The Role of a Network of Human Resources for Health Managers in Supporting Leadership for Health Systems Strengthening in Francophone African Countries

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Abstract—This article presents the Vision Tokyo 2010 Network, a unique model of peer learning and information sharing among human resources for health (HRH) managers in Francophone African countries. It describes the network’s origins, achievements, and factors underlying its success.

The network’s origins lie in an overseas training program in Tokyo between 2010 and 2014. Participants included directors and heads of HRH management departments at federal and provincial levels across nine Francophone African countries: Benin, Burkina Faso, Burundi, the Democratic Republic of Congo, Côte d’Ivoire, Niger, Mali, Senegal, and Togo. The network itself was established in 2012 based on the common strategic vision (Vision Tokyo 2010) developed during the training program, with an objective of tackling major problems to improve the performance of human resource development systems in the health systems of participants’ countries. Some of the main outcomes of the network, demonstrated during the Ebola outbreak include: improved use of human resource information systems in Senegal established as a result of peer learning within the network and technical cooperation between the Democratic Republic of Congo and Côte d’Ivoire to develop standard operational procedures and to train health workers in the management of Ebola.

Having a common strategic vision and contextualized framework—African house of solidarity—as a symbol for HRH system development, strong ownership by core members, participatory processes, a positive peer learning environment, and coaching-style support by partners were key elements of success in this initiative. The biggest challenge for this network thus far has been financial sustainability. However, steps are being taken to demonstrate the cost-effectiveness of networks such as these in order to garner further support from partners to invest in networked approaches rather than siloed, country-specific programs.
INTRODUCTION

Health workers are the core of health systems. Shortages of health staff, their often inequitable distribution, and gaps in their capacity, motivation, and performance were key obstacles in achieving the Millennium Development Goals. The Sustainable Development Goals that have replaced the Millennium Development Goals will only be achieved if dramatic improvements are made to strengthen the health workforce. Managing the issues mentioned above in the area of human resources for health (HRH) requires multisector coordination and collaboration. Efforts to improve communication, coordination, and collaboration among relevant stakeholders are ongoing at the international level through the establishment of networks or alliances, such as the Global Health Workforce Alliance (GHWA) and the Asia Pacific Action Alliance on Human Resources for Health (AAAH).

These networks and alliances have contributed significantly to a range of global and regional-level initiatives and achievements. These include prioritizing HRH on various global agendas; facilitating policies and actions by national governments to address HRH issues; and creating an evidence base using indicators of progress such as aggregate HRH density and comprehensive HRH national planning. However, there is no one-size-fits-all approach for all countries. The challenge to implement global and regional initiatives across countries is well recognized. Context-specific considerations and priorities must be taken into account in order to respond to and drive the agenda for effective implementation.

This article presents the Vision Tokyo 2010 Network, an international network of HRH managers at the Ministry of Health (MOH) level in nine Francophone African countries. It describes the network’s origins and its achievements in strengthening HRH systems in these countries and identifies factors that have stimulated this network to function as a platform of policy dialogue, policy implementation, knowledge generation and sharing, and capacity development within countries.

The next section discusses the case study methodology used to describe this network. We then go on to provide a brief history of the growth and evolution of the network; this is followed by the results with concrete examples of what was achieved. The discussion concludes by describing factors that influenced effective peer learning and implementation of HRH management strategies as well as some challenges.

METHODS

Case study methodology was applied to describe this network. Documents and reports in both the published and grey literature in French, English, and Japanese related to this network were reviewed, such as reports of training programs in Japan, minutes of network meetings, and workshops listed in Table 1 and in the References. Among coauthors, four Japanese authors in this article were members of the National Center for Global Health and Medicine (NCGM) who developed this training program and who have kept providing technical support to the network. One Senegalese author is the present coordinator of the network. Key informant interviews were conducted with three core network members and four training organizers who constantly participated in network activities. Interviews were conducted over the telephone in French or Japanese by the first author to collate and validate information from documents on the growth process of the network and to ask what factors stimulated this network to function as a platform. Notes were taken during interviews. Key words and sentences were extracted, coded, and analyzed repeatedly by coauthors. Limitations include limited number of key informants and the potential for recall bias. However, we dealt with the possible bias by identifying external sources of objective information from the network website and by triangulation of information among key informants.

