma/Ba/Di	GM	Nairobi	www.jkuat.ac.ke/	1994		pro@jkuat.ac.ke
32	Great LakesUniversity of Kisumu	Private	Health Car e Management	Ma/Dip	HSM	Kisumu	www.gluk.ac.ke	2008		linetny@yahoo.com
33	Kenya Institute of Administration (KIA)	Public	Strateg. Leadersh. Dev. Prog./Senior Mgt Course	SCo.	GM	Nairobi	www.kia.ac.ke	1961	2009	h_mukaya@kia.ac.ke
34	KenyaMedicalTrainingCollege	Public	Health Care Management	Di	HSM	Nairobi	www.kmtc.ac.ke	1961		mkanyottu@yahoo.com

COUNTRY: SOUTH AFRICA										
	Name of University	**Public/ Private**	**Programs Offered and Level**		**HSM or GM**	**Physical location**	**Website address**	**Institute Established/ Last Web Update**		**Contacts**
35	Walter Sisulu for Technology and Science	Public	Business Administration and Management	Ma/Ba	GM	East London	www.wsu.ac.za		2009	vc@wsu.ac.za
36	University of the Free State	Public	Health Services Management	Di	HSM	Bloemfoentain, Orange Free State	http://www.uovs.ac.za	1904	2009	Heunisj.hum@ufs.ac.za
37	University of Limpopo	Public	Health Systems Management	PhD/Ma	HSM	Pretoria	http://www.ul.ac.za	2005		Tel. (+27)012515036
38	University of Fort Hare	Public	Busin. Admin. &Mgt/ Pub. Sect. Mgt&Adm./Dist. Health Serv. Mgt& Leadership	Ba/Di	HSM	East London	www.ufh.ac.za	1916	2009	nmcako@ufh.ac.za
39	University of Cape Town	Public	Hlth Economics/ HlthMgt/ Bus. Admin.	Ma/Di	HSM	Cape Town	www.health.uct.ac.za	1829	2009	Olufunke.alaba@uct.ac.za
40	University of Pretoria	Public	Health Systems Management	Ma/Dip	HSM	Pretoria	www.up.ac.za/	1908	2008	Eric.buch@up.ac.za
41	University of Kwa Zulu-Natal	Public	Health Management Program	Ma/Ba	HSM	Durban,	www.ukzn.ac.za	2004	2009	jinabhai@ukzn.ac.za
42	Rhodes University	Public	Human Reso. Mgt/ Purch. & Supp. Mgt	Ba	GM	Grahamstown	www.ru.ac.za	1904	2009	registrar@ru.ac.za
43	University of Stellenbosch	Public	Business Management	PhD/Ma	GM	Stellenbosch	www.sun.ac.za	1874	2009	+2721 808 2225
44	University of Venda	Public	Public Health		HSM	Thohoyandou	www.univen.ac.za	1982		info@univen.ac.za
45	University of Western Cape	Public	Health Management/People Mgt/Planning & Resource Mgt/Budgeting Skills	Ma/Ba/ SCo.	HSM	Bellvile	www.uwc.ac.za/publichealth	1959	2009	mppetersen@uwc.ac.za
46	University of Witwatersrand	Public	Hlth Syst. & Policy/Health Care Financing/Hlth Systems Approah to Planning	Ma	HSM	Johannesburg	www.wits.ac.za	1904	2009	Andile.xaba@wits.ac.za
47	University of Johannesburg	Public	Public Health	Ba	HSM	Johannesburg	www.uj.ac.za/Home/tabid/36/Default.aspx	2005	2009	Aparekh@uj.ac.za
48	Nelson Madela Metropolitan University	Public	Human. Res. Mgt/Bus. Mgt/ Logistics Mgt/ General Mgt	Ba/Di	HSM	Port Elizabeth	www.nmmu.ac.za/	2004	2009	info@nmmu.ac.za
COUNTRY: SUDAN										
49	Al-Neelain University		Business Administration and Management	Ba/Di	GM	Khartoum	www.neelain.8m.net/ARABIC3.htm	1955		+2721 808 2225
50	Ahfad University for women	Private	Busin. Admin/Office Mgt	Ba	GM	OmdurmanSudan	www.ahfad.org	1905	2007	auwinfo@gmail.com

COUNTRY: SWAZILAND										
	Name of University	**Public/ Private**	**Programs Offered and Level**		**HSM or GM**	**Physical location**	**Website address**	**Institute Established/ Last Web Update**		**Contacts**
51	University of Swaziland	Public	Management	Ba/Di	GM	Kwaluseni, Luyengo, Mbabane	www.uniswa.sz/	1964		kwaluseni@uniswa.sz
Country: TANZANIA										
52	Open University of Tanzania	Public	Business Administration	PhD/Ma/ Ba	GM	Dar es Salaam	www.out.ac.tz	1992		drpgs@out.ac.tz
53	St. Augustine University of Tanzania	Private	Health Administration	Ma/Ba/Di /SCo	HSM	Mwanza	www.saut.ac.tz	1998	2009	saut@saut.ac.tz, vcsaut@saut.ac.tz,
54	University of Dar es Salaam	Public	Business Administration	Ba/Di/ SCo	GM	Dar es Salaam,	www.udsm.ac.tz	1966	2009	dvc-arc@admin.udsm.ac.tz
55	Zanzibar University	Private	Business Management	Ba/Di	GM	Zanzibar	www.zanvarsity.ac.tz	2002		zanvarsity@zitec.org
56	St. John's University of Tanzania		Business Administration	Ma/Ba/Di	GM	Dodoma,	www.sjut.ac.tz	2007		+255 26 239 0044
57	Muhimbili University of Health and Allied Sciences	Public	Public Health	Ma/Di/ SCo	HSM	Dar es Salaam	www.muchs.ac.tz	1963	2009	mmwangu@muhas.ac.tz
58	Mzumbe University	Public	Hlth Serv. Mgt/Human Resource Management	Ma/Di/ SCo	HSM	Mzumbe	www.mzumbe.ac.tz	2003	2005	info@mzumbe.ac.tz
Country: UGANDA										
59	Kampala University	Private	Hum. Res. Mgt/Pub. Admin	Ma/Di	GM	Kampala,	www.kampalauniversity.net	1999		
60	Nkumba University (NKU)	Private	Pub. Admin.&Mgt/Purch. & Suppl.	Di	GM	Entebbe,	www.nkumbauniversity.ac.ug	1994	2006	ar@nkumbauni.ac.ug
61	Uganda Martyrs University	Private	Health Serv. Management	Di	HSM	Nkozi,	www.umu.ac.ug	1993	2009	umu@umu.ac.ug
62	Uganda Management Institute (UMU)	Private	Pub. Admin. & Mgt/Finance Mgt/marketing	Di	GM	Kampala,	www.umi.ac.ug	1968	2009	uganda_dlc@gdlnmail.org
63	Fairland University (FLU)	Private	Proj. Planning &Mgt	Di	GM	Jinja,	www.fairvarsity.ac.ug	2001	2006	fairversity@yahoo.com
64	Uganda Christian University(UCU)	Private	Public Health Leadership	Di	HSM	Mukono,	www.ucu.ac.ug	1997	2009	pro@ucu.ac.ug
65	Gulu University	Public	Public Admin. &Mgt/Financial Mgt/Proj. Planning &Mgt	Ma/Di	GM	Gulu,	www.gu.ac.ug	2002	2009	+256 722 586 008 +256 722 395 186
66	Islamic University in Uganda	Private	Business Administration & Management.	Ba/Di	GM	Mbale,	www.iuiu.ac.ug	1988	2009	akoba@iuiu.ac.ug
67	Kampala International University	Private	Public Policy & Planning/Hum. Res.Mgt/Proj. Plann.&Mgt	Ma/Di	GM	Kampala,	www.kiu.ac.ug	2001		admin@kiu.ac.ug
68	International Health Sciences University (IHSU)	Private	Health Sys. Mgt/Public Health/Health Leadership & Management	Ma/Di	HSM	Kampala,	www.ihsu.ac.ug	2008	2009	vc@ihsu.ac.ug

	Name of University	Public/ Private	Programs Offered and Level		HSM or GM	Physical location	Website address	Institute Established/ Last Web Update		Contacts
COUNTRY: UGANDA										
69	Busoga University (BGU)	Private	Bus. Mgt/Project Plan. &Mgt/Hum. Res. Mgt	Di	GM	Iganga,	www.busogauniversity.ac.ug	1999		admin@busogauniversity.ac.ug
70	Makerere, University	Public	Public Health Policy/Hlth Planning &Mgt/HlthEconom. & Finance/ Hlth Systems Mgt	PhD/Ma/ Di/SCo	HSM	Kampala,	www.mak.ac.ug	1922	2009	wbazeyo@musph.ac.ug
71	Aga Khan University	Private	Health Policy & Management	Ma	HSM	Kampala	www.aku.edu/	1983		info@aku.edu
72	Mbarara University of Science & Technology	Public	Bus. Mgt/Hum. Res. Mgt/Project Planning Mgt	Di	GM	Mbarara	www.must.ac.ug	1989	2009	+256 4852 1373
COUNTRY: ZAMBIA										
73	University of Zambia	Public	Public Health	PhD/Ma/ Ba	GM	Lusaka, Zambia	www.unza.zm	1966	2009	dean-medicine@unza.zm
74	Mulungushi University	Public	Busin. Mgt/Human Res. Mgt	Ba/Di	GM	Kabwe, Zambia	www.mu.ac.zm	2008	2009	academic@mu.ac.zm
75	Zambia Adventist University	Private	Human Resource Management	Ba/Di	GM	Monze, Zambia	www.zauniversity.com	2002		deanbusiness@zauniversity.com mwanahibad@zauniversity.com
COUNTRY: ZIMBABWE										
76	University of Zimbabwe	Public	Business Administration	Ma/Ba/Di	GM	Mount Pleasant	www.uz.ac.zw	1952		+2634303211
77	Solusi University	Private	Business Administration	Ma/Ba	GM	Bulawayo	www.solusi.ac.zw	1894	2009	reg@solusi.ac.zw
78	Africa University	Private	Business Admin. &Mngt	Ma/Ba	GM	Mutare	http://www.africau.edu		2005	academic@africau.ac.zw

Admin. = Administration; Mgt = Management; Hlth = Health; Bus =Business; Serv. = Service; Res. = Resource; Int = International; Purch = Purchase; Suppl. = Supplies; Procurem. = Procurement; Gen = General; Info = Information; Tech. = Technology; Ma = Masters Degree; Ba. = Bachelors Degree; Di = Diploma; SCo = Short Course, GM = General Management Training; HSM = Health Systems Management Training

APPENDIX 2: Notes about Institutions of Higher Learning in the Four Selected Countries of South Africa, Kenya, Uganda and Tanzania:

A:

***Country*:** South Africa
Name of Institution: University of Cape Town
Year of Establishment: 1829
Geographical position in Country: Cape Town
Website: www.heu-uct.org.za

Date Institute Visited for Interview: 7th December, 2009

Contact Person and Address:

Dr. OlufunkeAlaba; e-mail: olufunke.alba@uct.ac.za
Tel: +27 (0) 21 406 6576
+27 (0) 72 438 7458

Faculty/Department: Health Economics Unit, School of Public Health and Family Medicine, Faculty of Health Sciences.

