

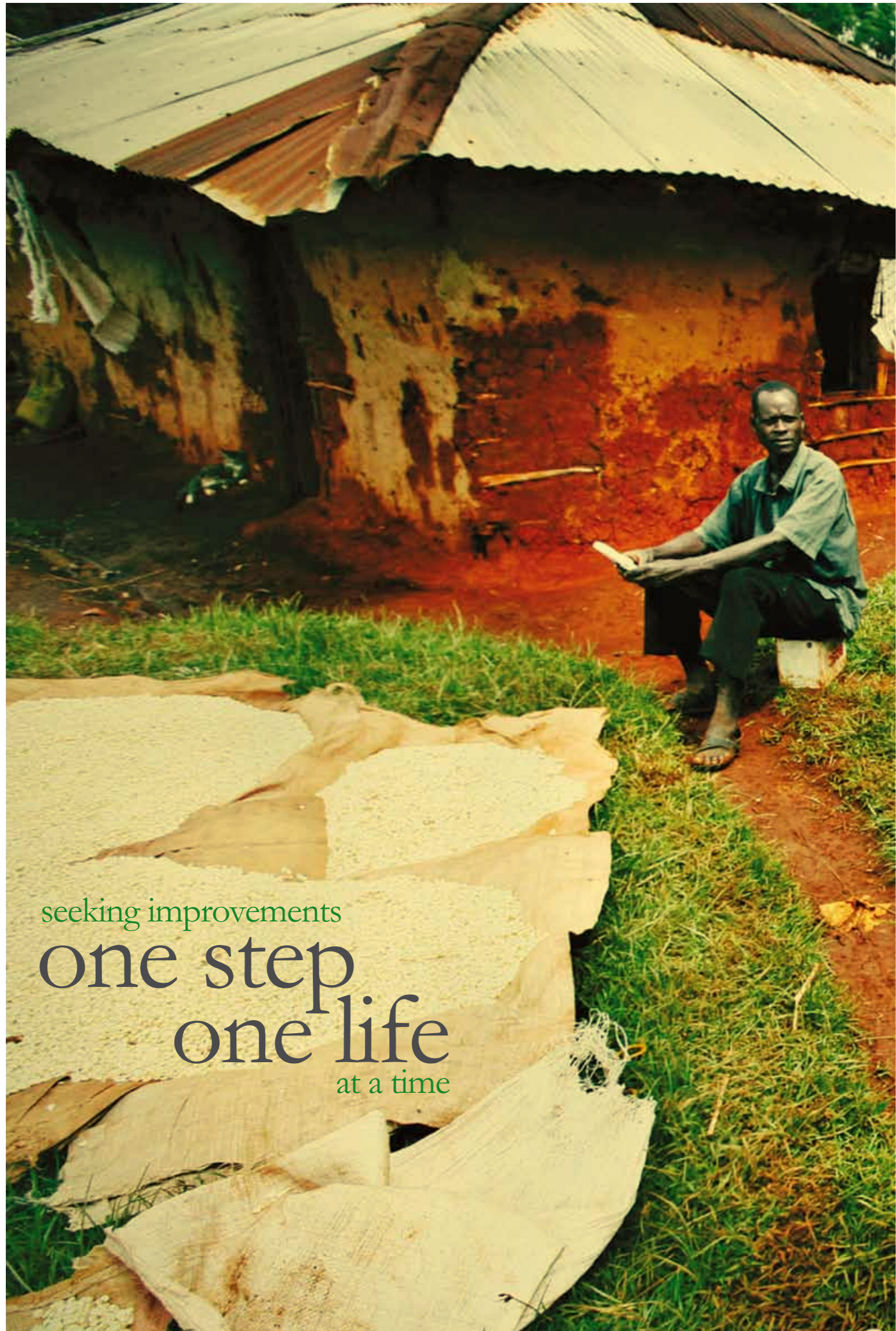
Catalyst for Change



The Global Health Workforce Alliance
2009 Annual Report



global health
workforce
alliance



seeking improvements
one step
one life
at a time



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Catalyst for Change

The Global Health Workforce Alliance

2009 Annual Report

2009: The year in review

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MESSAGE FROM THE CHAIR AND THE EXECUTIVE DIRECTOR

At the close of 2009, the Global Health Workforce Alliance stands as an established name among those engaged with the human resources for health crisis. It has lived up to its mandate as a global convener for mobilizing worldwide attention to the crisis, convening a vast array of stakeholders and sectors to bring collective wisdom to forging solutions, and generating political will and action to nurture positive change.