 Chronology of the Vision Tokyo 2010 Network (Table 1)

The seeds of the Vision Tokyo 2010 Network (Réseau Vision Tokyo 2010) were sown during a two-week-long training program in Japan in 2010. It was organized in Tokyo by the NCGM to which the four coauthors in this article belong and was funded by the Japan International Cooperation Agency (JICA). The training program aimed to improve HRH management skills at national and sub-national levels in nine countries in Francophone Africa. Participants were directors and heads of human resources management at ministry and provincial levels from the following countries: Benin, Burkina Faso, Burundi, the Democratic Republic of Congo (DRC), Côte d’Ivoire, Niger, Mali, Senegal, and Togo. The Senegalese author in this article was one of the participants in this 2010 training program.

During the training program, participants analyzed human resource management in their own country using the house model, a comprehensive and visible framework for human resource system developed by NCGM from experiences in postconflict and fragile countries (Figure 1). The roof of the house represents the health system response (including human resources) to the health needs of the people, and all other components contribute to providing the human resource structures upon which that objective will need to rest. Production, deployment, and retention are key elements of the process of the HRH system development and...
Member Countries

Nine countries: HRH managers participated in the training program in Japan (2010–2013): Benin, Burkina Faso, Burundi, the Democratic Republic of Congo, Côte d’Ivoire, Niger, Mali, Senegal, and Togo.

Two countries: joined after establishing the network: Guinée and Mauritania. Gabon and Cameroon are requesting to join the network.

Workshops and Meetings

Skills-building workshop on HRH information system and observatory at the Second Global Forum on Human Resources for Health, GHWA, in Thailand (January 2011).

Training follow-up seminar in Senegal. Dakar Declaration to establish a regional network of HRH managers in Francophone African countries (January 2012).

Network general assembly for preparation of country profile on HRH situation analysis and mapping of educational institutions among member countries (November 2012).

Workshop on HRH information system in Togo (June 2013).

Side meeting on retention of HRH in rural area at the GHWA Third Global Forum on Human Resources for Health in Brazil (November 2013).

Network general assembly for making an action plan and workshop on the qualitative study on rural retention (August 2014).

Workshop on developing guidelines for mobility of health personnel (December 2015).

Workshop on the rural retention study in Senegal using discrete choice experiment (April 2016).

Main Meetings With Partners or Other Networks

HRH-related meetings organized by WHO African Regional Office (October 2011, December 2012).

HRH-related meetings at West African Health Organization (June and December 2012).

AAAAH to learn from their experiences (December 2013).

TABLE 1. Membership and Main Activities of the Vision Tokyo 2010 Network

correspond to the pillars of the house, standing on the foundations (policy and planning, finance, legal) as primarily the responsibility of the government. Coordination, monitoring, and evaluation are shown as part of the base of the house, as they cut across the entire human resource system. The house model offers a visual symbol for developing and reconstructing key elements within the health system to be used for assessment, analysis, and the generation of appropriate human resource policy and planning.

During site visits, Japanese counterparts such as administrators at ministry and provincial levels made program participants aware of interventions and lessons learned in Japan on rural retention of health professionals. This peer learning-based analytical process made participants identify their problems and categorize them by components of the house model. This problem analysis resulted in developing what was termed a Francophone African house contextualized to their country settings (Figure 2). This Francophone African house led to the identification of four overarching problems in the area of HRH throughout the nine countries:

1. Insufficient production of health professionals.
2. Maldistribution of a limited number of health personnel.
3. Retention of health personnel in rural areas.
4. Lack of human resource planning based on appropriate information systems regarding health personnel.

