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Human Resources for Health - An update on recent progress.

**A key issue paper established in the frame of the SDC
Backstopping Mandate 2007 of the
Social Development Division's Health Desk**

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Table of contents

Abbreviations.....	3
Executive Summary	4
The human resources for health crisis	5
WHO/WHA Decade of Action on Human Resources	7
Global Health Workforce Alliance.....	7
Treat, Train, Retain (TTR) Initiative.....	8
African Health Workforce Observatory	8
HRH and the European Union.....	8
Role of the British Government	9
Role of the Norwegian Government	11
Relevance for SDC	12
References and Resources of Interest	14

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Disclaimer

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Abbreviations

ACOSHED	African Council for Sustainable Health Development
AfHRF	African Health Research Forum
AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical Research Foundation
BMZ	Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung
CIM	Centrum für Internationale Migration und Entwicklung
COHRED	Council on Health Research for Development
DFID	Department for International Development of the UK Government
ECSA	East, Central and Southern African Health Community
EFA	Education For All
EHRP	Emergency Human Resources Programme (Malawi)
EQUINET	Network on Equity in Health in Southern Africa
EU	European Union
G8	Group of 8 (used to refer to industrialised countries of Canada, France, Germany, Italy, Japan, Russia, the United Kingdom and the USA).
GFATM	Global Fund against HIV/AIDS, Tuberculosis and Malaria
GHI	Global Health Initiatives
GHWA	Global Health Workforce Alliance
HIV	Human-immunodeficiency virus
HLF	High Level Forum
HRD	Human Resource Development
HRH	Human Resource for Health
HR-HR	Human Resources for Health Research
IDRC	International Development Research Centre (Canadian)
IHR	International Health Regulations
ILO	International Labour Organisation
JLI	Joint Learning Initiative
MDGs	Millennium Development Goals
NEPAD	New Partnership for Africa's Development
NGO	Non Governmental Organization
ODI	Overseas Development Institute
PEPFAR	President's Emergency Plan For AIDS Relief
PRSP	Poverty Reduction Strategy Paper
SDC	Swiss Development Cooperation
SIDA	Swedish International Development Cooperation Agency
SWAp	Sector Wide Approach
TTR	Treat, Train and Retain
UNDP	United Nations Development Programme
USA	United States of America
USAID	United States Agency for International Development
VSO	Voluntary Service Overseas
WB	World Bank
WHO	World Health Organisation
WHR	World Health Report

Executive Summary

This paper has been elaborated under the advisory and backstopping mandate established between the Swiss Development Cooperation and the Swiss Centre for International Health. The objective is to present an overview of the recent developments in the area of human resources for health.

With the recoupled efforts to reduce Global Poverty and see progress towards the Millenium Development Goals, **human resources for health related problems have become more apparent** and moved increasingly into the spotlight of interest. The availability of appropriately trained, well-deployed and motivated human resources is critical for a well-functioning, sustainable health system. Yet **the world is experiencing a chronic shortage of well-trained health workers.**

International recognition to address this challenge has never been stronger. The level of urgency has been underlined by a series of reports – Human Resources for Health, Joint Learning Initiative Strategy Report 2004, WHO World Health Report, 2006 etc. These reports analyse how HIV/AIDS, labour migration and chronic under investment are all attacking the health workforce. Emphasis is placed upon integrating a reponse within overall health system strengthening – including on the part of Global Health Initiatives. The importance of protecting health workers and enhancing the effective deployment of health staff are underlined as crucial for the way forward.

Indeed, **2006-2015 has been designated a decade of action on HRH** by WHO. This key issues paper looks at initiatives at the international level – the Global Health Workforce Alliance, Treat, Train, Retain of WHO, resolutions of the African Union, the New Partnership for Africa's Development - and at the level of the European Union, before focusing in on the efforts of the bilateral agencies of the United Kingdom and Norway.

The relevance for the Swiss Development Cooperation is elaborated **with the key role SDC often plays in SWAp seen to be particularly pertinent.** SDC is also a well positioned agency when it comes to supporting Governments in linking macro level and sectoral developments – something which is crucial for policy change for HRH to be achieved.

