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# **Policies for human resource for health: why are they important?**

**A key issue paper established in the frame of the SDC Backstopping Mandate 2003 of the Social Development Division's Health Desk**

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## Abbreviations

GAVI	Global Alliance for Vaccines and Immunization
HRH	Human Resources for Health
MDGs	Millennium Development Goals
PHC	Primary Health Care
SDC	Swiss Agency for Development and Cooperation
TB	Tuberculosis

## Executive Summary

Human resource policies for improving the performance

This paper reviews **challenges** faced by national authorities in low- and middle-income countries **in the area of Human Resources for Health (HRH)** and policy issues that must be addressed in order to improve the management and performance of the health sector workforce.

In many countries, the **performance and motivation of health workers is low**. There are **many reasons** for this, among them: weak team building and supervision mechanisms, unpleasant physical working environments, low and sometimes even extremely low salary levels and monetary incentives, missing performance assessment, absent career plans and retention strategies, as well as incomplete implementation of governmental reform issues including health sector reform.

Why performance improvements?

**Performance improvements** are important as they **potentially can increase the number of services provided and service coverage and thus contribute to equity and efficiency gains**. In the context of scaling-up priority interventions, for example against malaria, tuberculosis or HIV/AIDS, performance improvements may strongly reduce the number of new health workers to be trained for successfully achieving the Millennium Development Goals (MDGs).

SDC and human resources for health

The Swiss Agency for Development and Cooperation (SDC) makes important investments in health systems strengthening through the provision of assistance to infectious disease control and health sector development programmes. In these efforts, HRH strengthening may not only be addressed through training courses, but more importantly also through systematically assisting HRH issues and policies. Today many of the SDC health sector priority countries such as Tanzania, Chad, Tajikistan or Kyrgyzstan have no coherent approaches towards HRH. Thus, assistance may be provided for the establishment or strengthening of policies at country level which do address HRH in a comprehensive way.

Coherent HRH policies should address: (1) **Review and planning the availability and requirements of health workers** to make sure that a sufficient number of personnel with the appropriate skills is available and that the personnel is adequately distributed; (2) **Education and training** including the establishment of training curricula adapted to the health policy objectives, pedagogic approaches, development of training infrastructures (e.g. decentralisation of training institutions), training of trainers; (3) **Performance assessments** for examining why and to what extent targets are or are not being met; (4) **Working conditions**: including guidelines and procedures to recruit and retain health workers, salary levels and monetary incentives schemes, career management, workplace mobility, inter-personnel communication, and individual performance assessment.

## Background

Human resource a crucial input for equitable and efficient health service delivery

**Human resources for health (HRH) are one of the key components for providing successfully health services.** The appropriate person at the appropriate place will determine if a service can be delivered effectively and efficiently. Or the quality of the interpersonal and technical interaction between a patient and health provider will influence whether and where a patient seeks care.

**HRH do absorb large parts of governmental expenditures** in the health sector in form of salary and other benefits. In low- and middle income countries HRH related costs usually amount to between 60 and 85% of public expenditures leaving few public resources for other cost items such as investments or drugs.

HRH and the scaling-up of priority interventions

Recent international initiatives such as the debt relief earmarked to the health and education sector, the Global Fund to fight HIV/AIDS, malaria and tuberculosis, the Stop TB partnership or the Global Alliance for Vaccines and Immunization (GAVI) call for the scaling-up of health related interventions. They are based on the idea that development can only happen if the health of the people improves.

For most priority diseases and major contributors to the global burden of disease, effective interventions do exist. For example, childhood illnesses and premature deaths can strongly be reduced through better vaccination coverage rates or through the appropriate prevention and treatment of diarrhoea, acute respiratory infections or malaria. Unfortunately in many countries only a minority of the population can benefit from these services. In most situations poor groups are those with extremely limited access to these services. Thus, **increased coverage of the population with health services is a prerequisite for achieving better health outcomes of the population** and the Millennium Development Goals (MDGs).