Interview Done: Yes
Questionnaire Sent to Institute: Yes
Questionnaire Filled and Returned : No

Level of Training: Masters Degree, PhD Degrees, Diploma and Short Courses
Program Type: Comprehensive Health Systems Management
Target Persons for Training: The Oliver Tambo Fellowship Program (OTFP) is a special program tailored for South African Senior Public Health Managers who are in employment. Other students are admitted to courses other than the OTFP.
Admissions from other countries: Students from other countries in the region are admitted for study. It includes those from Ethiopia, Kenya, Uganda, Zambia, Zimbabwe among others. Students from other countries are in the ratio of South Africa/Other countries, 3:1.
Payment for Training: The OTFP is a joint funded program by the South African government and other donors (SIDA). Thus the trainees are funded 50% by the public health facilities they manage and the other 50% by SIDA.

HSM Units Taught: Health Systems Management and Policy; Health Economics; Management of Health Resources; Financial Management; Health Management Theories; Health Information Systems

Partners and Collaborators: SIDA, KEMRI (Kenya), VITZ University, Makerere University, MoH South Africa, University of Nairobi, HEPNET, Ifakara (Tanzania), REACH Initiative, EQUINET.

Other Comments: The OTFP is likely to come to an end because the donor agency is proposing to withdraw funding after the end of 2010. The HEU also provides training through distance learning.

B:

***Country*:** South Africa
Name of Institution: University of The Western Cape
Year of Establishment: 1959
Geographical position in Country: Cape Town
Website: www.uwc.ac.za/publichealth

Date Institute Visited for Interview: 7th December, 2009

Contact Person and Address:

Prof. Marlene Petersen; e-mail: mmpetersen@uwc.ac.za
Tel: + 27 (021) 959 2809/2121/2132
Fax: + 27 (021) 959 2872

Faculty/Department: Faculty of Community and Health Sciences, School of Public Health (SOPH).

Interview Done: Yes
Questionnaire Sent to Institute: Yes
Questionnaire Filled: No

Level of Training: PhD, Masters Degree, Post Graduate Diploma, Diploma Certificate and Short Courses
Program Type: Comprehensive Health Systems Management
Target Persons for Training: District Health Facility Managers or any other health facility employees that are in management or leadership positions.
Admissions from other countries: Students from other countries in the Eastern and South African region train in the institution.
Payment for Training: There is no existing donor support for student's training. Students pay for their own training or seek any kind of scholarship from appropriate sources.

HSM Units Taught: Health Management, Human Resource Management and Development, Planning and Resource Management, Budgeting Skills, Health Information Systems, Health Systems Research, Health Promotion.
Partners and Collaborators:

Other Comments: The training provided at post graduate certificate in Public Health has a health management module which covers three key management areas i.e. Human Resource Management, Planning and Resource Management. Resource management include Finances, Drugs and Transport. At Master of Public Health level, training in management is provided as optional that include the areas of Health management, Monitoring and Evaluation of Health Development Programs, Information for Effective Management, Managing Humana Resource for Health and resource Development in the Health Sector.
Short and Certificate Courses are provide for a few days or weeks duration which cover one specific area or topic of health management.

C:

***Country*:** South Africa
Name of Institution: University of KwaZulu Natal
Year of Establishment: 2004
Geographical position in Country: Durban
Website: www.ukzn.ac.za

Date Institute Visited for Interview: 8th December, 2009

Contact Person and Address:

Prof. C.C. Jinabhai; e-mail: jinabhai@ukzn.ac.za
Tel: +27 (0) 31 260 4383
+27 (0) 82 774 0836

Faculty/Department: Nelson R. Mandela School of Medicine, Howard College, College of Health Sciences, Department of Public Health Medicine.

Interview Done: Yes
Questionnaire Sent to Institute: Yes
Questionnaire Filled: No

Level of Training: Masters Degree, Post Graduate Diploma, Ordinary Diploma and Short and Certificate Courses
Program Type: Comprehensive Health Systems Management

Target Persons for Training: Training targets health professionals managing health systems at various levels including district and regional.
Admissions from other countries: Students are admitted from many other countries of the Eastern and South African region including Zimbabwe, Zambia, Malawi, Kenya, Tanzania.
Payment for Training: Students pay for their training. However they are encouraged to seek scholarships from various donors. There is no existing sponsorship for the program.

HSM Units Taught: Hospital Management and Medicines Management, Health Services Management, Human Resource Management, Health Economics and Financing, Corporate Hospital Governance, Operations Management, Total Quality Management, National Health Systems, Public Health Policy and Legislation, Health Informatics and Risk Management.
Partners and Collaborators: University of Cape Town, Makerere University, University of Nairobi, University of Pretoria, University of The Witwatersrand.

Other Comments: Health Systems Management training is provided within Post Graduate Diploma in Public Health and Masters in Public Health as specialization areas

D:

***Country*:**	South Africa
Name of Institution:	University of The Free State
Year of Establishment:	1904
Geographical position in Country:	Bloemfontein
Website:	www.ufs.ac.za

Date Institute Visited for Interview: 9th December, 2009

Contact Person and Address:

Prof. Christo Heunis; e-mail: heunisj.hum@ufs.ac.za
Tel: +27 (0) 51 401 2181
+27 (0) 51 444 5011

Faculty/Department: Centre for Health Systems Research and Development.

Interview Done:	Yes
Questionnaire Sent to Institute:	Yes

Questionnaire Filled: No

Level of Training: Masters Degree, Advanced Diploma, Short and Certificate Courses
Program Type: Comprehensive Health Systems Management
Target Persons for Training: Health Professionals that manage health systems at all levels including primary, secondary and tertiary level facilities.
Admissions from other countries: Admits widely from other countries of the neighbourhood including Lesotho, Botswana, Zambia, Namibia.
Payment for Training: Currently payment for training is the responsibility of the student. As with the other institutions, students are encouraged and at times assisted to secure scholarship from donor sources

HSM Units Taught: Principles of Management, Administration/Management of Health Services, Concepts in Health Care, Health Care and Law, Health Care Planning, Health Programs and Specialized Services, Human Resource Management, Quality Assurance
Partners and Collaborators:

Other Comments: University of the Free State was involved in a massive short course training program for hundreds of South African health professionals in the period immediately following the South African Independence. This program was fully sponsored by the National Research Foundation (NRF) for Professional Development, South Africa and was intended to provide the indigenous medical personnel, who were taking over leadership of health facilities from the then apartheid personnel, with leadership skills. The program started around 2004 and trained particularly Nurses and Doctors. This program came to a halt three years after inception.

E:

***Country*:** South Africa
Name of Institution: University of The Witwatersrand
Year of Establishment: 1904
Geographical position in Country: Johannesburg
Website: www.uj.ac.za

Date Institute Visited for Interview: 10th December, 2009

Contact Person and Address:

AndileXaba; e-mail: andile.xaba@wits.ac.za
Tel: +27 (0) 11 717 3424
+27 (0) 11 717 3429

Faculty/Department: School of Public Health, Centre for Health Policy.

Interview Done:	Yes
Questionnaire Sent to Institute:	Yes
Questionnaire Filled:	No

Level of Training: Masters Degree and Certificate Courses
Program Type: Comprehensive Health Systems Management
Target Persons for Training: Training targets mainly middle and senior health managers working in public and non governmental sectors to improve their skills and prepare them to deal with changing policy dynamics and health systems challenges of South Africa and the rest of Africa.
Admissions from other countries: Students are admitted from several other countries of the Eastern and South African region.
Payment for Training: Students take care of their training costs. As with other institutions, students are encouraged and supported to seek scholarships from relevant organs.

HSM Units Taught: Health Systems and Policy, Health Care Financing, Health Systems Approaches to Planning, Hospital Management, Hospital Risk Management, Health Systems Evaluation and Research, Financial Resource Management and Health Economics, Quality Assurance in Health Care, Strategic Planning.
Partners and Collaborators: University of Kwa Zulu Natal,

Other Comments: The Systems Management program was started in collaboration with the University of KwaZulu Natal with initial funding support from the National Department of Health of South Africa.

F:

***Country*:**	Kenya
Name of Institution:	University of Eastern Africa, Baraton
Year of Establishment:	1989
Geographical position in Country:	Eldoret
Website:	www.ueab.ac.ke

Date Institute Visited for Interview: 16th December, 2009

Contact Person and Address:

Elijah Nyongesa (Dean); e-mail: dean_shs@ueab.ac.ke
Tel: +254 (20) 802 3018/802 23084/7
Fax: +254 (20) 802 3017

Mob: + 254 (20) 733 840319

Faculty/Department: School of Health Sciences.

Interview Done: Yes
Questionnaire Sent to Institute: Yes
Questionnaire Filled: Yes

Level of Training: Masters Degree, Degree
Program Type: General Management Program
Target Persons for Training: Training targets health professionals that manage health systems in both public and non governmental institutions.
Admissions from other countries: Students are admitted from within Kenya and other countries of the East and South African region including Ethiopia, Uganda, Tanzania, Malawi, Ethiopia.
Payment for Training: Students largely fund their training. The university supports students to seek scholarships from relevant organizations

HSM Units Taught: Human Resource Management
Partners and Collaborators:

Other Comments: This institution has a health systems management training program that is proposed to start in the newly established School of Public Health.