Finally, Switzerland is currently facing the challenge of **incorporating the 2005 International Health Regulations** of the World Health Organisation **into her domestic and foreign policy** – with goals being set to align national and international health policy and to enhance the overall management of migration.

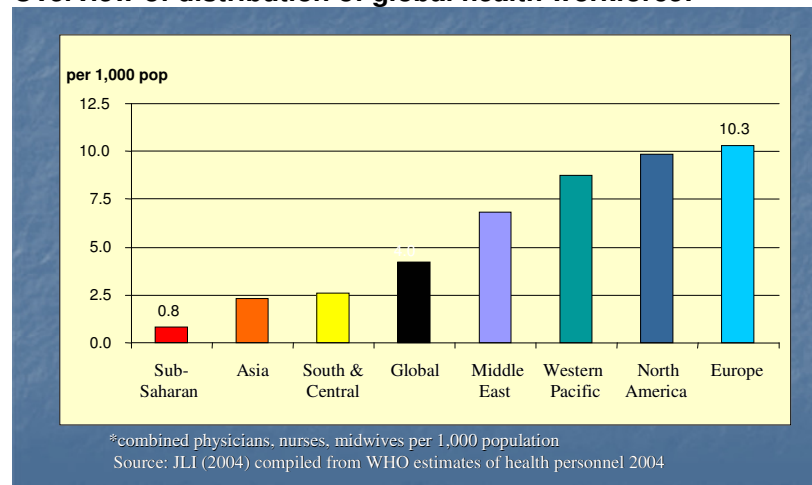
The human resources for health crisis

In recent years the funding available for health has reached unprecedented levels, in particular for HIV/AIDS, malaria and tuberculosis. These finances are largely international. One of the results of efforts to reduce poverty and see progress towards meeting the health related Millennium Development Goals (MDGs) is that the Human Resources for Health (HRH) related problems have become more apparent and moved into the spotlight of interest. At the same time many of these countries are experiencing deteriorating health outcomes, severe fragmentation of health systems, gaping inequalities and scant economic growth.

The availability of appropriately trained, well-deployed and motivated human resources is critical for an efficiently functioning, sustainable health system. Health workers with the “capacity” to deliver health interventions to their populations are the key to improving health outcomes (Anand & Barnighausen, 2004). **Today the world is experiencing a chronic shortage of well-trained health workers**, a crisis felt most acutely in those countries that are experiencing the greatest public health threats. There are more than 50 countries, mostly in sub-Saharan Africa, but also including Bangladesh, India and Indonesia, that face crippling health workforce shortages (WHO, 2006a).

Today the world is experiencing a chronic shortage of well-trained health workers

Overview of distribution of global health workforce:



The current situation has been developing slowly over many years, even decades

Wealthy countries are both affected, and intrinsically involved, in this situation as well: To give just one example, the recruitment of Canadian health care workers by the USA is a factor in the staff shortages which drives, in turn, Canada’s recruitment of health care workers for many Commonwealth countries, most notably South Africa. (Pang et al, 2002).

The current situation has been developing slowly over many years, even decades. Until recently, however, there was a tendency for individual actors to shy away from raising such a complex topic that, to a large extent, calls for decisions and actions that are much broader than the confines of the health sector alone. Recently the proportions of the problem have become so staggering that the en-

tire international community has recognised the need to urgently address human resources for health (HRH). The high level of this recognition is underlined by a series of reports for which a summary is hereby given:

- Human Resources for Health – Overcoming the Crisis – Joint Learning Initiative Strategy Report, 2004
- Third High Level Forum on Health MDGs, 2005 in Paris
- WHO World Health Report, 2006

Joint Learning Initiative (JLI) was created in 2002 as a unique endeavour supported by the Rockefeller Foundation in New York, John Snow Inc. in Boston and the Global Equity Initiative of Harvard University as well as several bilateral agencies.