Why performance improvements

**A better coverage of people with priority services requires human resources to implement them.** HRH will also heavily influence absorptive capacities of supplementary resources to health systems in low- and middle income countries. Thus, for any large scale effort to rapidly increase coverage of the population, HRH will be a key to success.

Better coverage can be achieved through the mobilisation of new resources or through a better use of existing resources. If use of health service inputs such as labour for a given level of output is high, an increase in service coverage might imply a need for enrolling new health staff. On the contrary, if productivity of labour for a given output is low, an increase in service coverage can potentially be achieved through productivity gains. Better performance in turn, implies that adequate policies exist and are enforced which address critical issues related to HRH.

Objectives and structure of this report

The current **paper aims** to:

- Review management and policy issues which may affect the performance of the health sector workforce;
- Examine important elements for national HRH policies;
- Assess the relevance of coherent HRH policies for SDC health sector priority countries.

Corresponding to these objectives, a first section of the report describes factors that do influence the performance of health workers. Then critical elements which should be addressed in national HRH policies are described. The third section reviews the relevance of HRH policies for three SDC health sector priority countries (Tanzania, Chad, and Tajikistan).

## Factors influencing performance

Low performance of health workers

Generally spoken, **performance of health workers is in many settings deficient**. Many places in Africa or Central Asia report that the productive time of governmental health workers - the time spent with patients, for outreach activities, administration, meetings, etc. – ranges not beyond 60%. Sometimes the productivity is even much lower and turns around 25%. In other words **important parts of the official working time are spent with unproductive activities such as waiting for patients or absences from the services**. Frequently it is also reported that health workers have to reduce working hours for following-up alternative income generating activities such as providing complementary services outside the public sector or food production.

Elements affecting performance

The low performance of health workers make it necessary to identify factors which influence performance. This in order to design, test and implement feasible and realistic approaches on how best to improve performance.

Generally, the following elements may affect directly or indirectly the performance of health workers:

- **Team building, supervision and interaction:** Health workers are motivated by a feeling of having responsibilities and working in a team environment where reliance on each other and differences are dealt with in a team spirit, and by feelings of technical and financial achievement.
- **Physical working environment:** An element for performance improvements may consist in offering health workers a decent physical working environment. For example, motivation to work in rural areas may be linked to the presence or absence of suitable health facilities.
- **Salary level and monetary incentives:** Salary level is strongly linked with motivation and retention. In many countries salaries of the governmental health sector workforce are low, in both absolute and relative terms compared to the pri-

vate sector.

- **Career plans and retention strategies:** Career plans, recruitment, appointment and retention procedures do strongly affect the motivation of health workers, where they practise and whether they stay in the health sector.
- **Regular performance assessments:** Staff performance has to be effectively monitored. Assessment practices, quality standards need to be defined, and attention has to be paid to transparent processes and performance audits.
- **Composition of workforce and skill mix:** Although there is limited evidence on appropriate skill mixes - the mix of grades and occupations within a given health service - surpluses or shortages of personal with specific skills at a given health service influence the individual and group performance.
- **Governmental reform issues including health sector reform:** Decentralization, the promotion of private practice, new financing and payment schemes, hospital and/or pharmaceutical reforms are currently promoted in many countries as a mean to improve performance of workforce and more generally of outcomes of national health care systems.

Geographical imbalances and migration

In case the above mentioned elements are not systematically addressed, they may not only negatively affect performance, but also more **broader HRH and health sector development issues such as the geographical and gender distribution of health sector workforce and migration of health workers.**

**Imbalances in the health workforce are a major concern and are reported in both developed and developing countries and for most of the health care professions.** The types of imbalance include profession/speciality imbalances, geographical imbalances, institutional and services imbalances, public and private imbalances, and gender imbalances. Some countries such as Chad or Zimbabwe report serious staff shortages in all health profession categories others such as Botswana, Ghana or Guinea Bissau mention shortages of doctors. In many African, Eastern European or Central Asian countries hospitals report to be over-staffed while rural health services lack crucially of personal. In some countries especially in Eastern Europe and Central Asia, the health sector workforce is mostly female (the same is also true for high income countries in Western Europe, the United States and Australia). In Africa, the share of women in the workforce is usually much lower and for example in Chad they make up less than a third of the workforce. Women generally appear at the bottom of the hierarchy in terms of authority, remuneration, and educational preparation.