G:

***Country*:** Kenya
Name of Institution: MoiUniversity
Year of Establishment: 1984
Geographical position in Country: Eldoret
Website: www.mu.ac.ke

Date Institute Visited for Interview: 16th December, 2009

Contact Person and Address:

Dr. John Simiyu Tabu, e-mail: idemken.tabu04@gmail.com
Tel: +254 053 203 0807

Fax: +254 053 203 1637
Mob: + 254 726 593 141

Faculty/Department: School of Public Health

Interview Done: Yes
Questionnaire Sent to Institute: Yes
Questionnaire Filled: No

Level of Training: Masters Degree
Program Type: Comprehensive Health Systems Management
Target Persons for Training: Health Professionals employed in public or non governmental health facilities.
Admissions from other countries: Students are admitted from neighbouring countries including Uganda, Tanzania and Sudan
Payment for Training: Students pay for their training. However, the Kenya government provides loans to students who apply for training funds through the Higher Education Loans Board**.** This is not given to non Kenyan students.

HSM Units Taught: Hospital Administration, Health Services Management, Human Resource Management, Health Policy and Planning, Health Care Financing, Health Economics, Health Management Information Systems for Hospital Administration, Management of Hospital Supplies, Management of Catering and House Keeping, Maintenance of Hospital Buildings and Equipment, Project Management and Evaluation,
Partners and Collaborators: Makerere University, University of Nairobi, African Medical Research Foundation

Other Comments: Training in Masters of Public Health is provided both Moi Universities main campus in Eldoret, Kenya as well as in collaboration with African Medical Research Foundation in Nairobi.

H:

***Country*:** Kenya
Name of Institution: Great Lakes University of Kisumu (GLUK)
Year of Establishment: 2007
Geographical position in Country: Kisumu
Website: www.gluk.ac.ke

Date Institute Visited for Interview: 17th December, 2009

Contact Person and Address:

LinetNyapada ; e-mail: linetny@yahoo.com
Tel: +254 057 20 23972
Mob: + 254 (20) 736 550 505/722 683 813

Faculty/Department: Tropical Institute of Community Health

Interview Done:	Yes
Questionnaire Sent to Institute:	Yes
Questionnaire Filled:	Yes

Level of Training: Masters Degree, Diploma and Short Courses/Certificate
Program Type: Comprehensive Health Systems Management
Target Persons for Training: Training targets health professionals who are in employment in the public or non governmental sector.
Admissions from other countries: Admission of students from many other countries has been going on regularly. Students are admitted from countries in the Eastern and Southern African region and beyond including Rwanda, Uganda, Tanzania, Malawi, Ethiopia.
Payment for Training: Being a private institution, students are solely responsible for payment of their training costs including tuition and accommodation. As with other institutions, students that seek scholarships from relevant organizations are supported to do so by the university.

HSM Units Taught: Health Informatics, Health Financing and Health Economics, Health Systems Development and Management, Health Services Planning and Management, Health Policy Analysis and Development, Development and Management of Decentralized Health Systems, Management of Essential Drugs, Human Resource Management and development, Disaster/Emergency Preparedness and Management.
Partners and Collaborators:

Other Comments: The Institution offers training on both full time and part-time basis. Training is conducted in both the main Kisumu campus in the west of Kenya and its other campus in Nairobi.

I:

***Country*:**	Kenya
Name of Institution:	Strathmore University
Year of Establishment:	2008
Geographical position in Country:	Nairobi

Website: www.sbs.ac.ke

Date Institute Visited for Interview: 1st December, 2009

Contact Person and Address:

Stephen Mukasa; e-mail: SMukasa@strathmore.edu
Tel: +254 (20) 604036/607277/603412
Fax: +254 (20) 607498

Faculty/Department: Business School.

Interview Done: Yes
Questionnaire Sent to Institute: Yes
Questionnaire Filled: Yes

Level of Training: Masters, Diploma and Short Courses
Program Type: Comprehensive Health Systems and General Management
Target Persons for Training: Training is also tailored for executive managers in health aimed at high performing health care institutions.
Admissions from other countries: Students are admitted, at the moment, mainly from Kenya and from other countries within the East and South African region including Tanzania, Uganda, Rwanda.
Payment for Training: Being a private institution, the institution relies on the payment for training by students to sustain itself. Students therefore pay for their training or seek scholarship from relevant organizations. The institution also participates in fund raising from donors to facilitate running of the training.

HSM Units Taught: Strategic Health Care Management, Innovation in Health Care, Health Care Law and Ethics, Talent Management in Health Care, Health Management Information Systems, Supply Chain Management in Health Care, Health Economics and Health Financing, Health Policy Planning and Development, Analysis of Business Problems, Managerial Decision Making, Management Communication, Quality Assurance and Control in Health Care, Quality Management.
Partners and Collaborators: University of Nairobi, AMREF, Moi University, Kenyatta University, United States International University (Kenya)

Other Comments: Strathmore runs a recently launched program, the Executive Health Care Management Program (EHMP) which is a short course (4 weeks) program targeting executives running health facilities. The training is provided in collaboration with African Medical Research Foundation.

J:

***Country*:** Kenya
Name of Institution: Kenya Methodist University (KeMU).
Year of Establishment: 2006
Geographical position in Country: Meru
Website: www.kemu.ac.ke

Date Institute Visited for Interview: 1st December, 2009

Contact Person and Address:

Dr. B.O. Naftali Oirere; e-mail: bon_oirere@yahoo.com , nairobicampus@kemu.ke
Tel: +254 (20) 2118443/2247987/2248172
Fax: +254 (20) 248160
Mob: + 254 733 372326/ 725 751878

Faculty/Department: Business School.

Interview Done: Yes
Questionnaire Sent to Institute: Yes
Questionnaire Filled: Yes

Level of Training: Masters Degree, Diploma and Short Courses
Program Type: Comprehensive Health Systems Management
Target Persons for Training: This training targets health professionals who are in employment in both public and non governmental institutions. Non employed professionals are also admitted for training.
Admissions from other countries: Students are admitted from other countries of the Eastern and South African region including Tanzania, Uganda, Malawi, Botswana
Payment for Training: Students carter for their training costs as well as scholarships that they earn from various organizations. In addition the Higher Education Loans Board provides loans for students who apply for the same.

HSM Units Taught: Health Care Financing, Health Care Law and Ethics, Health Management Information System, Health Policy Planning and Development, Projects Management and Evaluation, Management of District Health Services, Quality Assurance and Control in Health Care, Human Resource Management.
Partners and Collaborators: This institution collaborates with University of Nairobi, African Medical research Foundation, StrathmoreUniversity

Other Comments: Kenya Methodist University provides training as part-time or full time in both campuses in Meru and its constituents colleges in Nairobi. In service training is also offered to students that apply for it.

K:

***Country*:** Kenya
Name of Institution: African Medical Research Foundation
Year of Establishment: 1957
Geographical position in Country: Nairobi
Website: www.amref.org

Date Institute Visited for Interview: 1st December, 2009

Contact Person and Address:

Alice Lakati; e-mail: alice.lakati@amref.org
Tel: +254 (20) 699 3235/6994000
Fax: +254 (20) 606 340

Faculty/Department: Directorate of Capacity Building for Health Workers.

Interview Done: Yes
Questionnaire Sent to Institute: Yes
Questionnaire Filled: Yes

Level of Training: Diploma, Certificate and Short Courses
Program Type: Selective Health Systems Management
Target Persons for Training: Targets health professionals in employment including Nurses, Doctors and Managers of health institutions in particularly governmental.
Admissions from other countries: African Medical Research Foundation trains students from many countries of the Eastern and South African region including, Tanzania, Uganda, Rwanda, Ethiopia, Sudan, Mozambique, Malawi, Zambia, Zimbabwe
Payment for Training: Students admitted for training pay for their tuition and upkeep. Programs provided by this institution are sometimes funded by donors and therefore are not charged on the participants.

HSM Units Taught: Monitoring and Evaluation, Health Services Organization and Management, Strategic Management in Health and Development Programs, Health Finance Management, Logistics Management for Drugs and Other Health Commodities

Partners and Collaborators: University of Nairobi, Moi University, Strathmore University, Makerere University, United States International University

Other Comments: African Medical Research Foundation collaborates with many other institutions and is one of the organizations with a high number of country coverage including outside the Eastern and South African region.

L:

***Country*:** Kenya
Name of Institution: University of Nairobi
Year of Establishment: 1970
Geographical position in Country: Nairobi
Website: www.uonbi.ac.ke

Date Institute Visited for Interview: 2nd December, 2009

Contact Person and Address:

Prof. Walter Mwanda e-mail: walter.mwanda@uobi.ca.ke
Tel: +254 733 714 386

Faculty/Department: Faculty of Medicine, Department of Community Health.

Interview Done: Yes
Questionnaire Sent to Institute: Yes
Questionnaire Filled: Yes

Level of Training: Masters Degree
Program Type: Selective Health Systems Management
Target Persons for Training: Training targets health professionals in employment mainly in public health facilities. Health professionals from non governmental organizations are also often admitted.
Admissions from other countries: Students are admitted mainly from Kenya. However training is also provided for students from Sudan, Uganda, Tanzania, Rwanda, Malawi.
Payment for Training: Students pay for their tuition and upkeep. Kenyan students are provided with loans, on application for the same, by the Higher Education Loans Board.

HSM Units Taught: Health Services Administration and Evaluation, Health Planning and Development.

Partners and Collaborators: Makerere University, Strathmore University, Kenya Methodist University, Moi University, African Medical Research Foundation

Other Comments: Training in health systems management in this institution is provided within the Masters of Public Health Degree. It is taught as units within the program.

M:

***Country*:** Kenya
Name of Institution: Maseno University
Year of Establishment: 2001
Geographical position in Country: Maseno
Website: www.maseno.ac.ke

Date Institute Visited for Interview: 18th December, 2009

Contact Person and Address:

Prof. Joash R. Aluoch; e-mail: wodero@africaonline.co.ke
Tel: +254 (57) 351 620
Fax: +254 (57) 351 221

Faculty/Department: School of Public Health and Community Development.