The JLI Strategy Report was the result of a two year team effort and took the view that HIV/AIDS, increased labour migration and chronic under-investment were attacking the health workforce. Workforce supply, demands, priority diseases, innovations and coordination were all examined. The report presents recommendations including that all countries need to ensure a positive policy environment for addressing national health workforce planning, that sub-Saharan African countries aim to triple the current numbers of health staff, that core technical capacity in human resources (including education and training thereof) be increased to form up to 10% of donor contributions and that categorical funds and programmes – such as the Global Fund, the U.S. President's Emergency Plan for AIDS Relief, Global Alliance on Vaccines and Immunisations etc – develop explicit strategies to achieve disease control whilst building a sustainable workforce. The important contribution to solving the crisis that can be made by academic bodies, professional councils, labour unions and non-governmental organisations was also underlined in the report's findings which can be downloaded from: <http://www.globalhealthtrust.org/Report.html>

A vertical approach to tackling the HRH issue should be avoided

The High Level Forum (HLF) on the Health Millennium Development Goals provide an opportunity for dialogue between senior policy makers and for the identification of opportunities for accelerating action on the health-related MDGs. The third HLF held in November 2005 addressed global health partnerships, human resources for health and aid effectiveness. With regards to HRH, crucially it was agreed that a vertical approach to tackling the issue be avoided in favour of a response that is integrated within health system strengthening. The full report can be accessed at the following link:

<http://www.hlfhealthmdgs.org/Documents/GlobalHealthPartnerships.pdf>

The World Health Report (WHR), 2006 summarises evidence on HRH related aspects and identifies a series of priorities for action which include education and training, the protection of health workers, the enhancement of the effectiveness of the health workforce and the importance of addressing imbalances and inequities (WHO, 2006b). <http://www.who.int/whr/2006/en/>

***Human re-
sources are
needed to
“make health
research
work”***

In addition, a series of regional, consultative reports on Human Resources for Health Research (HR-HR) have been developed between 2005 and 2007 by seven partners (AMREF, AfHRF, Council of Health Research for Development (COHRED), ACOSHED, EQUINET, Global Forum for Health Research and IDRC). The reports take a comprehensive look at the human resources required to “make health research work...for equity and development”. The emphasis is upon translating research into action – and specifically how networks can help to achieve this. Whilst the WHR, 2006 highlighted the urgent need to improve human resources in the health sector, it doesn’t address the critical implications of skills and human resources needed by developing countries to improve the health research sector. The importance of networks as “knowledge brokers” to bridge the interface between researchers and the users of research evidence is highlighted. http://www.cohred.org/HR-HR/neglected_area_of_HRH.htm

***WHO/WHA
Decade of
Action on
Human Re-
sources***

At the opening of the 57th World Health Assembly the decade 2006-2015 was designated as a decade of action on HRH. Further, subsequent developments are hereby outlined: In April 2006 the G-8 (Group of Eight major industrial countries) summit for the first time included a Health Ministers’ meeting with participation of the EU, China, Brazil, Mexico, South Africa and representatives of UN agencies for health. Human resources for health was recognised as a key area in need of support.

In sub-Saharan Africa the issue of HRH is increasingly acknowledged by national governments and regional initiatives. Recent resolutions on the crucial relation between capacity building and strategic planning and policy of the African Union, the New Partnership for Africa’s Development (NEPAD), the WHO Regional Office for Africa and the establishment of the Touch charity, dedicated to training more health workers, <http://www.touchfoundation.org> testify to this recognition. In September 2006 the Ministers of Health of the African Union launched the “Maputo Action Plan” for universal access to comprehensive sexual and reproductive health services in Africa. The plan pays unprecedented attention to the human resources which would be required to strengthen health systems sufficiently for this to be achieved.

***Global
Health
Workforce
Alliance***

A key subsequent step that is traced directly back to the World Health Report 2006 is the establishment of the Global Health Workforce Alliance, a global partnership that focuses on the worldwide shortage of nurses, doctors, midwives and other health workers. WHO holds the Secretariat. The Alliance seeks to mobilise key stakeholders engaged in global health to help countries improve the way they plan for the education and employment of health workers as well as to identify practical approaches to urgent problems such as improving working conditions and reaching more effective agreements to manage migration. <http://www.ghwa.org/>