It is no mean achievement that it has received recognition by the G8 in two successive years, has built collaborations with major global health initiatives and offers several concrete, evidence-based and cutting-edge tools and processes to countries, members and global partners. Indeed, the Alliance is now poised to show its added value where it is most needed – in countries, in the vulnerable reaches and in the health care of the populations it was set up to serve.

The Alliance is pleased to present its report for 2009 which is structured around the six strategic directions laid out for 2009–2011 in the document *Moving forward from Kampala*. It aims to feed back its experiences, achievements and lessons learnt to its stakeholders, as well as pose questions for the future. It seeks to spark discussion, stimulate thinking and invite enhanced collaboration towards collectively achieving a breakthrough.

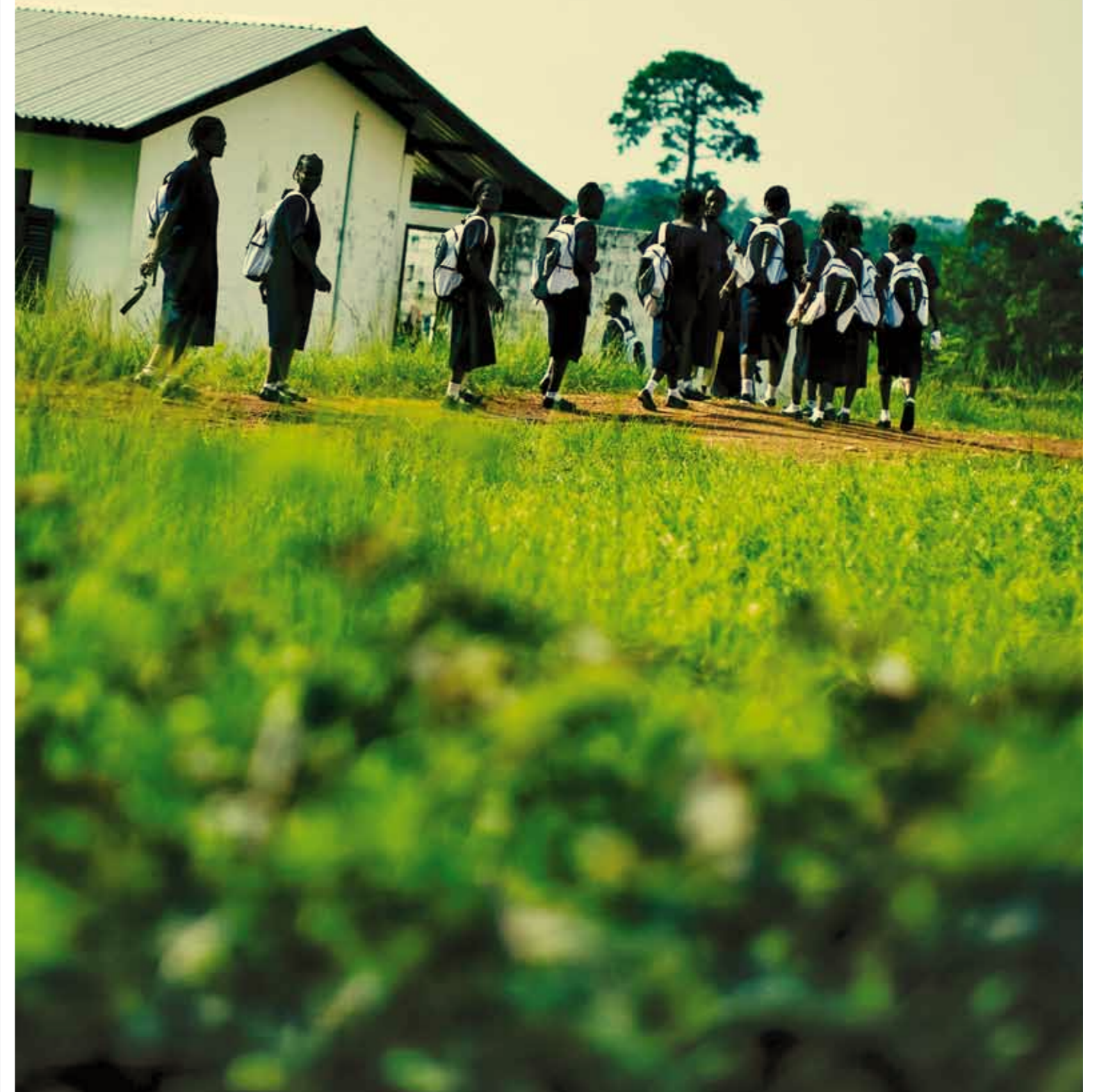
The first of what will be three yearly reports, the 2009 Annual Report reveals that although much needs to be done, the Alliance is on target with respect to meeting its goals and follow up from the First Global Forum on Human Resources for Health in Kampala in 2007. As it moves into 2010 with a significant focus on the Second Global Forum on Human Resources for Health, Bangkok, January 2011, it looks forward to serving as a nucleus for a growing movement of committed advocates determined to see positive change.