Interview Done: No
Questionnaire Sent to Institute: Yes
Questionnaire Filled: No

Level of Training: Masters Degree
Program Type: Comprehensive Health Systems Management
Target Persons for Training: Students that are targeted for training are health professionals in employment mainly in public health facilities. Health professionals from non governmental organizations are also admitted.
Admissions from other countries: This institution trains students from countries of the East African region mainly Uganda, Sudan and Tanzania
Payment for Training: Students pay for their tuition and upkeep. Kenyan students are provided with loans, on application for the same, by the Higher Education Loans Board.

HSM Units Taught: Management of Health Systems, Monitoring and Evaluation, Health Services Organization and Management, Strategic Management in Health Development Programs, Health Finance Management, Logistics Management for Drugs
Partners and Collaborators: University of Nairobi, Makerere University

Other Comments: The training in Health Systems Management is provided within the Masters in Public Health Program. This is a relatively new program compared with other institutions.

N:

***Country*:** Kenya
Name of Institution: Kenya Medical Training College (KMTC)
Year of Establishment: 1927
Geographical position in Country: Nairobi
Website: www.kmtc.ac.ke

Date Institute Visited for Interview: 1st December, 2009

Contact Person and Address:

Mary M Kanyottu; e-mail: mkanyottu@kmtc.ac.ke
Tel: +254 (20) 27275711/2/3/4 Ext. 352
Fax: +254 (20) 2722907

Faculty/Department: Medical Training College.

Interview Done: Yes
Questionnaire Sent to Institute: Yes
Questionnaire Filled: Yes

Level of Training: Diploma and Short Courses
Program Type: Selective Health Systems Management
Target Persons for Training: Training targets middle level health professionals in Kenya and beyond. These trainees are not necessarily employed at the time of admission for training
Admissions from other countries: The institution has provided training to many students of other countries in the Eastern and South African region. The countries include Uganda, Sudan, Tanzania, Malawi, Rwanda, Ethiopia, Botswana

Payment for Training: With respect to payment for training, students fall into three categories. Those that are admitted under government subsidy (Kenyans only) and whose amount paid is relatively low, those that are privately sponsored who pay much higher.

HSM Units Taught: Health Systems Management
Partners and Collaborators: African Medical research Foundation

Other Comments: The training provided in this institution is provided as a unit to all trainees of the different clinical and medical training programs.

O:

***Country*:** Kenya
Name of Institution: Kenya Institute of Administration
Year of Establishment: 1961
Geographical position in Country: Nairobi
Website: www.kia.ac.ke

Date Institute Visited for Interview: 2nd December, 2009

Contact Person and Address:

Humphrey T. Mokaya; e-mail:
Tel: +254 (20) 418 2311
Fax: +254 (20) 418 2306

Faculty/Department: Commerce and Business Administration Program.

Interview Done: Yes
Questionnaire Sent to Institute: Yes
Questionnaire Filled: Yes

Level of Training: Certificate and Short Courses
Program Type: General Management
Target Persons for Training: This training institution targets personnel working in public health institutions in Kenya and beyond.
Admissions from other countries: Training is provided to students from other countries including Sudan, Somalia, Rwanda, Ethiopia, Tanzania, Uganda.

Payment for Training: Unless paid for by the government or institution to which trainee is affiliated, trainees carter for their training costs.

HSM Units Taught: Human Resource Management, Management Information Systems, Operations Management and Strategic Management, Project planning and Management.
Partners and Collaborators:

Other Comments: This institution was established to provide training to personnel in employed in the Kenyan public sector. Health professionals working at the district, provincial and national levels have also been trained in general management and administrative skills. The institute has introduced a HSM program which has been launched to specifically train health professionals.

P:

***Country*:**	Uganda
Name of Institution:	Makerere University
Year of Establishment:	1922
Geographical position in Country:	Kampala
Website:	www.musph.ac.ug

Date Institute Visited for Interview: 4th December, 2009

Contact Person and Address:

Dr. William Bazeyo; e-mail: wbazeyo@musph.ac.ug
Tel: +256 414 543 872
Fax: +256 414 259 494

Faculty/Department: School of Public Health

Interview Done:	Yes
Questionnaire Sent to Institute:	Yes
Questionnaire Filled:	No

Level of Training: PhD, Masters Degree, Diploma and Short Courses
Program Type: Comprehensive Health Systems Management
Target Persons for Training: Provides training to health professionals that are in employment in both public and private institutions. Persons not in employment are also admitted for training.

Admissions from other countries: Students are admitted from other countries within the region including Kenya, Tanzania, Rwanda, Sudan

Payment for Training: Students admitted for training carter for their cost of training and subsistence.

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HSM Units Taught: Public Health Policy, Health Planning and Management, Health Economics and Finance, Health Systems Management, Human Resource Management

Partners and Collaborators: University of Nairobi, University of Dar es salaam, University of Cape Town, University of Zimbabwe, University of Ghana

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Other Comments: This institution also provides management training through Distance Learning programs. In addition, all undergraduate medical students are taught health policy and management during their rotation in public health.

Q:

***Country*:** Uganda
Name of Institution: International Health Sciences University
Year of Establishment: 2008
Geographical position in Country: Kampala
Website: www.ihsu.ac.ug

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Date Institute Visited for Interview: 4th December, 2009

Contact Person and Address:

Prof. Deirdre Carabine; e-mail: mailto:wbazeyo@musph.ac.ugvc@ihsu.ac.ug
Tel: +256 0312 307 400
Fax: +256 776 657 694

_____

Faculty/Department: Institute of Health Policy and Management

_____

Interview Done: Yes
Questionnaire Sent to Institute: Yes
Questionnaire Filled: No

Level of Training: Masters Degree, Bachelors Degree, Diploma
Program Type: Comprehensive Health Systems Management

Target Persons for Training: This institution targets mainly Ugandan health professional students who are either in public or private employment.
Admissions from other countries: Students from other countries also study in this institutions although in much fewer numbers. The countries include Kenya, Sudan, Tanzania.
Payment for Training: Students carter for their own training expenses in full including subsistence.

HSM Units Taught: Health Systems Management, Public Health Economics and Policy, Health Care Leadership and Management.
Partners and Collaborators:

Other Comments: This institution is a relatively new establishment (established in the past three years) and provides training either full time or full time. It also has introduced an e-Learning program.

R:

***Country*:**	Tanzania
Name of Institution:	Muhimbili University of Health and Allied Sciences
Year of Establishment:	2007
Geographical position in Country:	Dar es salaam
Website:	www.muhas.ac.tz

Date Institute Visited for Interview: 14th December, 2009

Contact Person and Address:
Dr. M.A. Mwangu; e-mail: mmwangu@muhas.ac.tz
Tel: +255 784 144045

Faculty/Department: School of Public Health

Interview Done:	Yes
Questionnaire Sent to Institute:	Yes
Questionnaire Filled:	Yes

Level of Training: Masters Degree, Bachelors Degree, Diploma and Short Courses
Program Type: Comprehensive Health Systems Management
Target Persons for Training: Training targets health worker professionals in employment as well as unemployed students who undertake this training as a profession.

Admissions from other countries: Training is provided to students from other countries in the region including Uganda, Kenya, Tanzania, Rwanda

Payment for Training: This program has been supported financially by a donor agency. However the donor is pulling out this support. During the time the support has been provided students, particularly Tanzanians, have not been paying fees.

HSM Units Taught: Health Administration and Management, Human Resource Management, Procurement and Supply Chain Management, Health Systems Management

Partners and Collaborators: Mzumbe University, Sokoine University of Agriculture and Technology, Makerere University

Other Comments: Although students have not been paying for training during the time donor funds have been available for training, the future of the program financing is uncertain without this support. The obvious course of action will be initiate payment of fees for training by all students.

S:

***Country*:**	Tanzania
Name of Institution:	MzumbeUniversity
Year of Establishment:	2006
Geographical position in Country:	Morogoro
Website:	www.mzumbe.ac.ta

Date Institute Visited for Interview: 14th December, 2009

Contact Person and Address:

Gabriel Komba; e-mail: mu@mzumbe.ac.tz
Tel: +255 754 694 029
Fax: +255 23 2604382

Faculty/Department: Faculty of Public Administration and Management

Interview Done:	Yes
Questionnaire Sent to Institute:	Yes
Questionnaire Filled:	No

Level of Training:	Masters Degree, Bachelors Degree, Diploma and Short and Certificate Courses
Program Type:	Comprehensive Health Systems Management

Target Persons for Training: This program targets health professionals in public employment or non employed professions seeking to acquire HSM as a profession. Health Administrators, Hospital Administrators, Hospital Secretaries and Health Planners.
Admissions from other countries: Students are admitted from other countries including Uganda and Rwanda.
Payment for Training: Students admitted into this institution pay for their training. Students are encouraged and supported to seek scholarships from relevant sources.

HSM Units Taught: Administration and Management, Human Resource Management, Procurement and Supply Chain Management, Health Systems Management
Partners and Collaborators: University of Dar es salaam, Makerere University, Muhimbili University of Health and Allied Sciences

Other Comments:

Appendix 3: Data for Assessing Institutional Capacities of Institutions and Program: Extractions from Filled Questionnaires