Treat, Train, Re- tain (TTR) Initiative

WHO launched the “Treat, Train, Retain (TTR) initiative in 2006 to strengthen and expand the global health workforce. “Treat” stands for a package of HIV treatment, prevention, care and support services for health workers, who may be infected or affected by HIV or AIDS. WHO will hereby collaborate with the International Labour Organisation (ILO) to support the roll-out of workplace programmes. For “Train” WHO will support standardised training and certifying of all cadres to deliver HIV services. “Retain” covers financial and other incentives and occupational health and safety. Migration issues are being examined with the International Organisation for Migration:

<http://www.who.int/mediacentre/news/releases/2006/pr37/en/index.html>

African Health Workforce Observa- tory

The African Health Workforce Observatory was launched in 2007 following a meeting held in Arusha, Tanzania in September 2006 by the East, Central and Southern African Health Community (ECSA), the World Health Organisation, the World Bank and the Capacity Project. Supported by the WHO Regional Office for Africa the Observatory serves as a platform for sharing, synthesis and dissemination of health workforce information between countries and regional networks. In its mission statement it reflects the need for “knowledge brokers” between implementers and researchers in line with the recommendations of the HR-HR consultations.

<http://www.afro.who.int/hrh-observatory/index.html>

HRH and the Euro- pean Union

The EU strategy for action on the crisis in human resources for health in developing countries sets out what the EU intends to do in order to assist developing countries respond to their human resources problems. In May 2006 the EU Council adopted a package of action oriented decisions derived from the strategy for action and including the incorporation of human resources issues in Poverty Reduction Strategies, health policy discussions and supporting and financing national human resources plans. Central importance is attached to the need for country leadership in taking this issue forwarded and raising visibility and political attention paid to health.

For the EU the crisis in HRH is not fully explained by poor working conditions, a lack of training, demoralisation, low salaries and other inadequate incentives. Rather, they add an additional fundamental reason – this being that **“many health workers in developing countries, and particularly in rural areas of developing countries, opt to migrate to either urban areas, neighbouring countries, or internationally to Europe or North America”**.

As regards coherence with the EU’s approach to migration, it is important to note that the strategy is in line with the Commission’s

Health worker movement is closely linked to issues of migration and brain drain

Communication on Migration and Development published in 2005. However, whilst it laudably highlights the need for human resources issues to be considered in the context of the policy debate around migration to optimise the benefits for all involved, it emphasises that **the “brain drain” is not the only cause of the HRH crisis.**

Consultations with the Commission’s High level Working Group on Asylum and Immigration are reported to have been only minimal in a case study paper drawn up by the Overseas Development Institute. So although the strategy commits the EU to exploring the value and feasibility of a code of conduct for ethical recruitment, **the entire issue seems to raise an internal policy coherence challenge** (Hudson, 2006).

In short, the EU calls on member states to *maintain* the numbers of health workers working within its borders and *invest sufficiently in training health staff here*. The case is made for increased monitoring of the mobility of health workers in, into and from the European Union. Concurrently it is reiterated that investments in the health systems of developing countries need to continue and that, at country level human resources issues be integrated into Poverty Reduction Strategies.

The European Union commits support for research into innovative and effective ways of increasing the number of people working in the health sectors of these countries. In particular, the development of training programmes and facilities, especially in Africa and mobilisation of more financial resources are highlighted for attention.

Role of the British Government

The Department for International Development picked up the HRH issue early on in the debate. Already in the 2000 UK government White Paper on International Development “Eliminating World Poverty: Making Globalisation Work for the Poor”, the need for developed countries to be more sensitive to the brain drain from developing countries – based upon examples from the UK and the commonwealth - was pointed out.

The Code of Practice governs the global recruitment of health workers in the UK

In line with the EU strategy for action DFID proposed to the British Government that a set of principles be developed to guide recruitment. Issued by the Department of Health in 2004 the “**Code of Practice for the International Recruitment of Health Care Professionals**” proscribes active recruitment of health workers by National Health Service Employers and tries to discourage the private sector from doing so. It seeks not to undermine the rights of health workers to migrate to countries that wish to admit and employ them. It outlines a framework of responsibilities between governments, employment agencies and the recruits. This includes, that the labour rights of international staff working in the UK health sector are promoted. (House of Commons, European Scrutiny, Seventh Report, 2006). It is to be anticipated that DFID will continue to be active in current efforts to develop a European level recruitment code of practice.

