Chapter 10

African Ministry of Health Perspectives

Speakers:
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Violet Opata, Kenya
Ron Mataya, Malawi
Bernice Dahn, Liberia
Victor Mbome Njie, Cameroon

African Participant: With partnerships, we can train more OBGYNs. I am saying this because in my country it is really just the department with the universities that are doing the training. But looking at what others are doing, I've seen that it is possible with partnership to train more. I've also seen that we have some opportunities within the country. For example, currently only one university is training and another university has just been opened like two years now, so there is an opportunity for us to really ameliorate the deficiency.

Ray de Vries: So, I think one of the questions that Frank is interested in is, 'What will happen to allow you to do that, to work with other countries?' How does that happen? The problem with meeting like this is that we come together, we have good ideas, but then we go back and we have a lot of work to do. Unless we have something planned, something concrete … We don't have to answer that now. [Laughter]

African Participant: Let me take it.

Ray de Vries: Yes, please!

Robert Odok-Oceng: I am very grateful to be able to participate in this meeting because this OBGYN, to me, I thought it was just another medicine. When you do medicine, you also do it. Therefore, you have enough of them. I did not know that there was a specialization, which I learned from here and from my colleague in Uganda that we have five medical schools, but only two training OBGYNs at masters levels and very few come out. The few who do come out are taken up by mainly by Sudan because Sudan is in a very poor shape in terms maternal health compared to Uganda. Of course, they pay better also so that we have a big shortage.

The fistula that they were talking about is a big problem in Uganda. Many women really also have it suffer. Some women decide to commit suicide because they cannot imagine living like that for the rest of their lives and very few people can handle it, even the medical practitioners that can handle it are very few. What I'm going back with in terms of policy is first to bring awareness in the Ministry of Education, where training the medical personnel falls, so that we target in terms of funding.

We ask universities to give us the data on OBGYNs and how many there are. Of course, our government is putting a lot of money in maternal care and maternal health, but I didn't know that this was a big component, which we did not ask who trains and should have been at the forefront. We have so many health centers for where there are theatres and doctors are posted there because women always have obstructed labor and deliveries, and they should have cesarean operation where the child is delivered safely; that is the intention. When there are so few people who have the expertise to face the challenge while the maternal health is in danger. So I think we shall put some

money in the budget and target the number of trainees using government resources. Of course, with the collaboration we are happy. In our group yesterday, we were talking about what level we can train. So if we can partner in this organization and this corporation, so if we can have staff from the US coming over some months to this unit and to do the mentorship, in five years we have may have developed our faculties at that level and continue the work. Now, there are only two universities and there are very few who don't have faculties. Through this cooperation we can have access to qualified staff in the US who can be allowed to come and teach their units and do their mentorship. As a government, we should put money after talking to the universities and they should let us know what is their need, so we can put some money for training and expand the facilities for training. We are lucky that we have got some money from ADB. That project is under me so I would also see that it is improving the facilities and the faculties of medicine in this respect. Because we have not started yet; we are about to start the project.

Ray de Vries: We have heard two problems, the problem of not having enough faculty and one you mentioned earlier, the problem of keeping trained OBGYNs in the country. In your country, it seems that they move out. Are there other problems in addition to these that you all see and think about ways you can address those? Are those common problems-with faculty?

Violet Opata: Thank you for this opportunity. I will want to take it from the perspective of university in the relation to the ministries, both the Ministry of Education and the Ministry of Health. At the university level, the collaboration is already existing under the School of Medicine and the IU, which is the Indiana University. From this perspective it is very clear that there are areas that can be taken up, that is training, research, and then as we undertake that, we must be able to align within the Ministry of Education to ask, 'What are the expectation for these programs to take off if we are a trainee?' The Ministry of Education has clear policies for any program to be implemented in any institution, that is if it is a university institution, it must be accredited. Accreditation procedures must be undertaken. Therefore at the school level and the department level, the department must develop the program that must meet the accreditation criteria that is offered by the Ministry of Education. That goes through the Senate, and after it goes through the Senate, it goes through the Minister of Education, that is under the commission of the university education for it to be approved. That is one aspect that we must align what we are collaborating in in line with what is required by the Ministry in order to control quality.