This analysis resulted in a statement of the common strategic vision (Vision Tokyo 2010) with an objective of tackling major problems to improve national HRH systems collaboratively. On the last day of training in Japan, participants expressed a strong wish to continue the mechanism of information sharing and peer learning on an ongoing basis. This two-week training program was thus repeated once every year until 2013, resulting in five trainings with a total of 76 participants. Along with the training in Japan, NCGM and JICA decided to provide support for ongoing communication among participants through holding workshops in parallel with international conferences, such as GHWA’s Second Global Forum on Human Resources for Health in Bangkok 2011.

In January 2012, participants gathered in Dakar in Senegal and developed the Francophone African house of solidarity (Figure 3), which has the same structure as the Francophone African house but this time focused on solutions, not problems. To implement the solutions at the country level, participants declared the official establishment of a network called “Réseau Vision Tokyo 2010.” It aims to enable the health system to adapt to changes imposed by external forces and to improve effective policy implementation on human resource management by improving communication, information sharing, and identifying necessary resources among members. Each country created a team headed by the director of human resource management at the Ministry of Health as a focal point. A secretariat was set up in Senegal with elected secretariat members. The network developed a five-year action plan and started implementing it with regular secretariat meetings twice a year and a general assembly every two years. Workshops were conducted based on the action plan to develop technical documents on topics that had been agreed upon at the general assembly. The NCGM training organizer team participated in the network as a support team and continuously facilitated the discussion during planning and implementation of network activities.
The following documents were developed through network meetings and workshops and shared among member countries and development partners.

- Problem analysis of human resources in member countries (2013).9
- Mapping of educational institutions in member countries (2014).10
- Guideline for mobility of health personnel (2015).11
- Report of qualitative and quantitative studies using in-depth interview, best–worst scaling, and discrete choice experiment for retention of health personnel in rural area in Senegal (2016).12

These products were shared with the broader public at GHWA’s Third Global Forum on Human Resources for Health in Recife 2013,13 the Global Symposium on Health Systems Research in Cape Town 2014,15 and a meeting with a similar network in a different region (AAAH).4 JICA and NCGM have thus far been the technical and financial partners for this network. The network secretariat is seeking possibilities with other partners in order to diversify the support structure.

RESULTS

Since its inception, the network has seen many successes realized due to its capacity in connecting national HRH leaders across countries with similar challenges. On their own, these leaders were sensitive to and aware of the needs of their respective communities; however, it was through the creation of a space to come together and training to conduct problem analyses within a group with similar resources and challenges that these leaders were then able to adapt solutions appropriate to their respective contexts. The support, backing, and motivation brought on by the network were key facilitators for improving HRH systems across these countries.

The section below provides two concrete examples of what was achieved. The first achievement, the creation and use of an HRH information system across countries, was in direct response to a problem identified by analyzing HRH systems and challenges, using the Francophone African house as a model. The second, enhance peer learning through collaboration, was a direct result of the underlying collaborative spirit developed through the network.
FIGURE 2. Francophone African House—Problem Analysis

FIGURE 3. Francophone African House of Solidarity
The creation of a robust HRH information system is a concrete example of how network collaboration mobilized the growth of HRH management capacities of member countries. At the country level, we focus on a successful example in Senegal established using learnings from all member countries. Through analysis, we identified five major stages of the growth of HRH management system, derived from steps for developing a scaling-up strategy: problem identification; fit-for-purpose solution (trial and error); expansion from pilot and modification; expansion; and outcome (Figure 4). Using the five stages, this process occurred as described in the following sections.

Stage 1. Problem Identification

From the beginning, network members recognized the importance of information systems on health personnel. Without knowing how many health workers of each cadre were working in a given area, MOHs cannot develop and implement appropriate human resource production, recruitment, deployment, and retention strategies to meet a country’s health care needs. Therefore, one of the agendas in the network based on the Francophone African house has been the establishment of a database to capture accurate, reliable, and timely information on human resources in the health system. The idea of a workshop on the HRH information system came from a discussion among core network members and NCGM during the initial training in Tokyo. This idea was realized in January 2011 as a skill-building workshop on HRH information systems at the GHWA Second Global Forum on Human Resources for Health in Thailand. It was technically and financially supported by NCGM and JICA. Several member countries such as Mali, Togo, Senegal, and DRC shared their national plans to introduce an open-source software for HRH information systems.