The new DFID Health Strategy launched on 5th June, 2007 lays out 4 key priorities for coming years.

- **More and better:** Delivering more resources for health
- **Working together:** Expanding access to basic services
- **Making it happen:** Improving the effectiveness of international funding for health
- **Gathering the facts:** Demonstrating results and building evidence of what works

Under **Working Together**, strong leadership and management skills are to be supported so that health systems can be strengthened and **“investment in human resources for health be made through comprehensive approaches to workforce planning; recruitment, deployment and retention; training; and maximising staff efficiency.”** Additionally, DFID calls for countries to make best use of non-state providers to deliver affordable, good-quality care and supports country to train more staff – in particular “mid-level” health workers and community health staff.

The case study of **Malawi and the Emergency Human Resources Programme (EHRP)** is explored in detail: Through a Sector Wide Approach, DFID, as one member agency of the SWAp, has provided £55 million over six years to support the training, recruitment and retention of health workers. The programme covers initiatives such as salary top ups, improvements in housing and training, the filling of short-term gaps with international volunteers and incentives for retired health professionals to return to work. Enhanced data collection regarding health workers recruitment and leaving of the services are also supported.

Voluntary Services Overseas is being used to recruit volunteer medical specialists and nurse tutors to fill critical gaps until more Malawians are trained. Training schools have been supported to increase intakes to double the number of nurses and treble the number of doctors. The GFATM is also supporting parts of the EHRP with a focus on training health surveillance assistants.

On the ground however, reports from Malawi include that the gap-filling policy for clinical staff has created a convergence of cultures and differing medical systems. Furthermore, many countries are not in favour of the training of large numbers of very lowly trained cadres such as health surveillance assistants due to the continued dilution of quality in the delivery of health services that this entails. In the case of Malawi, however, the urgency of the situation is seen to justify this in the short term.

Once again it is illustrated that **political commitment at the highest level is needed to see change in regard to human resources.** Furthermore, it is important to note that addressing HRH cannot be comprehensively achieved through a project approach.

Whilst this can be useful to pilot and monitor innovative ideas to recruit and retain workforce - eg. in rural hardship areas - **a sweeping, civil-service wide response is called for.**

Countries with SWAp arrangements in place are increasingly seeing health sector officials and development partners pushing Governments to take up the issues on a national scale. In Tanzania, for example, in January 2006 a pay reform was introduced for all civil servants including for health staff. As a result, however, church run health facilities are finding themselves unable to match the increase and are losing health staff in their droves to the public sector. As such agencies often serve disadvantaged areas of the country concerns about equity are arising. The complexity and need for solutions embracing all service providers are again laid bare.

Role of the Norwegian Government

Since 2004 the administration of Norwegian development cooperation was exclusively mandated to the Ministry of Foreign Affairs.

<http://www.regjeringen.no/en/dep/ud.html?id=833>

The Ministry of Foreign Affairs was quick to become active in HRH at the international level rather than in specific countries and took up the challenge of assisting WHO in implementing the Global Health Workforces Alliance (GHWA) Strategic Plan.

http://www.who.int/workforcealliance/GHWA_STRATEGIC%20PLAN_ENGLISH_WEB.pdf

A series of consultative meetings were held in Oslo commencing in 2006 with officials from EU, GFATM, UNDP, World Bank, International Council of Nurses, SIDA, DFID, BMZ/GTZ, USAID, NEPAD and the Netherland Cooperation.

A key output of GHWA so far is the HRH Action Framework website which represents a collaborative effort between the U.S. Agency for International Development (USAID) and the World Health Organization (WHO). The Capacity Project is the website administrator. For the following action fields useful tools, guides and reference documents have been compiled:

- HR Management Systems
- Leadership
- Partnership
- Finance
- Education Policy

and can be accessed at: <http://www.capacityproject.org/framework/>

The outline of the Norwegian contribution to health is at: <http://www.regjeringen.no/en/dep/ud/Documents/Reports-programmes-of-action-and-plans/Reports/2002/Health-poverty-and-development.html?id=450237> Overall, a focus upon encouraging countries to take up HRH issues across all the social sectors can be discerned.