Working and living conditions in a low-income country will determine whether health staff is encouraged to perform well, to work in the health sector or to leave the country. With various high-income countries such as the USA, UK or France having a high demand for health professionals trained outside their country, there is a growing concern that they absorb large numbers of health staff from low-income countries. For example, it is reported that the US

is short of several hundred thousand nurses. At the same time it is estimated that over 50% of doctors having graduated in Ghana are living and practicing outside the country. **In case there is no possibility to address at the same time pull factors of migration in high income countries and push factors in low-income countries, investments in medical and nursing training are likely to be in vain.** One element will be well balanced and solidly elaborated national retention strategies being part of more broader HRH policies.

## HRH policies: why and which issues should be addressed?

Why HRH policies?

Health policies are a comparatively recent initiative and steam back to the end of the 1940s, when national policies become a prerequisite for financing Europe's reconstruction under the Marschall plan. Nowadays, national policy frameworks including Poverty Reduction Strategy Papers (PRSPs), are often a prerequisite for low-income countries in order to benefit from financial and technical aid.

There are **6 important reasons** why HRH policies can be a useful tool:

- HRH policies can **assist planning**: Policies facilitate to establish perspectives for the future, define short-, mid-, and long-term availabilities and requirements
- HRH policies can **define and delineate legal and institutional arrangements** and define roles and responsibilities;
- HRH policies can **set priorities**;
- HRH policies can **assist decision-making**: a framework based on explicit criteria (e.g. on effectiveness, equity and sustainability), can choose priorities and guide their implementation;
- HRH policies **allow the assessment of performance** against defined and agreed on standards;
- HRH policies may **allow concerted action across various stakeholders** (e.g. different professional groups) and facilitate implementation of critical actions: Complex decisions (e.g. a shift from specialists to family practitioners) may be better accepted by concerned people and institutions if they have been established in a participatory way.

Issues to be addressed in HRH policies

For obvious reason, there are **many aspects to be considered and included while establishing a national HRH policy**. Depending which levels are concerned - national, regional and local - they range from considerations at individual level up to the macro-economic, social and political context of a country.

For example, most low-income countries in Africa give priority to services which address maternal and peri-natal conditions. They usually require female personnel with midwifery skills in rural areas. At the same time midwives are much less likely to work in rural areas and tend to be concentrated in cities. Thus a HRH policy

may need to identify feasible strategies that are able to address gender-related differences in terms of choices for different training options or workplaces. Often women cluster in specific professional categories and levels of the health system, have lower incomes than men, and exit the workforce earlier due to pregnancy and the raising of children.

Or, multi-sectoral approaches and policies are required for an effective and efficient HRH development. Unless health sector development is not an agreed on high priority of a country, it is not likely that there is enough backing for the health sector to carry forward the strengthening and eventually the extension of services. Political support to HRH development needs to be followed by budgetary support. However, the political and economic feasibility of increases in public expenditure may reveal difficult, as other sectors may disagree with priority given to the social sector(s). Further, various countries still are under considerable pressure from international organization to pursue structural adjustment with the consequence that allocation to the social sector can not be increased. The development of HRH will need to tie into such considerations.