Then the other aspect is also to align us with the Ministry of Health and look at in today's universities. What are some of the areas that the Ministry of Health will want to be researched on, so that we bring the output to the Ministry to implement into their respective area? There is lack of collaboration between those two areas because the university is focusing on research, which is not informed by the Ministry. We need the Ministry to come and say these are the lines on which we are really hard-pressed. We need the university to take it up in order to do research and come improve the situation in the society. I am very happy at the moment. The Ministry of Health through the first lady have come up with a program for improving maternal mortality in the country, but we need now to narrow it down to the university. How can the universities come up and help in achieving this particular pertinent goal? So the issue of policy must be clear, the issue of accreditation and certification must be in order, in order to run this collaboration. But already, we have the collaborations ready. Thank you.

Ron Mataya: From the Human Resource perspective, we at the Ministry level have to ensure that we have an enabling environment, so that we attract the trained obstetricians to be part of the faculty. For instance, in Malawi we have some people who are in the private sector. This could be roped in to increase the faculty within the training institutions. But at the same time, we also need to ensure that those who are coming out of the college have the job opportunities and are incentivized to stay within our country. I think there is need for us to collectively work as different Ministries of

Health to ensure that movement of trained obstetricians that do come out do not find it easy to move from Malawi to Zambia, for instance, so that we retain whatever training efforts we are putting out. That is one aspect that we need to think of.

Something else that I've learned is the approach that Rwanda and Liberia is doing. Whereby the Ministry of Health is the main driving force ensuring that specialists are trained within the countries. Right now if you come to – let's say for instance, my country – the training initiation is either a grouping of specialists or a specific type of specialty that is starting off its training. Probably the Ministry of Health needs to put more effort or resources to ensure that adequate resources are put out for the training or the different specialties. I think that is something that I learned here.

Ray de Vries: Tell me more about Malawi. Is there a way that the Ministry of Health, or maybe also in Liberia, can interface with the Ministry of Education?

Ron Mataya: Yes, we do interface. The training institutions are owned by the Ministry of Education while the hospitals are owned by the Ministry of Health. The Ministry of Health is responsible for health policy, so there is an interface.

Bernice Dahn: And then in addition to that, the education for some reason, the Ministry of Health understands the health training program better than the Ministry of Education, so they feel more comfortable working with Health to design these programs.

Robert Odok-Oceng: What I have not mentioned which clearly applies to all of us is that the council or medical councils work together with the University Commission or the National Council for Education, which is the regulatory body to accredit and license institutions. They don't do it alone, although these institutions of education work together with the Ministry of Health to license and accredit and ensure quality.

Ray de Vries: Is that true in Kenya?

Violet Opata: Yes, it is true.

Bernice Dahn: What did not come out clearly in the presentation is the retention issue. The retention issue has been a global challenge. It has not been a one-country problem. Just listening to the presentations, I did not get really how people are retaining. Maybe it would have been good to hear, especially from Ghana, since there was a time when all of the professionals were out of Ghana and were in different countries. The strategies they used to bring them back or train and retain now. Right now Ghanaians are working in Ghana and that is different than before.

Ron Mataya: One thing is that is glaringly obvious is that the different countries are at different levels in terms of establishment of training facilities. I think one of the things that I want to learn from maybe our Ghanaian counterparts is that back in 1989 how did they get country buy-in to training our programs that are local, because right now what Malawi does is that we send our junior doctors outside of country – they go mainly to South Africa for training. So now that we are establishing new trainings in country, to try and convince people to actually join this training is quite a challenge. The Ministry will probably incentivize so that we are attracting young doctors to come forth for this training, because right now it is very difficult for us to train them.

Bernice Dahn: Though we are just starting, this is a response to your concern. I know that the doctors in Liberia express concern for quality. For us to be able to ensure that concern, the clearing exams are essential to them. So we agreed that yes, you will be certified locally, but that you will be provided an opportunity for the West African College exams. We also won recognition from the

West African College. It is necessary to build the confidence that with what you are actually giving me, I can compete with my colleagues in other areas.

African Participant: If I may, won't it be a way that you will lose in the field your training?

Ray de Vries: I was thinking the same thing.