The Alliance Board and the Secretariat would like to take this opportunity to acknowledge and thank all of its partners, members, champions, collaborators and diverse supporters, and its host, the World Health Organization, for their sustained support and engagement throughout 2009. We recognize and reiterate their invaluable contribution to the collective achievements of the Alliance and look forward to continued collaborations throughout the coming years.

Sigrun Møgedal (Chair)
Ambassador, Ministry of Foreign Affairs
Norway

Mubashar Sheikh
Executive Director
Global Health Workforce Alliance

“The Alliance as
a nucleus for a
growing movement
of committed
advocates...”



PREFACE

It takes a village to raise a child. But it takes far more to train, deploy and retain a single health worker. One decade into the 21st century, the world continues to face a health workforce crisis of unprecedented proportions. Even as climate change, economic upheaval, conflict, population growth, rapid urbanization, natural disasters and the destruction of habitat propel populations into a new era of putative and emerging threats, the numbers of health workers required to fill this need can only grow.

Today, the inability of countries to train, retain and distribute health workers poses a serious threat to individuals, communities and the attainment of all health-related Millennium Development Goals. Health workers represent the very foundation of a functioning health system. It is they who provide essential life-saving interventions such as childhood immunizations, safe motherhood services and access to treatment for HIV/AIDS, tuberculosis and malaria, among many others. It is they who succour the sick, ease the pain of the dying and help prevent and treat chronic and communicable diseases.

But training, deploying and retaining a skilled health workforce is no easy task. It is a long-term commitment that requires the public sector engagement of ministries of health, labour, finance and education working together with governments, donors, civil society, training institutions, health professional associations and the private sector to train even one worker – let alone the millions required.

This means it will take a comprehensive effort to deploy and maintain workers where they are needed most. At the same time, all stakeholders need to understand that health workers have the right to a safe work environment, decent remuneration

and the ability to choose where he or she will practise and under what conditions, while at the same time paying heed to the impact of unequal distribution and large-scale migration on health outcomes.

Launched in 2006, the Global Health Workforce Alliance is an innovative partnership made up of national governments, donors, nongovernmental organizations, multilateral and bilateral organizations, research institutions and the private sector. Its aim is to advocate solutions to the health workforce crisis, broker knowledge and convene stakeholders, thereby bringing about a healthier world for all through access to skilled, motivated and supported health workers.

This annual report demonstrates that since its launch the Alliance has made a significant contribution in addressing the global human resources for health crisis, despite challenges along the way. Through its actions, the Alliance has established itself as a truly collaborative partnership of dedicated professionals – one that is advocating, and facilitating, solutions to one of health care's most intractable challenges.