Generally spoken, the following **4 aspects** appear as **most important** to be addressed while establishing HRH policies (based on Martinez and Martineau - see resources and selected links):

- **Review and planning the availability and requirements of health workers.** This aims to make sure that a sufficient number of personnel with the appropriate skills is available and that the personnel is adequately and equitably distributed across geographical regions, health facilities and levels of care. Addressing profession/speciality imbalances, geographical imbalances, institutional and services imbalances, public and private imbalances, and gender imbalances is among the biggest challenges and involves the conceptualisation and successful implementation of incentives for addressing these imbalances.
- **Education and training.** Training approaches need to tie into national health policies and priorities, such as the promotion of family medicine services or PHC and respond to required HRH skill patterns. Issues to be address may include: establishment of training curricula adapted to the health policy objectives, development of new pedagogic approaches, development of training infrastructures (e.g. decentralisation of training institutions), training of trainers, etc. With regard to initial training, appropriately trained staff implies often significant changes in existing medical and nursing curriculum, pedagogical methods, and in admission criteria. With regard to continuous education and in-service training, it is not only important to develop and implement corresponding policies for maintaining and improving quality skills of health staff but to address motivation and performance especially in rural areas. Further, public health, administration and management skills and/or the training of district managers require attention.
- **Performance assessments.** This relates to examining the performance of HRH policies by comparing planned with achieved

activities and commitments. One important focus of such performance assessment mechanisms is to examine why targets are or are not being met, in terms of the processes or means that have been chosen to achieve a given target, and the level of success of implementation of these processes or means. Performance assessment relates also to the optimisation of service production processes and to ensuring that health workers are motivated to provide effective, efficient and high quality services which do match the demand of the population. Issues to be addressed within HRH policies include: guidelines with regard to the division of work, payment methods, management practices, accountability mechanisms.

- **Working conditions.** This relates to guidelines and procedures to recruit and retain health workers, salary levels and monetary incentives schemes, career management, workplace mobility, inter-personnel communication, and individual performance assessment.

Participatory establishment of HRH policies

Many different persons and groups are directly or indirectly concerned by HRH policies. Minimally they include (based on Dussault and Dubois, see resources and selected links):

- **Those who define and negotiate working conditions:** Ministries of Health, Finance, Civil Service, Planning as well as trade unions and hospital boards;
- **Those who define standards and professional practices:** associations of professionals, regulatory agencies;
- **Those who produce health workers:** Ministry of Education and medical training institutions;
- **Those who produce services:** public and private health care providers such as hospitals, clinics and primary care health services;
- **Those who finance services:** Ministries of Health, Finance, Social Security, social and private insurances, citizens, donors;
- **Those who consume services:** users, user associations;

The involvement of these concerned people and institutions in the development of HRH policies, even though it will require more time, discussion, negotiation skills, political power games and energy, appears important as it will ease the approval, implementation and sustainability of policies. In other words, **HRH policies which are established in a concerted and participatory way are likely to be more successful** than those which are elaborated by limited number of institutions (e.g. only Ministry of Health and its departments).

Conditions for success of HRH policies

There are various factors which do influence the success or failure of HRH policies. Four appear to be especially relevant (based on Dussault and Dubois, see resources and selected links):

- **Institutional capacities:** The development, implementation and evaluation of HRH policies require a broad set of skills including methodological and practical information on needs assessment, planning, evaluation methods, economic feasibility, policy analysis and communication. Knowledge and practice on these aspects are an essential resource.

- **Political feasibility:** HRH policies must define realistic targets taking into account the physical, financial and human resources likely to be available. They must also consider potential opposition to change especially from powerful interest groups such as physicians or pharmacists.
- **Social acceptability:** New policies may potentially face social or cultural opposition and thus the acceptability of any policy must be considered;
- **Affordability:** HRH policies may require substantial new financial investments, for example in the area of training of medical personnel. Therefore, a realistic assessment of cost and financial resources likely to be available should be part of any HRH policy elaboration process.