Bernice Dahn: In terms of quality, yes. Right now, I am planning a strategy to bring all of the stakeholders together to chart the future. The reason is that if we don't and we train and don't remunerate well, we might lose them. Currently the way we have started, we are having challenges with the Finance Ministry who is telling us that people need to pay defect and so, the strategy is to bring all of the stakeholders together and prepare a good presentation that can put everybody on the same page and then we plan how we move into the future. We have started with doctors in four disciplines that will train other disciplines. We will do sub-specialties in the end. As we are doing, we will also need the nursing profession improving. It is bigger than just the four disciplines. We really need to plan the future.

Victor Mbome Njie: I am Victor Mbome Njie from Cameroon. I think the meeting has been very enriching in terms of learning. In Cameroon, the context is really very peculiar, firstly because of our bicultural nature – English and French are our official languages. It goes along with the culture. I came along with two colleagues from faculty. A new faculty in English-speaking Cameroon which is just passing out the first batch of medical students. We are going to pass out the second batch. We are just going to start postgraduate training. Now in Cameroon, maternal mortality is really high and the ministry has made it a priority to improve maternal health so that we can cut down maternal mortality. We have indicators in the field. The big lesson I am learning here is that the need to train OBGYNs is one way of improving service delivery costs to cut down maternal mortality. We are going to need an increase in human resource potential to do that in the field. Now I think one of the challenges from this meeting is what do we do before we can get the first batch of trainees of specialists? Something on the field. Are we going to improve the capacity of midwives? Are we going to intensify training of registered nurses? One of the indicators on the roadmap of the Ministry of Health is to increase the number of assisted deliveries. And the big question is assisted deliveries by whom? So we must train at all levels. We must train nurses and midwives and then make sure that this partnership can take off as soon as possible to start training OBGYNs. Then on the other side, they have started training gynecologists before, specialist training in Douala University, the French-speaking University. With that again, we must now organize and move forward. We have one college. Are we going to work with the Ghanaian college, the West African College? It is quite a big lesson for us.

Ray de Vries: I think that is the big idea that Ministries can share. Ministries that have been a step ahead can manage that problem. We have heard some models here in the meantime, while you are trying to get going with postgraduate training, how you can get something organized, how you can use help from other countries in Africa, countries outside of Africa? I don't know if having the idea of having the ministers meet somewhere to share this. It sounds like people have plans, and the idea in Liberia sounds really good. If we can get together and ask how we are going to plan for the future.

African Participant: The question is what are the major lessons learned. We have learned that right now we are not producing enough OBGYNs and with partnerships, we can do much more. And also, that we have to be careful on how these partnerships are formed. I think you made that very clear. I think that is one area that we neglect. And then that affects certain ability. Just to be very clear, it should be a win-win situation for those who are coming to help us and ourselves. When there is transparency, everyone who puts their cards on the table … because what happens is that when people feel that they are not fully involved … for example you can come to Zambia. They

tried to speak and, "oh no, no" and then they will try to speak and say okay, then they will listen and let you do what you do. But after that, they go and the program just dies down.

For me that was really discouraging because I experienced it back home, where you get this feeling that people are just doing research and projects. People have this agenda, in fact researchers we call them mosquito researchers, because they come and draw blood and go away. We don't get a share of those results. For us, right now the projected number of OBGYNs from now to 2015 is seven per year. The establishment is such that we need two per general hospital. We have 101 general hospitals and currently we have about 40 OBGYNs.

So there is a need for us to increase. Of all the countries we have seen, it seems that we are the ones that are a little bit behind. Most of the other countries have partnerships which have really stabilized and they are moving forward. We already have right now another – like I said, the medical school has been open on the Copperbelt, where already they are saying, "We are going to train MMeds." But who asks the question, "What is in place? Who are going to teach certification and all those things?" So this also has helped us. It is not a matter of training. You have to really think through the selection, the screening, have people who really have experience. This partnership has a fast forward initiative to have more OBGYNs. For me, that is my take home.

Ray de Vries: It is even more complicated because in listening to groups talk, let's say you train 15-20 OBGYNs, those OBGYNs need nurse midwives, need nurses, need equipment to work with. That is where the Ministry of Health is important, because you can see that. An OBGYN can work by herself.