	MUHAS	KMTC	STRATHMORE	UoN	KeMU	AMREF	GLUK
Country	Tanzania	Kenya	Kenya	Kenya	Kenya	Kenya	Kenya
Curric. Review	Every 5 Yrs	3 – 5 Yrs	Annually	5 Yrs	3 Yrs		Annually
Curr. Reviewer	University	Curr. Committee	University Staff	University	Department		Departments
Date Last Curr. Rev.	2 yrs Ago	2007/2008	2009	2005	2008/2009		April 2009
Pre Service Training	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Level of Training	Degree	Diploma	Certificate/Diploma	Certificate	Degree	Cert./Dip/Degree	Degree
Student No.	250	500	35		50+	800+/25/44	70
Past Year Graduates	2	500	35		Graduate 2010	800+/23/Not yet	10
Reason for 1 Failure	Poor Acad. Perf.				Graduate 2010		Delay Thesis Submission
Hlth Worker Training	Yes	Yes	Yes	Yes	No	Yes	Yes
Level of Training	Certificate	Diploma	Certificate/Diploma	Certificate	Planned	Cert./Dip/Degree	Degree
Student No.	30	20	35		Planned	1000+/25/40	100
Past Year Graduates	30	20	35		Planned	To graduate	45
Reason for Failure	All Pass						
Other Count. Student	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Students From	Uganda	UG/TZ/ET/S.SD/MW/Nam*	UG/TZ/Rwanda	DRC/Rwanda	Sud/TZ/Namib	Many Countries**	MW/SUD/ERIT/NGR/ RNDA/JAMAICA/ETH IOP
Level of Training	Degree	Certificate/Diploma	Certificate/Diploma	Degree	Diploma/Degree		Dip/Cert.
No. from Other Count	Not Sure	20 - 30	10		6		15
Other Inst. Training	MZU/UD/ESAMI	KIA/Strath/ESAMI/USIU	AMRE/KIA/USIU/KeMU	AMREF	AMRE/KU/Moi/UoN	Moi/Strathmore	Moi/KU/KMTC
Staff	50 (Sch. of Publ. Hlth)	676 (all institute)		7	10	9	52
Bachelors	15	85	X			4	15
Masters	20	93	X	6	6	3	30
PhD	15	3	X	1	4	2	7
Facilities: Lecture RM	2	41	4			6	
Capacity	40 students	60	60			30 to 60	40
LCDs	2	Several	Several		14	5	6
Computers	2	Several	Several		80	35	7
Projector Screens	2	Several	Several				
Facility Adequacy	No	No	Yes	Yes	No	No	Yes
Add. Requirements	3 Classes	Modern Tech. Equipment			Class Space	Class Space/Facilities	
Partners	Bergen University	AMREF, Moi	AMREF, UoN,	AMREF	AMREF, UoN	Strathmore, Kemu, Moi, UoN	WHO/MoH/Moi/Emory Univers/Univ. of Ottawa
Funding Organ	NORAD (Ends 2013)	GoK/Tuition Charges	Institute Tuition Charges, Fund raising	GoK/ Tuition charged	Tuition Charged/ Church Sponsor	Self Fund Raising/Tuition Charged	WHO/MoH/Wellcome/I DRC/DFID/ Tuition Charges
Students Pay Fees	No	Yes/ Ks. 80,000.00	Yes/Ks. 306,600.00	Yes	Yes/ 600,000 – 900,000	Yes	Yes
Constraints	Staff/Facilities/Fundin g	Staff/Facilities	Infrastructure			Staff/Facilities	Ksh. 480,000.00

*ECSA countries. ** S.Sudan, Siera Leone, Ghana, Nigeria, Somalia, Rwanda, Tanzania, Uganda, Liberia

Appendix 3 (Continued): Data for Assessing Institutional Capacities of Institutions and Program

	University of East ern Africa, Baraton	Kenya Institute of Administration
Country	Kenya	Kenya
Curric. Review	Every 5 Yrs	Every year
Curr. Reviewer	University	Institution
Date Last Curr. Rev.	-	2008
Pre Service Training	No	No
Level of Training	N/A	-
Student No.	N/A	-
Past Year Graduates	N/A	-
Reason for 1 Failure	N/A	-
In Service Training	Yes	Yes
Level of Training	Degree	Short Course/Certificate
Student No.	5	200
Past Year Graduates	5	200
Reason for Failure	N/A	None
Other Count. Student	Yes	Yes
Students From	Kenya, Uganda, Tanzania, S. Africa	Eritrea, Tanzania, Ethiopia, Malawi, Sudan
Level of Training	Degree	Certificate
No. from Other Count	158	None
Other Inst. Training	2 Public Universities	Strathmore, KeMu
Staff	26	30
Bachelors	7	-
Masters	17	30
PhD	2	-
Facilities: Lecture RM	2 Main lecture rooms	12
Capacity	250 students for the two rooms	20-40
LCDs	18	12
Computers	23 laptops	Many
Projector Screens	-	12
Facility Adequacy	No	No
Add. Requirements	Lap tops, LCDs, Scanner, Printers, Copier	Lecturers, Student Hostels
Partners	University of Kuipio, Finland	AMREF, University of Nairobi
Funding Organ	Tuition Charged/Church Sponsor	Kenya Government/Tuition Charged
Students Pay Fees	Yes	Yes
Constraints	Funding	Funding

N/A = Not applicable.

APPENDIX 4: List of Institutions** which Were Interviewed and/or Questionnaires Were Filled.

South Africa		Date of Visit	Contact Person and Title
	University of Cape Town*	7th December, 2009	Dr. Olufunke Alaba (Researcher) and Allison Stephens (Communications Officer)
	University of the Western Cape	7th December, 2009	Prof. Marlene Petersen, Head of Department
	University of Kwa Zulu Natal*	8th December, 2009	Prof. C.C. Jinabhai
	University of the Free State	9th December, 2009	Prof. Christo Heunis (Head of Centre) and Dr. Katinka de Wet (Researcher)
	University of the Witwatersrand*	10th December, 2009	Andile Xaba (Communications officer and Ms. Prudence Ditlopo (Researcher).
Tanzania			
	Mzumbe University* √	14th December, 2009	Gabriel Komba, Associate Director
	Muhimbili University of Health and Allied Sciences* √	14th December, 2009	Dr. M.A. Mwangu (Program Coordinator)
Kenya			
	University of Eastern Africa, Baraton* √	16th December, 2009	Dr. Elijah Nyangema, Dean
	Moi University*	16th December, 2009	Dr. Peter Gatongi, (Dean) and Dr. John Simiyu Tabu (Lecturer).
	Great Lakes University* √	17th December, 2009	Linet Nyapada (Deputy Director TICH) and Prof. Dan Kaseje, Vice Chancellor
	Maseno University	18th December, 2009	Prof. Joash R. Aluoch (Dean) and Prof. Wilson Odero, (Director)
	Kenya Institute of Administration* √	2nd December, 2009	Mr. Humphrey T. Mokaya, Ag. Head of Department
	University of Nairobi* √	2nd December, 2009	Prof. Walter Mwanda, Head of Department.
	Kenya Methodist University* √	1st December, 2009	Dr. B.O. Naftali Oirere, Head of Department
	Kenya Medical Training Centre* √	1st December, 2009	Mrs. Mary W. Kanyottu
	Strathmore University* √	1st December, 2009	Mr. Stephen Mukasa
	AMREF* √	5th January, 2010	Alice Lakati
Uganda			
	Makerere University*	4th December, 2009	Dr. William Bazeyo, Dean
	International Health Sciences University*	4th December, 2009	Prof. Deirdre Carabine, Vice Chancellor

*Institutions which were visited and discussions held.
√ Institutions that returned a filled questionnaire to investigator
** Criteria for selecting these institutions is provided on page 18, section 3.2.

APPENDIX 5: Questionnaire for Assessing HSM Training in Institutions

Needs Assessment for Strengthening Capacity for Health Systems Management and Administration (HSM).

TRAINING RESOURCE ASSESSMENT TOOL

GENERAL INFORMATION

Date of visit ……..……..

1. Name of country……
2. Name of Country region where institution is situated
   …….
3. Name of Institution/organization
   ……
4. When was this Institution
   established……
5. Position of Respondent in
   Institution/organization……
6. Length of service of Respondent in the Institution/organization
……

7. Communication contact/s of the interviewee (officer)
   Telephone ……..……
   Fax…… …..……...
   E-mail……..……

8. Are these contacts easily accessible? YES [ ] NO [ ]

9. Type of Institution [ ] Academic [ ] Research

10. Level/s of training provided by the Institution
[ ] Post Graduate Degree [ ] Degree [ ] Diploma [ ] Certificate

11. Is Institution [ ] Private [ ] Public

12. Institutions web site if any……

Administrative information

1. Is there a policy for Health Systems management (health administration and leadership) training in your institution? YES [ ] NO [ ]

   (i) If YES for what cadres is this? (Degree, diploma, certificate)?.....
   (ii) If NO, Why?……

3. Is there a regulating body for the Health Systems Management/Managers (HSM) profession in the country? YES [ ] NO [ ] DO NOT KOW [ ]

   (i) If YES (for 3), does it regulate both training and practice?
   YES [ ] NO [ ] DONOT KOW [ ]

   (ii) If YES (for 3 (i)) explain which ones……

   (iii) If NO, explain who does this……

4. Is the body involved in both pre-service and in-service curriculum development for national HSM?
   YES [ ] NO [ ] N/A [ ]

   (i) If YE, explain
   ……

   (ii) If NO, who develops the curriculum? .....

5 How often are the HSM curricula reviewed in your institution?
   ……

6. When was the current curriculum in your institution last reviewed (date)
   ……

7. Is there a formal process for this curriculum review
   YES [ ] NO [ ]

   If Yes, describe the process……

8. Do you provide pre-service leadership training in HSM in this institute?
   YES [ ] NO [ ]

   (i) If Yes, at which level?
   Certificate [ ] Diploma [ ] Degree [ ]

   (ii) If Yes, state the numbers (on average) that are admitted annually
   Certificate [ ] Diploma [ ] Degree [ ]

   (iii) If Yes, state the numbers that graduated last academic year.
   Certificate [ ] Diploma [ ] Degree [ ]

   (iv) For the student who failed to graduate as required, state the commonest reason/s
   ……

9. Do you provide in-service leadership training to health workers? YES [ ] NO [ ]

(i) If Yes, at which level?
Certificate [ ] Diploma [ ] Degree [ ]

(ii) If Yes, state the numbers (on average) that are admitted annually
Certificate [ ] Diploma [ ] Degree [ ]

(iii) If Yes, state the numbers that graduated last academic year.
Certificate [ ] Diploma [ ] Degree [ ]

(iv) For the student who failed to graduate as required, state the commonest reasons
……

10. Are there students from other countries that train in this institution YES [ ] NO [ ]

(i) If Yes, which are these countries……

(ii) If Yes, at what level?
Certificate [ ] Diploma [ ] Degree [ ]

(ii) If Yes, state the numbers (on average) that are admitted annually
Certificate [ ] Diploma [ ] Degree [ ]

(iii) If Yes, state the numbers that graduated last academic year.
Certificate [ ] Diploma [ ] Degree [ ]

(iv) If NO Why? .....

11. What other institutions/organizations, that you know of, offer leadership training for health workers in this country?