Stage 2. Fit-for-Purpose Solution (Trial and Error)

Mali and Togo, in 2012 and 2013, respectively, introduced the same open-source software to facilitate the generation and use of HRH related information. However, they had been struggling with expansion from a pilot project in limited provinces to a nationwide system. Senegal had a plan to introduce the same software and started preparation from early 2013, aware of the challenges that Mali and Togo were facing. DRC also had some provinces with the available technical support to introduce the same software. In June 2013, the network conducted a workshop in Togo to share the problems identified with the use of the open-source software, to discuss lessons learned, and to find solutions using input from member countries. These collaborative efforts and sharing of experiences resulted in a teaching and

FIGURE 4. Growth of HRH Management System—Achievement of the Network Activities
learning opportunity for network members and allowed for problem solving.

Stage 3. Expansion From the Pilot Projects/Modification for Improved Use of the Tool

After the workshop in Togo, through regular network meetings as well as daily communication via email and telephone conversations, members continued sharing information about the strengths and weaknesses of the software and analyzed how to overcome weaknesses as human resource managers. As a result, network members understood that they had to carefully modify each item in the software to adjust to their own country context rather than following recommendations from external technical consultants. This process made members realize their critical role as head of HRH management and further strengthened their leadership. The network bond allowed individual members not only to expand their knowledge but also to be motivated to find solutions in their own contexts that could support the work of the network as a whole.

Senegal introduced the software beginning with two pilot provinces in December 2013, after extensive modification. This modification reflected lessons learned from the experiences of other member countries. Information on all health professionals working at all government health facilities in the entire country was finally entered into the database in collaboration with provincial health offices in September 2015. During the process of nationwide expansion, the chance to assess the value of this information system arrived in 2014 when the Ebola outbreak occurred.

Stage 4. Expansion and Use in Ebola Outbreak

From March 2014, at the early stages of the Ebola outbreak in three neighboring countries in Africa (Guinea, Liberia, and Sierra Leone), the Ministry of Health and Social Action in Senegal was well prepared with a detailed response plan. This preparation included the creation of a health-focused emergency operations center and the implementation of an emergency response strategy. One of the biggest challenges was to educate health workers on how to address Ebola, because no one had any experience with this particular disease in Senegal.17

Using the human resource database in the carefully modified software, the Senegalese Ministry correctly identified health personnel working in the border regions and designated hospitals for effective logistical support and training to protect the population from Ebola. As a result, despite the first confirmed Ebola case in Senegal arriving by road from neighboring Guinea in August 2014, Senegal successfully quelled Ebola by October and never had another case.18

Stage 5. Outcomes

The HRH information system in Senegal was also used for collating information on retired staff and mapping the distribution of midwives to make a plan for new recruitment. In addition, when a study was conducted on rural retention in Senegal based on one of the identified problems in the Francophone African house, this information system allowed improved sampling for better evidence generation.

Collaborative work and capacity building through peer learning in the network were observed from stages 1 to 3 in member countries. However, scale-up from the pilot projects (stage 4) and outcomes (stage 5) in each country were different according to the country context; for example, Mali could not expand nationwide because of the political situation and the capacity of the Ministry, and the DRC had several types of software used in different provinces supported by different development partners in this huge country, causing some level of fragmentation.

Enhanced Peer Learning Process Through Collaboration

From the early period of the Ebola outbreak, the network declared a strong commitment to protect HRH working in member countries. Communication, coordination, and peer learning among member countries enabled effective interventions in responding to Ebola at the country level.