African Participant from Kenya: Let me tell you a little bit about the Kenyan factor, but first what I have learned, having been exposed to another partnership with the first university that starts training at postgraduate level. First of all, what we have gone through confirms that the developed world has realized that at one stage you may not have everything. You know, somebody will have opportunities and somebody else will have other opportunities that are very different. You may have money; you may not have the facilities. You may have the facilities but you may not have the money. The learning materials – when I am talking about facilities, I am also talking about learning materials. When you are talking about an OBGYN, there should not be a difference between one from America and one from Ghana for example, or one from Ghana and one from Rwanda. Ultimately it should be one type. Of course the individual differences will be there. But because it is about saving women's lives, really the ultimate goal should be about producing one OBGYN that is able to help any country at whatever level to reduce all those bad indicators.

And so it is unfortunate that we have one side of the world that is very developed and another side of the world that is underdeveloped. That to me, from what I have seen, the opportunities for the partnerships are more than ever before and the attitude, I have really come to like about it. It is not the one of poaching. It is one of creating opportunities for practice and being able to save women's lives. That is what I am learning. I am very happy about it.

Because of the differences, the individual differences that we see in countries in worlds, in meetings, in international meetings, it has been recommended throughout the world that if by any chance that a country is lucky to have resources, it would only be prudent to help the other country that does not have resources so that we sort of start reducing the gaps. The work of the Ministry or government is really to take the lead in any effort that has a reflection of a country's goals.

That is what is happening in Kenya now. We are realizing that the intersectoral collaboration, which is between the Ministry of Health that employs these people, the Ministry of Education that trains these people, and the Ministry of Finance that finances the two processes. That in the last many

years has been very minimal, but now we are realizing that these ministries cannot prosper independently; we just have to work together. Still at the individual level, for you to come out as a reputable person, you need the opportunity. The best opportunity will be provided by the Ministry of Health and then the University will support your research capacity so then you are also felt in academia circles.

That has been realized and we may not have that many American universities partnering with our universities in Kenya, but when you go into the universities you realize that the opportunities are there and how lucky that Americans are there working with us; us providing the facilities, the patients; them coming in with technology, sharing skills and experiences, and it is coming out very well. The University of Nairobi, which is the old medical school, has the University of Maryland and the University of Washington. Now supporting a sort of devolved medical education. Taking our medical students into our hospitals. Not just in teaching hospitals.

The numbers are overwhelming and they are coming out into the rural areas for many reasons, not just for the learning opportunities, but also stimulating sort of a devolved training that we know in the end will help us retain and it will help us in having our clinicians getting opportunities or learning opportunities at the very early stage of disease development. Because if you confine them in national universities and hospitals, then most of the cases are the very complicated cases that come there, and sometimes the diagnosis is already made, as opposed to when you send them out there in the smaller primary care hospitals where people come from home with very early stages of disease. So we feel that it is a major, major opportunity for learning and also for research.

The other thing is the research component, which we have been very weak in. There is a lot of investment in now building the capacity for research in the faculty. We are seeing that is starting to retain them in the university. To me that is also a major achievement and I feel that it is an opportunity to welcome the support in collaboration and partnership that these universities in the US are really helping us.

The issue of retention has us having to do with recruitment and fortunately Kenya is in a stage of transition. We have just moved from one national government to now two levels of government and we have 47 county governments which have just been formed. At the moment, they are mapping the Human Resources for Health and we know that the gaps are there. We are not even half way in terms of OBGYNs. We have only registered 323 and the Ministry has managed to retain 85 of them. What we know is the country should be having 260, so the other 60 or so out of the country. But retaining 85 in the public sector against 260 is not of course a good percentage.

Ray de Vries: Where do they go? Do you know?

African Participant from Kenya: The US and the UK. Basically those two countries because of the way we have elected in the past. Then a few in South Africa, because at one point in the early 2000's, everyone in Africa was going to the South, like Botswana. I think at one point the Minister for Health – was it Botswana or Swaziland? – it was Botswana I think; the Minister of Health was from Kenya. We have many colleagues, like those who are my classmates, I have two in Botswana; I have three in South Africa; I had two in Namibia and Swaziland.

Ray de Vries: This seems like a place where Ministries of Health really need to talk to each other. How do you prevent yours from going to South Africa? And if you look, I don't know if it is shown here, but the differences in pay across African countries, you can understand why people move. I don't know if that could be solved with an international panel of African countries.

African Participant: Yeah, I think there is some agreement written that people can't employ doctors or health stuff from other countries.