## HRH and SDC health sector priority countries

HRH and SDC

The Swiss Agency for Development and Cooperation (SDC) makes important investments in health systems strengthening through the provision of assistance to infectious disease control and health sector development programmes. One of the key priorities of SDC consists in “*Strengthening good governance in relation to health to assure the careful and responsible management of the resources that help promote the health and well-being of the population*” (extract from the SDC health policy 2002 to 2010). **Human resources, as crucial component of health systems, are a decisive factor for successfully addressing SDC key priorities.**

Among priority countries in which assistance is provided to health sector are Tanzania and Chad in Africa and Tajikistan in Central Asia. The subsequent paragraphs briefly review the situation of human resources in these countries with special consideration of HRH policies.

Tanzania

The adaptation of the Arusha Declaration by Tanzania in 1967 was coupled in the health sector with significant investments in infrastructure and the training of health professionals. This approach proved financially unsustainable and in 1993, the government instituted a public employment freeze under the policy guidance of the International Monetary Fund and the World Bank. Additional re-trenchments were conducted such as voluntary retirement plans. The employment freeze was partially lifted in 1998. However, a full lift of the employment freeze is not foreseeable.

In 2002, the total number of currently active health workers was estimated between 35'000 (Health Management Information system of the Ministry of Health) and 48'000 (census Ministry of Health) in Tanzania for a total population of around 33 millions. Unskilled workers form the largest group within the health labour force with around 31% of workers, followed by the professional group of nurses and midwives. Approximately 35% of the Tanzanian health workers are employed in the private sector of whom 40% worked in the for-profit private sector. Staff per population

ratios vary widely between districts, between a factor of 2.5 to 12 depending on the cadre.

Although the country is in a process of health sector reform since the mid of 1990s, HRH issues are not systematically addressed. Thus, the country faces the typical problems such as low performance of governmental health workers due to various reasons such as low salary levels, weak accountability mechanisms, migration of health workers to neighbouring countries including to Botswana and South Africa, strong geographical imbalances in the health sector workforce and others.

Chad

In Chad available human resources in the health sector in 2002 accounted for 3'632 persons for a population of around 8 million. Staff working at the level of the private profit making sector is very scarce and accounts for less than 1% of the total workforce. There are serious geographical imbalances with around half of the physicians and mid-wives working in the capital city, N'Djaména. Persons with no formal technical, clinical or managerial skills account for half of the workforce (49%). Health workers with nursing and midwifery skills total 35%, while physicians account for 8% of the personnel. Of the total workforce, 62% of the personnel operate at district level including first contact level (district administration, district hospital and dispensaries). Personnel with better qualification skills are highly underrepresented at this level.

Until recently, the commitment of donors to training has been limited, but faced with massive shortages of human resources most donors now see training as a high priority. Since 1998 the "Decentralised Initial Training Project" has established 3 peripheral paramedical schools for basic training. These centres are intended to train male and female nurses, who will be assigned to the region in which they were trained. The 8th European Development Fund (EDF) project of the European Union and the World Bank are financing the establishment of these training nuclei.

Albeit the high priority given to the training of human resources there is no coherent HRH policy established which addresses the current main problems. For example, efforts to achieve a redistribution of health workers have all failed, mainly because of the absence of feasible policies and the unattractive working conditions in rural areas. Staff shortages result in a situation where many positions are held by workers who do not have the appropriate skills and training for the job and cannot function efficiently and effectively.

Tajikistan

Opposite to Chad and Tanzania, Tajikistan has a large number of health personnel as required under the former Soviet norms. These are virtually all employed in the public sector. The number of professional staff in the health sector in 1998 totalled 47'448, comprising 11'771 physicians for a total population of around 6 million people. Over the last years a large number of people have left the health sector mainly due to low salaries and migration to Russia. In terms of staff proportions, Tajikistan is closest to the United Kingdom, but the latter has a well developed government

health care service. Tajikistan has also an uneven distribution of physicians across its regions ranging from 7.4 per 1000 population in the capital city Dushanbe to 0.4 per 1000 in remote areas. Governmental statistics do not report the female to male proportion in the workforce.