……

12. What is your current teaching staff numbers and qualifications? .....

Degree holders……. Bachelors[ ] Masters [ ] PhD[ ]

Diploma holders……OD[ ] HND[ ]

13. What measures are in place to maintain teaching staff competence? .....

……

14. What are the various facilities at your institution used in training of Human Resource Managers?

(i) Lecture rooms [ ]

(ii) Total capacity of Lecture rooms [ ]

(iii) Major training equipment

Type…… Number [ ]

Type…… Number [ ]

Type…… Number [ ]

Type…… Number [ ]

Type…… Number [ ]

16. In your opinion, are these facilities adequate for the student population?

    YES [ ] NO [ ]

17. If NO, what immediate requirements would you have to improve this position……

1. Are there any local / international organization that you partner with, in the provision of HSM (kindly list them)

   ……

   Who are the key funding organizations of this (HSM) training institution? .....

2. Which other organizations fund this institution?.....

3. Do students pay fees? YES [ ] NO [ ]

   (i) If YES, what are the total fees for a course offered?

   ……

   (ii) If NO, how are training costs met?

   ……

4. What are the constraints to HSM for health systems training in the institution? .

   ……

SUMMARY

Please use the space below to add any comments and recommendations.

……

……

APPENDIX 6: Terms of Reference:

Title: Human Resources for Health Specialist A

1. Background

There is a concern that many countries in Africa are behind in their progress toward achieving health-related MDGs by 2015. Though there are several impeding factors, the vulnerability of the health systems in most of the African countries, especially the critical shortage of human resource for health, is considered to be one of the biggest constraints.

African countries, through AU resolution in the Africa Health Strategy 2007-2015, collectively regard development of human resources for health as one of the priorities in health development in the region. As part of the responses from the donor community, the Government of Japan made a commitment to train 100,000 human resources for health in Africa over 5 years and in accordance with the Yokohama Action Plan which was adopted in TICAD IV in 2008.

Takemi Working Group, an independent group organized by former Japanese parliamentarian, Mr. Keizo Takemi, with an aim of informing the policy formulation process of TICAD IV and G8 on global health, published a series of thematic papers on health systems strengthening. One of the recommendations on human resource for health was *to strengthen the international networks of higher education institutions to provide access to health and medical education in areas with limited resources*.

Like other building blocks of the health systems, the issue of human resource for health should be addressed by individual countries reflecting needs and constraints unique to each country. However, regional networking of research and training institutions is deemed effective for the training of health administrators and managers, as the participants will benefit from exposure to experiences of other countries and from mutual learning process.

Based on the above background, JICA is conducting a study to explore the possibility to support regional programs and activities in Eastern and Southern Africa which can contribute to the sustainable development of human resource for health (HRH) in the region. Among the diverse cadres included in HRH, focus will be given to the training of health administrators and managers in the area of health systems management as they will benefit more from regional exchange of experiences and lessons learned.

2. Objectives

As part of the regional programming exercise of JICA, the consultant is expected to identify higher educational and research institutions, both public and private, in 23 countries in Eastern and Southern Africa[1], which poses strategic implications for sustainable development of human resource for health (HRH) in the region. Those institutions which offer training programs in the areas of health systems management (e.g., policy & planning, monitoring & evaluation, governance & leadership, health facility management, health program management, health financing, HRH management, health information management, logistics management, etc.) and those actively receiving students from other countries in Africa shall be prioritized for selection. Not only specialized institutions for health professional education (e.g., schools of public health), but also general schools (e.g., schools of public administration) which offer management training for health professionals shall be included as much as possible.

[1] Twenty three (23) countries which belong to either EAC, ECSA-HC, IGAD or SADC. List of countries are provided in Annex 1.

Such information as details of the programs offered including short-term programs, geographic coverage of the students, areas of specific competency, cooperating partners, membership to any networks of training institutions (e.g., network of schools of public health, etc.) shall be compiled for each of the selected institutions.

Even though the study intends to cover 23 countries in East and Southern Africa, institutions located in countries with full-scale JICA offices, especially Kenya and South Africa, shall be given priority to be consistent as much as possible with JICA's country programs in those countries[2].

Based on the survey, the consultant is expected to present recommendations for strengthening existing programs. Recommendations should also be made on possible future JICA partnership with such institutions[3].

3. Expected Specific Tasks

(1) Identifying existing databases of higher education and research institutions for HRH development in Sub-Sahara Africa (Approx. 5 days)

The consultant is expected to identify existing databases of higher educational and research institutions in Sub-Sahara Africa, with focus on Eastern and Southern Africa, which can be utilized for the study. The consultant is expected to search for and liaise with organizations with the possibility to access such databases, e.g., with WHO Regional Office for Africa, Global Health Workforce Alliance, Africa Health Workforce Observatory, Regional Economic Cooperation Organizations (e.g., EAC, ECSA-HC, IGAD, SADC) and networks of educational institutions to obtain relevant information from available databases. If needed, JICA will provide facilitation for communication with such organizations.

(2) Identifying other readily available data sources of higher education and research institutions for HRH development in Sub-Sahara Africa (Approx. 5 days)

The consultant is expected to identify other readily available data sources of higher educational and research institutions in Sub-Sahara Africa, with focus on Eastern and Southern Africa, which can be utilized for the study. The consultant is expected to search for such sources using internet and other means to obtain relevant information.

(3) Analyzing information obtained from exiting databases, web-sites and other readily available sources (Approx. 20 days)

The consultant is expected to analyze the information collected from the readily available sources, such as existing databases obtained from other organizations, web-site of each institution, and other existing materials. First, the consultant is expected to identify institutions which offer training programs (both long and short courses) in the area of health systems management.

Specific areas may include the following.

- Health policy and planning
- Monitoring and evaluation of health policies and programs
- Health governance and leadership
- Health financing
- Health facility management
- Management of human resources for health
- Health information management
- Health logistics management

---

[2] List of the countries with permanent JICA's presence is provided in Annex 2.

[3] List of examples of such institutions are provide in Annex 3. The list is not exhaustive.

Not only specialized institutions in health professional education (e.g., schools of public health) but also general schools which offer management training for health professionals (e.g., schools of public administration) should be included in the selection as much as possible. Both public and private institutions should be included in the selection.

After the selection, the consultant is expected to collate detailed information on each institution. Such information may include the following.

- Name of the institution
- Location
- Contact information
- URL (Web-site)
- Relevant Programs offered
- Geographical coverage of students/trainees
- Specific areas of technical competency
- Administrative capability
- Membership to network organizations
- Partner organizations

(4) Collecting additional information through questionnaire survey (Approx. 5 days)

In order to augment information collected from readily available sources, the consultant is expected to conduct a questionnaire survey. The consultant is expected to develop, send, collect the questionnaire and analyze the additional information collected from the survey.

(5) Conducting on-site survey of selected institutions (Approx. 8 days x 2 countries)

The consultant is expected to conduct on-site interview survey to further verify the capacity and challenges of the identified institutions. It is desirable to conduct on-site survey for each of the institutions, but in consideration of the administrative constraints, maximum two (2) countries shall be selected. Further, in consideration of the relatively higher concentration of candidate institutions and consistency with the current country assistance programs of JICA, South Africa and Kenya are tentatively selected for on-site surveys. The consultant is expected to provide debriefing to JICA Office in the country after the survey. The consultant is expected to make travel arrangements by him/herself, though JICA can provide facilitation when needed. The traveling expenses shall be provided separately by JICA according to its standards.

(6) Drafting a report (Approx. 5 days)

The consultant is expected to write up and submit a report which summarizes the study findings, including all the information and material collected. The report may include the following in the contents:

- Overview of health systems management training capacity in Eastern and Southern Africa
- Summary of programs in each institution
- Strengths and weaknesses of each institution and its programs
- Measures to improve on existing programs
- Possible areas of future partnership for JICA with selected institutions

Details of individual institutions shall be presented as annexes.

(7) Dissemination workshop of study results (Approx. 1 day)

The consultant is expected to make a presentation at a dissemination workshop which shall be organized by JICA. The consultant is expected to take note of comments and opinions raised during the workshop and take them into account in finalizing the report.

(8) Finalizing a report (Approx. 3 days)

The consultant is expected to finalize the report with proper indexes, charts and references and submit two hard copies and one electronic copy to JICA. Relevant materials collected during the survey shall be properly indexed and submitted to JICA.

4. Outputs

The consultant is expected to submit draft report by the 15th January, 2010. Revised final report shall be submitted by the end of January 2010 in two (2) hard copies and one (1) electronic copy, together with relevant materials collected and properly indexed.

Promoting Governance and Accountability for improved service delivery

in the Eastern Africa Health Sector

AMREF International Training Center, Nairobi, Kenya
March 21-25, 2011

The learning event *"Building Capacities for Promoting Governance and Accountability in the East Africa Region"* brought together a diverse group of policy makers and senior program managers from the Government, Civil Society Organizations actively engaged in improving health services for the poor and members of the Africa Health Leadership and Management Network (AHLMN), an important regional think tank aiming to build capacity for leadership and management in support of national health systems in Africa. The workshop created much needed awareness amongst the participants from Burundi, Kenya, Rwanda, Tanzania, and Uganda about challenges of poor governance and accountability in the delivery of health services.

This learning event was jointly organized and conducted by the African Medical and Research Foundation (AMREF), Japan International Cooperation Agency (JICA) and the World Bank (WB) for the East African countries. Within the Bank, the Health Systems Strengthening program worked in partnership with the Kenya Social Development Team, Governance and Anti Corruption in Projects Unit, Regional Governance Focal Point, Health Nutrition and Population Anchor and the regional Water and Sanitation Program of the WB in the planning and conduct of the workshop. The five day program aimed

1. To familiarize the participants with emerging concepts of governance, accountability and corruption and

2. To build skills in

   - identifying the risks associated with bad governance in the health sector and

   - using the new tools for undertaking assessments and for appropriate mitigation covering both demand and supply side governance.

Case studies were used to allow learning from country experiences about strategies, core elements and innovations to improve governance in the health sector including advocacy for good governance to apply in their own country context.

The workshop agenda provided room for extensive discussions amongst participants and allowed for valuable sharing of experience. During the workshop, participants developed Country Action Plans comprising measures that should help in improving governance and accountability in the participants' countries. Participants were also introduced to health systems Communities of Practice (CoPs) coordinated by the Harmonization for Health in Africa (HHA) to sustain cross-country learning and networking. A number of them subsequently enrolled in the CoP in the area of Governance and Service Delivery.