Additionally, the Norwegian Development Cooperation continues to

Relevance for SDC

emphasise the importance of education. Major investments are being made in the Education for All (EFA) Initiative. This interest extends to the health sector in Malawi where via the SWAp Norwegian funds have been earmarked for pre-service training of health staff. Furthermore, the case is made that tertiary education together with broad based research are fundamental building blocks in development and provide the necessary knowledge, professional qualifications, critical thinking and analysis for advising governments. Norway views institutions of higher learning as essential for a vibrant private sector and societal development.

Norway seeks to support its partner countries by ensuring a critical mass of human resources in science, management, administration and policy-making. The challenge is also to sustain this critical mass. Without more and better national tertiary education, developing countries will find it increasingly difficult to benefit from the knowledge based economy.

The importance of tackling the “human resource for health crisis” as an integral part of efforts to strengthen health systems is now acknowledged by all development partners including SDC. In countries which are particularly affected increased attention to the issue of capacity building can already be seen within health sector strategy discussions.

Global Health Initiatives are also beginning to invest in health systems – including human resources. The Global Fund to Fight AIDS, TB and Malaria, apart from delivering over 2 billion US dollars in the fight against these three diseases, is now providing funding for human resources for health through health systems strengthening interventions. However few countries have taken advantage of this to date. Draeger et al, 2006 put together an analytical review arguing that countries need support to go beyond short-term objectives and **link their Global Fund activities to a long-term development of their human resources for health**

<http://www.human-resources-health.com/content/4/1/23>

In the changing context of aid the challenge of working with Governments to keep all efforts coordinated and aligned is continually growing – particularly in countries where even capacity at the highest levels is low. **As SDC often plays a key role in supporting coordination efforts - in particular through SWAp arrangements - this is an area of ever increasing relevance.**

In many countries **HRH development lies at an intersection between parallel, complex reforms.** Involvement at the macro level in good governance, decentralisation, civil service and health sector reform processes is required. Achieving these over-arching synergies determine in an important way the effectiveness of an agency’s contribution to HRD. SDC is an agency well placed to rise to this challenge. SDC is also an agency that can appreciate the importance of addressing investments in human resources development in a systematic and concerted way.

There is a need to “stick with such change processes”. Some voices are already reporting that the pressure for speedy results in this area is leading some agencies to resort back to project-level interventions. These are, however, not as likely to be sustainable as they are not systemic. (Schmidt-Ehry “personal communication”¹).

There is indeed a dilemma between the pace that change in this area can be achieved and the urgency of the need for action. The executive director of the GHWA has already commented that in 2007 the Alliance stands at the crossroads between just articulating “the need to do” and actually starting to “do” and to describing “what has been done” and “is being done” (Omaswa, 2007).

This year International Health Security has been selected as the topic of WHO’s World Health day. The 2007 World Health Report. “Invest in health, build a better future”

<http://www.who.int/whr/2007/en/index.html> underlines how socio-economic, natural and man made threats can jeopardize people’s development and rights and magnify our global interdependence and the importance of the International Health Regulations (IHR). Since they were issued in 2005, Switzerland has been at the forefront of countries working to incorporate the full ramifications thereof into its broader domestic and foreign policy.

In the Swiss Health Foreign Policy five focus areas have been elaborated in regard to IHR- protecting the health interests of the Swiss people, alignment of national and international health policy, improvement of the performance of international development cooperation, improvement of the global health situation, taking forward the Swiss role as host country of WHO and other international, multilateral agencies. Within the rubric “alignment of national and international health policy” the goal has been set for Swiss Federal Offices that “Migration of health staff be so managed, that the needs of markets in industrial and middle income countries are satisfied without developing countries being deprived of essential, needed staff”. The importance of a managed approach to migration - in view of the commitment to strengthen health systems worldwide, for which a health workforce is the single most important prerequisite – is of crucial significance for all the Federal Departments, particularly for the Federal Office of Public Health and the Federal Office of Migration.

¹ Schmidt-Ehry, Bergis (GTZ) Senior health advisor, Programme Manager, Chair of Development Partner Group AIDS, Tanzania.

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HRH RH Global Resource Center. <http://www.HRHRResourcecenter.org>

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