Global Health Workforce Alliance Champions

Lord Nigel Crisp, former Chief Executive of the National Health Service, United Kingdom

Dr Marc Danzon, former Regional Director of the WHO Regional Office for Europe

Professor Keizo Takemi, former State Secretary for Foreign Affairs, Japan

Professor Sheila Tlou, former Health Minister, Botswana



INTRODUCTION

Mrs Mani Kanza rides a rickety bicycle to her place of work from home 18 kilometres away in the town of Mbandaka. 730 kilometres north-east of Kinshasa, Mbandaka is a town with no electricity or piped water, almost no buses or taxis and no ambulances. Malaria, tuberculosis, leprosy, acute respiratory infections, sexually transmitted infections and HIV/AIDS are endemic, and epidemic prone diseases such as measles and meningitis are widespread. Mrs Kanza is a nurse and theatre technician at the Mbandaka General Reference Hospital.

"The lack of facilities does not deter us. We use charcoal to fuel the sterilizing unit and make the most of what we have for the benefit of our patients," says Mama Susan, as she is better known. Mrs Kanza became a deputy chief theatre technician in 1984. After observing doctors for several years, she performed an operation for the first time in 1995 and has since conducted over 50 surgeries, including a caesarean section under the light of a hurricane lamp.

Mama Susan earns US\$ 16 a month, but does not charge her neighbours, who she knows cannot afford to pay for her services. "Mrs Kanza accepts fruits and vegetables as payment. Without her, pregnancy-related complications and childbirth-related deaths would have consumed my family," says neighbour Papa Malwengo. "She has saved my family and the lives of many others."

Colleagues, patients and neighbours agree that Mrs Kanza's enthusiasm is inspiring. "She is a positive force, and wears a permanent smile." After four decades of service, Mama Susan wishes she could do what she is doing better. "We need electricity, clean water and modern surgical instruments," she says.

Source: WHO Heroes for Health (www.who.int/features/2006/heroes/en/index.html)

Papa Malwengo's words of gratitude will resonate with many people throughout the developing world who have experienced the vital care of accessible health workers. But not everywhere are people lucky to have a Mama Susan to call upon.

Today, the World Health Organization (WHO) estimates that millions of people living in less developed countries lose their lives every year for want of quality health care services. Although the reasons are complex, experts agree that a severe shortage of health workers, coupled with poor distribution and unequal access, is making an already acute situation even worse.

Inadequate remuneration and incentives, stress, overwork and unsafe working conditions are just a few of the reasons why so many developing country health workers migrate to more highly paid jobs in urban areas or to wealthier nations.

At the same time, in wealthier countries, an inability to train health workers fast enough to meet growing national demands is likewise forcing them to go further afield in search of new recruits. The end result? Fewer skilled health workers willing to serve an ever-growing pool of those most in need.

Although the worst shortages are in 57 countries¹ – primarily located in Africa and Asia – the situation is by far the most dire in sub-Saharan Africa. With only 11% of the world's population, Africa carries 24% of the global disease burden. It is also home to only 3% of the world's health workers. In some cases, that translates to only one health worker for every 600 000 patients.

WHO estimates that almost 2.3 million health service providers and nearly 2 million support workers – a total of nearly 4.3 million – are needed to bridge the gap.

Global Health Workforce Alliance

In 2006, donors, partners and key stakeholders launched the Global Health Workforce Alliance (the Alliance) as a global focal point that could catalyse action and focus the attention of all actors to comprehensively deal with the human resources for health (HRH) crisis. Because developing and deploying human resources requires so many actors and takes time – in some cases as much as three to five years – the global HRH community required a single partnership that brought all stakeholders together in order to resolve the crisis. The Alliance has fulfilled this role through three core functions, often known as the ABC of the Alliance:

- **advocating** the availability of an adequate health workforce, both in resource-poor and rich countries;
- **brokering** access to necessary expertise, up-to-date data and knowledge to ensure that policies speak to particular community needs;
- **convening** all parties to chart the necessary course on specific challenges, through technical working groups, task forces, consultations and forums.