African Participant from Kenya: The thing is that of late, Namibia is not respecting that that anymore.

African Participant from Zambia: Yes, but what has Namibia done? They have come to Zambia; they have engaged and said we have looked at areas of collaboration. We have actually agreed that these are areas we can collaborate. This is one of the major issues that, like she said, we did not hear about. So I think that as we go back we need to learn on how we retain. For example, just in general we have what we call after internship, every doctor does a rural posting. In that one, for you to even do postgraduate you have to have done two years of rural posting.

Ray de Vries: Yes, that is true in Ghana.

African Participant from Zambia: Maybe postgrad as well, there can be a period of where one serves…

African Participant from Kenya: Let me tell you something that we are struggling with, whereby we have the country's needs sort of overwhelming the regulatory requirements. For example, for purposes of recognition you need to work under a senior gynecologist after you have finished. The country needs more senior doctors in the primary care facilities. Today we can afford to have two gynecologists in a primary care facility. You find that fellows who are finished and we as a Ministry deploy them to the primary care facility. Because the number of doctors is increasing, we are also increasing the number of internship centers. So we need a list of gynecologists, pediatricians, physicians, and surgeons in a primary or in a hospital before we establish an internship center for the young intern doctors.

So it becomes difficult to place the newly qualified gynecologist under a senior gynecologist because then people will continue suffering. But for the purposes of having the right people, the properly trained people, the regulatory requirements were you stand tall over and above the country's needs. But those are issues that I feel we still need to make a decision. I think the numbers today, I think somebody said that the numbers today is our biggest challenge. What a struggle with them first …

Ray de Vries: Haha, before we go too far. So, what would you like to see happen next? What should be the next step for this project but also for the Ministries?

Robert Odok-Oceng: I think the Ministries, as you're suggesting, the government Ministries of Health and Education need to talk not only at the level of the country, but the regional unit. We have an additional East Africa community, we have West Africa communities, we have Southern communities. Why do I say this? I know that we do not have qualified faculties for that level of training. But when we come together, we can borrow. It is cheaper to borrow from Ghana than it is to get to the US. Much, much cheaper. Also Kenya to give another case. That would help one to educate clear policy by the Ministries on how to move. Because it is true that there is collaboration between health and education, but it is also true … I do not know whether our country's things are fine. In terms of hospitals, presenting that the students have too many interfering in their work. Of course, the Ministry of Education and the universities have funded students when you don't give them opportunity to go for training.

So I think the interface of the two Ministries with two Ministries from other countries makes them learn, so this friction is taken away. You say that we cannot do without one another. Which are the four ministries? Health, Education, Finance, and Public Service. For a public service employee,

Finance funds the process and pays the latter. Then education training - health employee that work in health. So these Ministries should really come together and have common strategies to achieve this. If that is done, I feel that can happen. Most of the time we save money. If we don't think fast, money will be wasted.

Violet Opata: What I would like to see is to network the regional colleges to support one another. The support could be with faculty within the region. It could be student exchange. If you listen, it could be presentations, the shortcomings in some of the programs, in programs what they have, what they don't have, or what another institution in the region could have. So you could also have those short-term visitations and trainings in other countries. We could share examiners and also maybe question banks and things like that. All those things would help to make the program better.

Ray de Vries: Yeah, there is no sense in every country doing it themselves from the start when other countries have done it and it can be easily modified.

African Participant from Cameroon: I would add to what the two have already said. The strength of all of what we are saying is because all of Africa, sub-Saharan Africa, has a common denominator, which is the key in maternal mortality reduction. That should go into policy. It means that Ministries of Health, we have different strategies; we have different realities on the field. So I would love to see a situation where we go back, each of us. Each country looks at the specific of what it is doing. We share that and then we come out with a common front. That's okay, this is common here, this is common here, this is what we are doing, and then we will build off from there. We develop a partnership amongst Ministries that will influence policies and will influence direction. That will strengthen our cooperation and then we can start sharing – the colleges, the existing colleges, which are the existing colleges, which are the new colleges that are coming up, who is mentoring them, what do we have in place for sustainability?

Ray de Vries: You think countries can do that? Every country has its own pride, so it is like, "Oh, well Cameroon. But this is just how we do it in my country." I am just asking for kind of a realistic look at whether we are willing to share and listen to each other.