Some countries, such as the DRC, have a long history of effective management of Ebola. In Côte d’Ivoire, a coordination committee was set up for tackling the Ebola outbreak but was not well functioning until a concrete national operational plan was developed based on the World Health Organization’s (WHO) recommendation for Ebola response during a workshop in Abidjan in March 2015.19 This workshop was organized by the Ministry of Health, supported by the WHO and a facilitator team from the DRC. The DRC team continued technical support to conduct training of national trainers based on the WHO standard module.20 With support from DRC, Côte d’Ivoire was able to develop standard operational procedures validated in July 2015. Training was also conducted in DRC with hands-on practice at an Ebola care center in August 2015 and January 2016 as a part of a continuous program for multidisciplinary teams from eight member countries of the network. This training structure and mechanisms for support provided by the network supported leaders at the country level by providing sufficient tools and resources to their teams, thereby enhancing their effectiveness. In
every process, focal points of the network (DRC, Côte d’Ivoire, and Senegal as the coordinator of the network) played an important role in selecting the trainer teams and appropriate participants, ensuring quick communication to organize timely workshops in order to effectively contribute to capacity building of health workers in member countries.

DISCUSSION

The network established by countries sharing similar challenges has supported leadership to improve the management of human resources for health. We identify several factors below that we believe influenced effective peer learning and implementation of HRH management strategies.

Common Strategic Vision and African House of Solidarity as a Hub for HRH System Development

The house model, a visible framework for human resource system development, has been the core value of this network since the beginning. This model offers a visual symbol for strengthening key elements within the health system, highlighting overarching functions required to address the needs of the community, and emphasizing how underpinning components must fit together and reinforce one another if a sustainable structure is to be established. The context-specific Franco-phone African house of solidarity with the common strategic vision, developed by member countries, has served as a guide for collaboration across leaders from member countries.

Strong Ownership and Commitment

This network was created through members’ own initiatives. Members were facing similar difficulties, and having the time and space away from daily tasks during their off-site training in Tokyo provided enough room for fostering mutual understanding and friendship. After developing the common strategic vision (Tokyo Vision 2010), the first year’s participants, most of whom were working at the director level, showed strong leadership and commitment to select the next year’s participants from technical positions that are not influenced by the political situation in the Ministry of Health, enabling the creation of institutional memory in the ministry. The training in Tokyo was repeated once a year for five years with 76 participants. As a result, the vision has spread across individuals working in the ministry at the country level, allowing for improved coordination efforts.

A Team of High- and Middle-Level Technical Managers at the Ministry of Health

As seen in the case of the Ebola outbreak, the network functions as an effective platform of policy dialogue on HRH management. Core members are directors, which is the highest technical position at the Ministry of Health; they are linked to policy and decision making and responsible for policy implementation. When there is a need for collaboration, they can take prompt action without long bureaucratic procedures. As their immediate subordinates, such as assistant directors, have also received training in Tokyo, a common vision has been created based on the house model. This level of coordination is something that undoubtedly facilitates policy processes within ministries.

Common Language and Health System

The existence of a common language, French, and similar health systems management structures influenced by France and Belgium during the colonial period is used as an asset in this network. Communication through social media or the telephone is quite easy without a language barrier. Once developed as a shared document, technical guidelines or tools to improve daily HRH management can be applied easily to other countries. When the mobility guideline for health personnel in rural area, a guideline to define the condition and criteria for reallocation of personnel to or from a rural area, was developed through the network activity, Burkina Faso quickly made it a ministerial order to start implementation in the country. It is worth noting that when establishing other such networks, considerations of cultural and language barriers can be the critical difference between a functional and dysfunctional network.

Participatory Process and Ownership

Under the strong leadership of core members, participatory processes of planning, monitoring, and evaluation of network activities facilitate peer learning. Topics of workshops, both among member countries and across a wider audience during international conferences, were decided through discussion among members. All documents were primarily developed by members during workshops organized by the network, not by external consultants, demonstrating the capacity building dimension of this process. In the case of the study on rural retention in Senegal, research demand came from the network, and study design was developed through discussion with network members and a research team who had been invited by the network to provide technical support. This was a key to success because it meant that network members felt ownership of
the research evidence being generated and were held accountable to its use. Research is an important source of evidence for the network to inform the formulation of effective policy, especially in Francophone African countries where research activities are not as widespread compared to Anglophone Africa. Study results are often kept locked inside the shelf and not used for policy formulation or implementation. On the other hand, due to the ownership of the study and network members’ positions inside the ministry, study results produced by this network are far more likely to be taken up for the next step of policy formulation and implementation.