There are no consistent policies in Tajikistan addressing the main HRH related issues, such as migration, the distribution of health workers and their re-allocation to family medicine services, motivation, skill mix, etc. In addition, the pay of health workers is extremely low and a typical salary is by far not enough to cover what is needed to survive. Consequently motivation is low and performance poor.

Over the last years many donors invested in the training of family practitioners. As there has been few coordination in this area, with the result of fragmentation and duplication of activities, SDC assists – through project Sino – the elaboration of a national training policy for training in the area of family medicine. A national expert group representing various Tajik key stakeholders (Ministry of Health and relevant training institutions) reviews past and current achievements and problems with regard to training of family doctors and nurses. Activities of the expert group are assisted by technical assistance provided by the Swiss Centre for International Health of the Swiss Tropical Institute which feeds into the policy elaboration process relevant international experiences. Results are actively shared with major partners of the Ministry of Health (World Bank, Asian Development Bank, WHO, etc.). In a second step the expert group establishes a needs assessment for initial training and re-training of physicians and nurses for all parts in Tajikistan. The expert group also realistically estimates expected enrolment rates and the curriculum changes required to modify the existing university program. Costs of these activities are estimated taking into current and potentially future national and external resources.

SDC and HRH policies

Typically SDC addresses human resource strengthening through assisting training of collaborators and through assisting training institutions such as the Ifakara Health Research and Development Centre (IHRDC), Tanzania. However, there are so far **few SDC experiences in specifically assisting the elaboration and implementation of HRH policies.**

At the same time, most (if not all) of the SDC health sector priority countries such as Tanzania, Chad, Rwanda, Tajikistan or Kyrgyzstan have no coherent approaches towards HRH. Thus, in future assistance may be provided for the establishment or strengthening of policies at country level which do address HRH in a comprehensive way. Doing so the following aspects need to be addressed (for details see above):

- Review and planning the availability and requirements of health workers
- Education and training
- Performance assessments
- Working conditions

## Lessons learnt and recommendations

Lessons learnt

The Swiss Agency for Development and Cooperation (SDC) makes important investments in the health sector in low- and middle income countries. With regard to Human Resources for Health (HRH), **SDC supported activities have permitted to learn a number of lessons.** They include:

- The success of SDC supported activities largely depends on **HRH**. They are **one of the key components for successfully planning, managing and providing health services**. The appropriate person at the appropriate place will determine if a service can be delivered effectively and efficiently.
- Coherent and well formulated HRH policies are an important element for addressing HRH related issues. Unfortunately there are few experiences on comprehensive HRH policies;
- **HRH capacity building is typically addressed through training courses**. Usually these courses are not integral part of a more comprehensive national training policy.
- There is a **large potential for performance improvements of HRH**. For example team building, supervision and interaction, the physical working environment, salary level and monetary incentives, or career plans might be addressed systematically within health sector development projects.

Lessons learnt with regard to the Millennium Development Goals

In the context of **national and international efforts to scale up health systems in order to achieve the Millennium Development Goals, the following general conclusions** can be drawn:

- Human resource availability is a key determinant of the pace of scaling up of priority interventions in the health sector;
- The scaling up of training capacities (investments in new medical schools and retraining) needs to precede the scaling up of health services;
- Those countries which have not sufficient human resource available for providing all priority interventions will have to prioritise interventions based on the quantity and quality of human resources required for service provision.

One recommendation

While conceiving and implementing new health sector development projects and programmes, **it is recommended that SDC considers:**

- Essential elements of successful improvement of HRH problems may consist in **providing assistance to the elaboration and implementation of HRH policies and strategies** that fit into health sector reforms and the political and macroeconomic context of a given country. Such policies need to be comprehensive in nature, and review the availability and requirements of health workers, education and training, performance assessment and working conditions. HRH policies should also consider the affordability of plans, institutional capacities for

implementation, the political feasibility, the social acceptability.

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