African Participant from Cameroon: I think that from what he said and what she said, the fact that we have a common challenge in maternal mortality. Why should African countries not come? What policy decisions are we taking as a sub-region? Now we must take leadership for us to be able to turn around the challenges on the field. The partnerships are not enough. We must take ownership and leadership, and we can only do that if we can sit at the table and say, 'This is what is in Cameroon, this is what is in Liberia. What is in Kenya? What is in Zambia?'

African Participant: We must accept that there is already a community. In East Africa there is already a community. In Southern Africa there is already a community. So there is a framework in place. Only that we are not utilizing it, we are not exploiting it. Because in Uganda to in East Africa, we share everything we do. We are harmonizing our education and curriculum in the region. We are harmonizing the curriculum, we are harmonizing our staff to move across the border. Our president is really pushing the East African Federation. So I think that that framework is a good ground or springboard when you bring this automatically in the region. Now if it is done in East Africa and it is done in West Africa, then you can see how it is spread in the South.

Violet Opata: Already as he has mentioned, we already have the collaboration framework. For example, in East Africa, when you look at universities, we already have what you call inter-university consults within East Africa, which is our framework that is uniting almost four countries or five.

African Participant: Five

Violet Opata: Yes, five countries in places. And therefore, if that is the case, it means that the training program that is being offered in Kenya can easily be adopted in Rwanda or even in Tanzania or Uganda. That being the case, it means that the accreditation policies can work for all of us without necessarily having each country. Therefore, if an accreditation body in Kenya approves a curriculum, it means that that curriculum is accepted in other countries, and therefore a student can move from Makerere and come to the University of Nairobi and come to Moi University without necessarily hearing, 'We can't allow you because your curriculum is substandard curriculum.' Really the thing is that the way forward is that the community, whatever, collaboration is very essential.

Ray de Vries: Is it a suggestion that you come together in these regions – West African, East, Central, and South?

African Participant: I am of a different view. We are at different levels in the countries and as has been said, in the past we used to send people to go out to train and they have remained. But now we have an opportunity in our own countries to have the trainings within our own environments but with the help of those who are advanced, who are quite developed. The natural course is to say, "Okay, develop our own school, train our own trainers, or employee people from outside." Obviously that takes a long time and is expensive. But through the partnerships, we have an opportunity to think outside the box and utilize the resources without getting people permanently from Europe or from America, and without us also getting people to go out.

There are two things. One, there is the training. Two, there is the collaboration. I think we have to define very clearly what we want to achieve by the South-South collaboration and to be very clear on what we want from the partnerships. We have enough patients, maybe the patient load for competence-based practices. There is no need for me to take someone from another country. But we can agree on exchanges maybe for trainers to come and assist in training, whether it be from America or another region, but not to remove people. I'm just saying that in my country, for example, we are just opening up another university, an opportunity to also do the MMED program there. But we need help in establishing an MMED program. How do we do that? So with the knowledge we have gotten to go back and define our problem, define our way forward in terms of developing these partnerships and to define clearly what we want to learn from our colleagues.

African Participant: One thing that I think I would like to say is that some of the partners that are in Malawi are also from other countries. We could potentially also use that network to try and strengthen the linkages between the different countries. I know that UNC is in Malawi and also in Zambia. One of our partners is also in Liberia. We could try to use this network for the betterment of the training, especially when you are thinking about the exchanges of the different registrars.

Ray de Vries: Is it literally the same people? Or is it the same institutions?

African Participant from Malawi: Um, a bit of both. Well, they know each other. They are from the same faculties.

Bernice Dahn: Well I was just trying to support what he said earlier about the framework assisting that we can use. If you take the West African College of Surgeons for example, it would be where you can start. From there you can go to the West African Health Organization, the ACOWAS, the African Union. Those kinds of frameworks exist. It is itself a good platform. Another thing, too, is to see how these organizations, especially the West African College of Physicians and Surgeons, the way they function now. Are they meeting the needs of various countries? Maybe there is a need for a reform, because if you have an organization that is administering training, it cannot train to meet the demand. And countries are beginning to start their own programs. Maybe it is better to go in a

decentralized manner and then have a way of harmonizing and making sure that the training costs across is the same and things like that, instead of the status quo.

