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Training for whom?

The US government has embarked on a programme to try to increase the number of health professionals actively working in Africa by 140 000. The US President's Emergency Plan for AIDS Relief (PEPFAR) funding is being channelled to a dozen countries (and institutions within) under the Medical Education Partnership Initiative (MEPI).

And yet, the rapid expansion of private universities in Africa means that there are now more medical schools in Africa than in the USA. Can this be true? Well, according to results from the Sub Saharan Medical School Survey (SAMSS) there are now 168 medical schools in sub-Saharan Africa. There are only 130 such institutions in the USA. Of course pro rata to population the USA output is higher (300 million v 800 million), but nevertheless it is a quirky statistic.

We know that the quality of some graduands from some African institutions is less than optimal. A lack of public sector investment has eroded teaching quality and teaching hospitals are poorly equipped. It is also early days for useful analysis of the accreditation of the many new private universities.

But key questions need to be asked? First, Are we training the right people? After all, less than 1% of doctors are to be found at the health centres where most people report for healthcare in the first instance. Second, for those trained to be specialists, is their ability to practise going to satisfy their competency needs? Without proper facilities and tools to practise, people quickly become disenfranchised and leave.

It will be recalled that the Global Fund

for HIV/AIDS, TB and Malaria (GFATM) very quickly realised that it was impotent to help unless there was a workable health infrastructure in its sphere of operations. Health System Strengthening quickly joined the big three diseases in its funding disbursements.

MEPI has as its cornerstone, 'making medical schools in Africa fit for purpose'. This is approaching the problem from the right end. What are the needs? How can they be achieved? What will the resource requirement be? If the outcome is a new generation of health professionals who are accountable for the health outcomes of the populations that they serve, much will have been achieved.

For too long many governments have been struggling to find the resources to sustain non-performing institutions whose output has been unsatisfactory. And then rather than invest and improve, political expedience too often persuade them to try to establish new institutions without factoring in human resource and recurrent budget needs. Such progress leads to a spiral of decay.

The dynamics of migration, of contented employment, and of human resources for health representation at different levels of the health pyramid are complex. This issue takes a look at aspects of training. Greater dialogue would be welcome.

Bryan Pearson
(bryan@fsg.co.uk)