Day 1 started with a warm welcome from Nzomo Mwita, AMREF Head of Training, Eiichi Shimizu, JICA Regional Project Formulation Advisor (Health Sector), and Chris Lovelace, WB Senior Advisor. The subsequent presentations by WB governance and health-specialists Sahr Kpundeh, Ramana, Chris Finch and Denyse Morin provided an overview on the basics of governance in the health sector, including a framework for comprehensive risk assessment highlighting the core principles of transparency, accountability and participation. An animated discussion amongst the participants and introduction to the Country Action Plans completed the first day.

Day 2 was focused on risk assessment and included presentations, case studies and discussions on Political Economy Analysis, Value Chain Analysis and Public Expenditure Tracking Surveys. Main facilitators were Sahr Kpundeh, Denyse Morin and Ramana. Guest speaker Nigel Shipman, Chief of the technical support agency for the Kenya Public Procurement Oversight Authority (PPOA), provided insights into the role that Public Procurement Authorities play in promoting governance and accountability.

Day 3 shed light on the importance of demand-side governance. Embedded in an overall framework of demand-side governance, Citizen Report Cards, Community Scorecards and rapidly evolving role of Information and Communication Technology (ICT) for governance were some of the tools which received particular attention. Coordinated by Ramana, the overall workshop facilitator, Christopher Finch, Lilian Achieng Otiego and Stephan Eggli from the World Bank made the presentations and shared case studies. The afternoon saw a well received session on 5-S Kaizen for improving governance, facilitated by JICA Health Sector Consultant Naphtali Agata followed by a presentation by Jane Waireri and Isaac Mwangangi from Ministry of Medical Services, Kenya, on how this new approach helped to improve the governance and transparency of the personnel registry. Mr. Lovelace introduced the Communities of Practice being supported under the Harmonization of Health in Africa initiative.

The day was concluded by a reception at AMREF, where JICA Chief Representative Masaaki Kato, AMREF Director General Teguest Guerma, WB Senior Advisor Chris Lovelace and WB Sector Coordinator Helen Craig spoke to the participants and highlighted the increasing criticality of improved governance for achieving the health sector outcomes in the region. They welcomed the new partnership among AMREF, JICA and the World Bank and appreciated the commitment shown by the faculty to organize this learning event at such a short notice. They further emphasized the potential arising from the partnership amongst the three facilitating organizations as well as the broader community of practice created at this workshop.

Day 4 was devoted to supply side tools for risk mitigation. WB specialists Denyse Morin, Sahr Kpundeh, Cosma Gatere and Ramana introduced approaches to smart program design, improved public financial management and effective communication with stakeholders. The afternoon session, conducted by WB advisor Richard Messick, looked into corruption issues arising during program implementation.

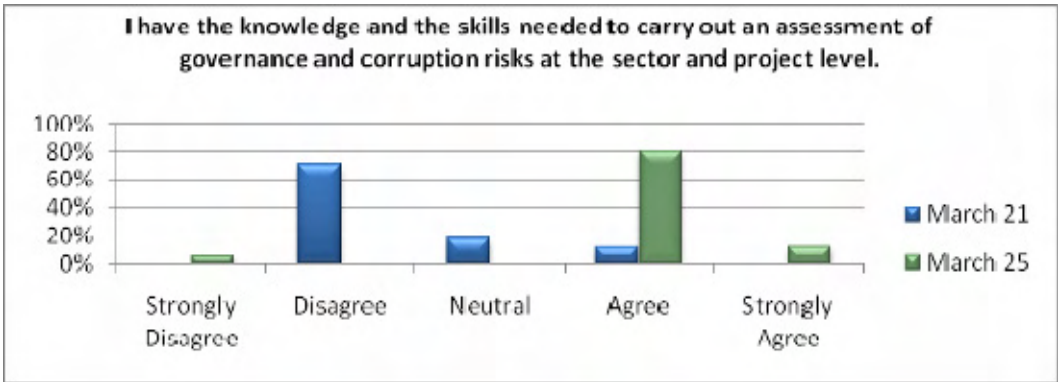
Day 5 started with a session on GAC in the pharmaceutical sector. The introduction by Lombe Kasonde from the WB was followed by an excellent presentation by Jonathan Mbului on Mission for Essential Drugs and Supplies (MEDS), a procurement agency established to support the evolving needs of Faith Based organizations in Kenya. The lessons from MEDS on improving governance in procurement and supply of pharmaceuticals generated animated discussion among participants on the challenges being faced by Central Medical Supplies Agencies of member countries.

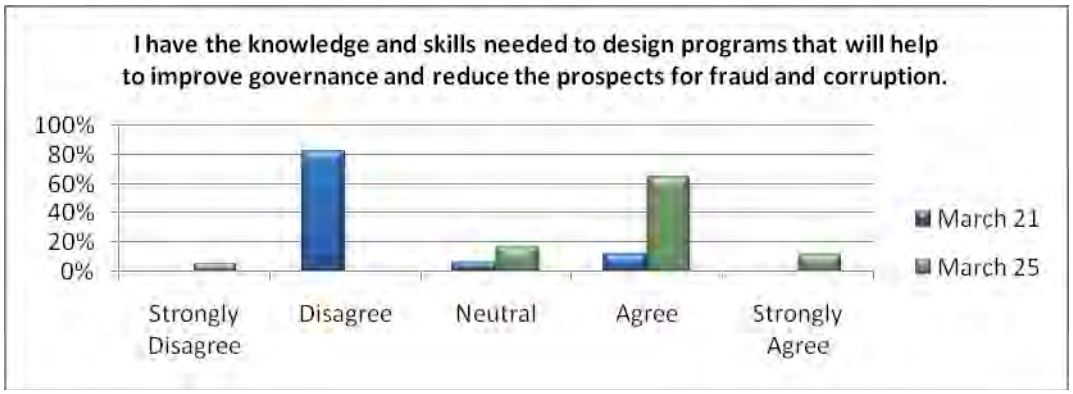
Having finalized their Country Action Plans, the participants presented the governance initiatives they would like to implement in their respective countries. These action plans covered a wide range of innovations: to improve HRH skills in governance and accountability (Rwanda); to improve quality and reduce leakage of pharmaceuticals (Burundi); to improve governance at a health facility (Tanzania); to reduce absenteeism at district hospitals (Kenya); and to improve delivery of malaria control services (Uganda). The faculty was impressed by the participants' ability to apply the tools introduced in the program and to modify them in order to fit their specific country context.

The workshop ended with a post-evaluation, certificate presentation ceremony and concluding remarks by Sylvester Kugonza, representing the participants, Peter Ngatia, AMREF Director for Capacity Building, Eiichi Shimizu, JICA Regional Project Formulation Advisor, and Ramana, overall facilitator of the workshop.

Participant Feedback:

Turning Point (e-Voting) assessment by participants (n=18):





WBI standard evaluation form results (n=18):

The evaluation suggests that this learning event, to a large extent, succeeded in achieving its objective of creating an understanding about governance and corruption risks in the health sector among participants and provided them with skills to undertake assessments and plan interventions.

	Mean (1=minimum, 7=maximum)
To what extent did the workshop fulfill your learning needs?	**5.722**
To what extent did the workshop achieve its announced objectives?	**5.889**
How would you rate the workshop's content or subject matter?	**6.278**
How would you rate the order in which the content was presented?	**5.722**
How would you rate the materials used during the workshop?	**6.000**
How would you rate the overall quality of the workshop?	**6.111**
How would you rate the overall usefulness of the workshop?	**6.167**
How would you rate the relevance of this workshop to the Bank's mission to fight poverty?	**6.176**
My knowledge/skills increased as a result of this workshop.	**6.176**
The knowledge/skills gained through this workshop are directly applicable to my job.	**5.941**
Overall Rating	**6.018**

Proposed Next Steps:

This training event successfully established new partnership between AMREF, JICA and the World Bank to collaborate and support ongoing regional efforts to strengthen health systems. The participation of the African Health Leadership and Management Network and Civil Society Organizations helps in further strengthening the demand side initiatives.

In line with the first GAC Health Sector Workshop for East Africa organized by the World Bank in 2010, this jointly organised course showed both the benefits and the demand for such learning initiatives. The participant's feedback also highlights the need for sustained support to build governance capacities at the country level. It is important to sustain the interest of this group by facilitating the implementation of action plans prepared and regular engagement through Communities of Practice as well as exchange of information and sharing innovations through e-mails and periodic video conferences. Taking these issues into consideration, the following actions are proposed:

- Work with the JICA and World Bank country teams to facilitate implementation, monitoring and evaluation of action plans developed and extend technical support from the Bank's Health Systems Strengthening Hub and JICA Regional Strategy Unit for Africa.
- Support sustained engagement through quarterly video conferences, news-letters and Communities of Practice.
- Organize more such learning events on health sector governance and accountability covering Southern and Western Africa including Francophone countries.
- AMREF to continue providing core support function in developing capacities in Africa withing the context of CoP and AHLMN.
- Explore the possibility of establishing a multi-donor trust fund for supporting proposed governance initiatives in the health sector.