Robert Odok-Oceng: Collaborations become faster and more efficient when you come into a region if all of the collaborators working in the region come there together. Their impact will be greater because the information is got by many people. At the same time, rather than you going to one institution - for example in my country we go to Mbarara. Mbarara is in southern Uganda; it is very far. So a lot of medical schools are there, but we don't know what is happening in Mbarara. But if we are there together, in the region with the other Eastern countries and the University Council of East Africa brings together all universities, you find that automatically things are recorded and the information moves around. If a person from this organization meets, for example, in the University Council in their meeting, the information that he would have labeled would have affected and enticed other countries. That is the deed of the framework. Which starts from the region after the African Union Level.

Ministry Participant: If you have to get it on the government's agenda, then that is the way to go. Once you start with the colleges like West Africa, it goes to WAHO, it becomes an South African Ministry meetings and it becomes an agenda option. From there is goes to ACOWAS, and from there is goes to the African Union.

Ray de Vries: Comments?

Ministry Participant: I think that the long term is important. I would love to … I mean maybe when I am gone for posterity that this partnership could help us have partnerships in Africa where the West African College is somewhere in East Africa overseeing training, making exchanges, having people on the field. We must take ownership of it. It is cost effective. Then we can really be having people training within our context to understand our specificities and make it better.

Ray de Vries: And this is why it is so important that you all are here, because a university-to-university partnership is important, but if that is all that is, as you were saying, that happens at some corner of the country, the Ministry if it is going to be sustainable, the Ministries have to be …

Ministry Participant: Yes, engaged.

Ray de Vries: So thank you all for your comments and thank you for being here. You are probably the most important part of this meeting.

Ministry Participant: This is another issue. That the kind of people we train are stationed in urban centers but the biggest problem or the biggest maternal health problems are in rural areas. We cannot get the support there. Is there a way this partnership can find a way also to train clinical officers, training nurses or midwives who deal with this problem? Because they are the ones sustaining our health sector.

We are not saying it, but it remains a fact that doctors are in urban centers, these clinical officers with diplomas, the nurses, midwives with certificates and diplomas and the ones in rural areas and they are faced with this difficult situations. These mothers are dying in their hands because the doctors are not there. So how have you thought about it on your level?

Ray de Vries: Well, I think one idea that we learned in Ghana, though I have to say that it hasn't been completely successful, is that if you train enough obstetricians, eventually they move out.

Ministry Participant: Right, because there is no space.

Ray de Vries: There cannot be so many obstetricians in Accra.

Ministry Participant from Kenya: In Kenya, what we have done is that we have concluded the process of revising our health policy framework, which is supposed to have started last year and is should to move on up to when we shall have our national vision achieved by 2030. We have a heart to reorganize the health service package and have now moved away from the level one, which is at the community level, to the level two, which is the dispensary, then three the health center, then four the district hospital, then the regional hospital, and then the national hospital.

We have regrouped that and said we should have level one, which is still the community level, and then level two, which is now the primary care hospital. By the end of the vision period, all dispensaries and health centers should be primary care hospitals so they are going to offer comprehensive or emergency obstetric care, meaning they should have operating theaters dedicated for obstetrics - cesarean sections and related surgeries.

That way you should have gynecologists at the first level of care at the hospital. That is the strategy. Of course a long-term strategy should require a lot of money, because converting every health center and dispensary to a health center is a lot of money. The idea is to change the thinking. Right now health centers and dispensaries are facilities for poor people, but people are the same.

So as we push for this National Security Insurance Fund, Social Security Insurance Fund, then we should develop this facility so that everybody who will be covered by that fund should be able to access services at the primary care level. Then the secondary care facility now remains like the county referral hospital. The tertiary referral facility now is depending on where they are, now they will take their own fields to develop it into centers of excellence. Then we will still have the national facilities finally belonging to universities for the purposes of training their doctors. So, that is a long-term thing, but perhaps that is the best way so that you don't have two types of health system for two different people in one country. I think that is not a good thing to have. It is not fair.

Ministry Participant: You know, I think it is starting the mindset. You change the mindset, and then the next thing make it a policy, and then you mobilize resources, and you start doing things.

Ministry Participant from Kenya: And as one of the Ministers was saying, 'When the politicians buy in, then …'

Ray de Vries: Exactly, exactly. And the framework is there.