Peer Learning Environment and Coaching Style
The role of the NCGM team was an important factor. The NCGM team adopted a coaching method as opposed to a teaching method. During the training in Tokyo, they facilitated discussion among participants and with counterparts in Japan (Japanese administrators working at ministry and provincial level) and created a peer learning environment without insisting on using the views or ideas underlying the Japanese models. The NCGM team participated in most of the network meetings held in member countries as a support team and continuously facilitated the discussion during planning and implementation of network activities. HRH problems are quite common all over the world. Having more than 25 years of experience in implementing various health projects in Asian, African, and Latin American countries in the health sector, the NCGM team shared lessons learned from other parts of the world using the same analytic framework (the house model) and provided technical support for activities of this network including research. The goal is to create an environment that facilitates knowledge generation and uptake through shared learning and problem solving.

The key ingredient for the establishment of this environment for leaders is to have a physical space and time where busy leaders are able to step away from their daily tasks and reflect on the challenges facing their constituents and other stakeholders. In addition, the models and ideas presented by the network and then adapted and adjusted by members stimulate new thinking that may not have occurred had these leaders not been brought together.

Based on mutual trust with the network, NCGM, as a research center, benefits from collaborative research on health systems. JICA also benefits from the network in developing new project involving technical cooperation in member countries. This win–win relationship motivated JICA and NCGM to provide continuous support.

Challenges
All problems identified in the Francophone African house by the network need to be overcome by strong political commitment for policy formulation and effective policy implementation. Despite the fact that this network is dynamic as an implementer in the field, being influential in policy decision making is still difficult from time to time from positions inside the bureaucracy of the ministry. Addressing the health workforce crisis requires solidarity and partnership among relevant stakeholders. This actively engages all stakeholders across sectors to implement and monitor effective strategies and policy interventions to develop a well-performing health workforce. Creating and sustaining a coordination mechanism across different sectors is still challenging at the country level where higher political commitment in the Ministry of Health and leadership is not particularly strong. In some member countries, the political situation is not very stable, making buy-in difficult. During the past six years since the creation of the network, coup d’êts have occurred in several member countries. Political regime changes affected ministries, security situations worsened, and network members faced further difficulties in managing health personnel in conflict or insecure areas.

As technical managers at the MOHs, all network members are busy in their routine tasks. It is difficult to implement the longer term strategies agreed within the network into their routine work, which is overwhelmed by daily micromanagement. It is also hard to devote their time to prepare workshops and meetings and to finalize and produce documents after the workshop that include all input from members. Full-time staff, both technical and administrative, are needed for the secretariat with sustained financial support from the network.

The financial sustainability of the network is another challenge. HRH is a cross-cutting issue and recognized as a critical agenda for health system strengthening. However, HRH seems to be neglected by global funding trends. Because there is no membership fee and no support from the governments of member countries, the network needs funding to continue its activities. To this end, the network secretariat has prepared a manual for seeking funding from other partners besides JICA and NCGM.

CONCLUSION
The Vision Tokyo 2010 network in Francophone African countries is a unique model of a peer learning and information sharing network with its origins in an overseas training course. It also functions as a platform for policy dialogue and policy implementation. The strong ownership by core members and
coaching-style support by partners have been keys to success. Although financial sustainability of the network, political commitment, and political situations are major challenges, there are many lessons to be learned with regards to establishing similar networks in other regions. The achievements outlined in this article demonstrate to donors and funders that investment in such networks is a cost-effective means of improving resource use and strengthening of health systems at the country level, especially in resource-limited settings.

Where members share similar challenges, have a common strategic vision, and share values with strong ownership and commitment, this network model can be applicable to any issues and any regions. A similar network could be created for English-speaking African countries or Spanish-speaking Latin American countries for region-specific health systems challenges. Having a focused agenda and concrete activity plans that connect daily responsibilities and long-term health systems strengthening initiatives can help similar networks to support capacity building and facilitate effective leadership.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

No potential conflicts of interest were disclosed.

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