Participants

#	Title	First name	Last name	Designation	Institution	Country
1	Dr.	Rachel	Nyamai	Head, Division of Peadiatrics	Ministry of Medical Services	Kenya
2	Dr.	Pacifica	Onyancha	Provincial Director of Medical Services, Nairobi	Ministry of Medical Services	Kenya
3	Dr.	Joseph	Karanja	Deputy Director, Finance and Administration Department	Kenya Medical Training College (KMTC)	Kenya
4	Mr.	Jonathan	Mbului	Training Manager	Mission for Essential Drugs and Supplies (MEDS)	Kenya
5	Dr.	Benedict	Osore	Provincial Director of Medical Services, Rift Valley	Ministry of Medical Services	Kenya
6	Dr.	Gideon	Mburu	Provincial Director of Medical Services, Eastern	Ministry of Medical Services	Kenya
7	Mr.	Sylvain	Misago	Training Director	Institut National de la Santé Publique (INSP)	Burundi
8	Dr.	Evelyne	Ndabaniwe	Chief of Clinical Sciences Department	Institut National de la Santé Publique (INSP)	Burundi
9	Dr.	Aflodis	Kagaba	Executive Director	Health Development Initiative (HDI) Rwanda	Rwanda
10	Mr.	Zachary	Bigirimanaa	Senior Lecturer	Kigali Health Institute	Rwanda
11	Mr.	Aimable	Mwananawe	National Coordinator and Chairperson	Rwanda NGOs Forum on HIV and Health Promotion	Rwanda
12	Mr.	Samuel	Kyambadde	Undersecretary and Accounting Officer	Ministry of Health	Uganda
13	Mr.	Ivan	Twinomuhwezi	Consultant, Public Policy and Governance	Uganda Management Institute (UMI)	Uganda
14	Dr.	Sylvester	Kugonza	Head, Dept of Public Policy and Governance	Uganda Management Institute (UMI)	Uganda
15	Ms	Robinah	Kaitiritimba	Executive Director	Uganda National Health Consumers Organisation	Uganda
16	Ms.	Delphine	Mugisha	Deputy Head of Development, Training Department	MS-TCDC	Tanzania
17	Dr.	Marcel	Madili	Assistant Director, Planning, Monitoring and Evaluation	Christian Social Services Commission (CSSC)	Tanzania
18	Dr.	Pamella	Lulu Sawa	Registrar of Public and Private Health Facilities	Ministry of Health	Tanzania
19	Dr.	Festus	Ilako	Country Director AMREF in Tanzania	AMREF Tanzania	Tanzania

Organisers, Facilitators & Guest Speakers

1	Ms.	Denyse	Morin	GAC in Projects OPCS	World Bank	US
2	Mr.	Stephan	Eggli	Junior Professional Officer	World Bank	US
3	Mr.	Richard	Messick	Team advisor, Governance	World Bank	US
4	Dr.	Sahr	Kpundeh	GAC focal point in Africa	World Bank	US
5	Mr.	Christopher	Finch	Senior Social Development Specialist	World Bank	Kenya
6	Ms.	Lilian	Achieng Otiego	Social Development Specialist	World Bank	Kenya
7	Ms.	Lombe	Kasonde	Operations Analyst, Global HIV/AIDS program	World Bank	US
8	Dr.	Ramana	Gandham	Lead Health Specialist, Africa Region	World Bank	Kenya
9	Mr.	Chris	Lovelace	Senior Advisor, Health, Nutrition and Population	World Bank	Kenya
10	Mr.	Cosma	Gatere	Communications Specialist	World Bank	Kenya
11	Dr.	Peter	Ngatia	Director for Capacity Building	AMREF	Kenya
12	Mr.	Nzomo	Mwita	Head of Training	AMREF	Kenya
13	Ms.	Wairimu	Njoroge	Project Coordinator	AMREF	Kenya
14	Dr.	Naphtali	Agata	Consultant (Health)	JICA	Kenya
15	Mr.	Eiichi	Shimizu	Regional Project Formulation Advisor for Health	JICA	Kenya
16	Ms.	Jane	Waireri	Personnel Registry	Ministry of Medical Services	Kenya
17	Mr.	Isaac	Mwangangi	Quality Assurance	Ministry of Medical Services	Kenya
18	Mr.	Nigel	Shipman	Chief of Party	ARD Kenya	Kenya
19	Dr.	Hezekiah	Chepkwony	Director	National Quality Control Lab., Kenya	Kenya

Special guests for Reception

1	Dr.	Teguest	Guerma	AMREF Director General	AMREF
2	Mr.	Masaaki	Kato	Chief Representative	JICA
3	Mr.	Christopher	Lovelace	Senior Advisor and Program Leader Health Systems Strengthening Hub	World Bank
4	Ms	Helen	Craig	Sector Coordinator Human Development	World Bank

Program

March 21	Activity	Purpose	Faculty
8:30 AM	Welcome and Introductions	Knowing each other and Workshop Objectives Partnerships for Regional Capacity Building for Health Systems Strengthening	*Chris Lovelace, Coordinator HSO Hub, Nairobi* *Eiichi Shimizu/Naphtali Agata JICA and Peter M. Ngatia and Nzomo Mwita AMREF*
9:00 AM	"Turning Point" Exercise	Sharing Participant perceptions about Governance and Anti Corruption Course overview Setting Ground Rules	*Denyse E. Morin and Stephan Eggli, GAC in Projects Working Group, OPCS, World Bank* *Ramana* *Participants*
10:00 AM	Coffee/Tea		
10:30 AM	Governance and Accountability basics	Introduction to concepts and definitions of governance, corruption, accountability, transparency	*Sahr Kpundeh GAC in Projects Focal Point, Africa Region, World Bank*
11:30 AM	Accountability and Health Systems Performance	Facilitated discussion on benefits of improved accountability on health systems performance, including demand-side governance, followed by case studies to learn from practical experiences on approaches for promoting accountability in the health sector	*Ramana, Christopher Finch, World Bank*
13:00 PM	Lunch time - Speech		
14:30 PM	Comprehensive risk assessment: a framework	Looking at risks in a systematic, holistic and in an integrated manner	*Denyse E. Morin, World Bank*
15:30 PM	Tea		
16:00 PM	Country Action Plan I: Group work in country teams	Introduction to the concept of Country Action Plans. Listing governance challenges in health sector. Learning from each other about country innovations in promoting governance.	*Ramana* *Participants*

March 22	Activity	Purpose	Faculty
8:30 AM	Assessing GAC risk and emerging good practices	How to do Problem Driven Political Economy Analysis	*Sahr Kpundeh, World Bank*
9:30 PM	Assessing GAC risk and emerging good practices	How to do Value Chain Analysis	*Denyse E. Morin and Ramana, World Bank*
10:30 AM	Coffee/Tea		
11:00 PM	Assessing GAC risk and emerging good practices	How to do Public Expenditure Tracking Surveys	*Sahr Kpundeh, Christopher Finch, World Bank*
12:00 AM	Implementing PETs in the health sector	Case study from Kenya	*Economic Planning Units, Ministries of Health Kenya*
13:00 PM	Lunch -Role of Public Procurement Authority in promoting Good Procurement Practices	Challenges in procuring goods and works in the health sector and practical approaches to improve governance.	*Nigel Shipman, Chief of Party, ARD , Kenya*
14:30 PM	Case Study	Political Economy Analysis in practice	*Participants facilitated by Ramana*
15:30 PM	Tea		
16:00 PM	Country Action Plan II continued: Group work	Discussion on how Political Economy Analysis, Value Chain Analysis and Public Expenditure Tracking Surveys could be used in the specific country context	*Participants*

March 23	Activity	Purpose	Faculty
8:30 AM	Understanding demand side governance	Introduction to tools of demand side governance	*Christopher Finch, Social Development Specialist, Kenya*
9:30 AM	Case Study on Demand Side Governance	Citizen's Report Card on urban water, sanitation and solid waste services in Kenya followed by DVD Presentation	*Lilian Achieng Otiego supported by Christopher Finch*
10:30 AM	Tea & Group Picture		
11:00 AM	Discussion	Discussion on improving demand side governance in the health sector	*Participants and faculty*
12:00 PM	ICT tools for governance	An overview of ICT tools used to promote governance	*Stephan Eggli, World Bank*
12:45 PM	Innovative approaches in Promoting Governance – Use of ICT – USHAEDI		
14:15 PM	Promoting demand side governance	SMS for life Case study from Tanzaina	
15:15 PM	Role of 5-S Kaizen in improving health sector governance	Lessons from 15 countries in promoting transparency and participation to improve quality of hospital services	*Naphtali Agata/JICA*
16:00 PM	Tea		
16:30 PM	Enhancing Accountability of the Personnel Registry through 5S-	Highlighting the outcome of applying the 5 S Kaizen principles at the personnel registry	*Jane Waireri and Isaac Mwangangi, Ministry of Medical Services*
18:00 PM	Reception		

March 24	Activity	Purpose	Faculty
8:30 AM	Moving forward from Analysis to action I	Smart program design and beyond – Sharing experiences from the countries	*Denyse, Sahr and Ramana, World Bank*
9:30 AM	Mitigating GAC risk and emerging good practices	Improving Public Financial Management	*Sahr Kpundeh, World Bank*
10:30 PM	Tea		
10:45 PM	Moving forward from Analysis to action II	Communication and stakeholder engagement – Art of Advocacy	*Christopher Finch, World Bank*
11:45 PM	Anatomy of corruption in the Health Sector	Facilitated discussion on corruption vulnerabilities of the health system	*Ramana*
12:45 PM	Lunch		
14:15 PM	Corruption in Health Sector – country case study	Presentation of findings from on corruption in a Health Project investigated by the World Bank	*Richard E. Messick, Preventive Services Unit, Department of Institutional Integrity, The World Bank*
15:15 PM	Coffee/Tea		
15:45 AM	Corruption in Health Sector – country case study	Corruption in Health Sector – Case study Group discussion on positive and negative factors in the public procurement systems, and how they may mitigate or provide opportunities for corruption	*Richard E. Messick and Ramana*
16:45 PM	Group Exercise	Identification of Corruption "Red Flags"	*Richard E. Messick and Ramana World Bank*

March 25	Activity	Purpose	Faculty
8:30 AM	Patterns of Dysfunction in effective use of Pharmaceuticals	Challenges for enhancing governance in pharmaceutical sector	*Lombe Kasonde, The World Bank*
9:30 AM	Practical steps for improving pharmaceutical supply and use	Strategies for promoting pharmaceutical governance, evidence and effectiveness and emerging Good Practices	*Lombe Kasonde, World Bank.*
10:30 AM	Coffee/Tea		
11:00 AM	Video	Innovations to detect counterfeit and substandard drugs – the Nigerian example	*Lombe Kasonde, World Bank.*
11:15 AM	Group Discussion – Promoting Pharmaceutical Governance in East Africa	Facilitated discussion on promoting pharmaceutical governance in East Africa focusing on • Efficient pharmaceutical supply chain management • Harmonization of licensing	*Lombe Kasonde and Ramana, World Bank.*
12:00 PM	*Lunch Time Speech - Improving Pharmaceutical Quality in low Resource Settings - Hezekia k Chepkwony, Director, National Drug Quality Control Lab, Kenya*		
13:30 PM	Country Action Plan IV: Group work by country teams	Development of country specific plans for improving governance including listing of risk assessment-, supply- and demand-side-activities and need for technical assistance	*Country teams*
14:30 PM	Coffee/Tea		
15:00 PM	Presentations of Country Action Plans	Country teams present their Action Plans, followed by a discussion	*Country teams*
16:00 PM	Discussion on sustaining the network and Community of Practice	Open forum	*Country teams and Faculty*
17:00 PM	Participant Feedback-Turning point Exercise		*Stephan Eggli*