¹ See *Working together for health: the World Health Report 2006*, page 6, Figure 3 (www.who.int/whr/2006/06_overview_en.pdf).

The aim is to ensure maximum efficiency, sustainability and clear policy direction, based on the best information available.

Thus the Alliance is the “glue” that binds multiple HRH actors together. It reinforces relationships between all stakeholders by working through the coordinated actions of its members to ensure that those nations most in need achieve universal access to the prevention, treatment and care of all major health problems and attainment of the health-related Millennium Development Goals.

Kampala Declaration and Agenda for Global Action

In March 2008, 1500 delegates attended the First Global Forum on Human Resources for Health in Kampala, the capital city of Uganda. At the Forum, delegates unanimously endorsed the Kampala Declaration and Agenda for Global Action. Both identify what all relevant stakeholders need to do in order to expand, retain and support human resources for health. The Agenda for Global Action recommends six interlinked strategies:

- building coherent national and global leadership for health workforce solutions;
- ensuring capacity for an informed response based on evidence and joint learning;
- scaling up health worker education and training;
- retaining an effective, responsive and equitably distributed workforce;
- managing the pressures of the international health workforce market and its impact on migration;
- securing additional and more productive investment in the health workforce.

Moving forward from Kampala

At the Kampala Forum, delegates tasked the Global Health Workforce Alliance to monitor implementation and to reconvene in 2011 to review and report on progress. As

a follow-up, the Alliance produced *Moving forward from Kampala*, a document that outlined its strategic priorities from 2009 to 2011. It focused on two main objectives:

- to enable country leadership in national planning and management to improve the HRH situation and respond to shortages of skilled and motivated health workers;
- to address global policy challenges through evidence-informed actions to tackle transnational problems relating to the health workforce in areas such as insufficient and inefficient use of resources, fiscal restraints on health sector spending, migration, priority research and cooperation among stakeholders.

In order to ensure that these objectives are met, it is critical that countries work closely with all relevant stakeholders – be they within the public and private sectors, labour unions, academic institutions, civil society and financiers – from the very beginning of the planning process. Although the Alliance cannot guarantee the outcome it can work towards ensuring that the process is as inclusive and comprehensive as possible and that stakeholders respond to real needs on the ground.

In *Moving forward from Kampala*, the Alliance goes several steps beyond the Kampala outcomes by establishing a set of priority actions:

- facilitating country actions
- continuing advocacy
- brokering knowledge
- promoting synergy between partners
- monitoring the effectiveness of interventions
- programme management and coordination.

Each is accompanied by a set of expected results and indicators against which to measure progress. Real change on the ground will depend on the degree to which these six inter-linking strategies interact. This document seeks to showcase the Alliance’s key achievements and lessons learnt in 2009 through the expected outcomes of each strategic priority. These will be outlined in the introduction to each chapter.



2009: The year in review

FACILITATING COUNTRY ACTIONS

Facilitating country actions means building the capacity of priority countries to assess, formulate, manage and implement the appropriate policies and interventions necessary to address the HRH crisis in their own communities. It also means assisting them to ensure that a sustainable, motivated and skilled cohort of health workers is available in each country to meet health care needs, and working with partners to ensure that funding and technical expertise is available to launch much-needed programmes.



In *Moving forward from Kampala*, the Alliance identified two expected results for this strategic priority:

- Crisis countries are addressing the HRH crisis with the required capacity and mechanisms;
- Adequate mechanisms are functional at regional level for supporting the countries on HRH.

The Alliance accordingly, in 2009, supported countries and key relevant stakeholders to work more closely together with respect to all aspects of HRH, from planning and financing through to implementation. The critical actions taken in this context are described below.

Country Coordination and Facilitation

The Alliance worked with its members and partners to develop what represents one of the most critical outputs of the partnership to date: the Country Coordination and Facilitation (CCF) process.

Based on hundreds of hours of consultations with stakeholders, CCF provides all national stakeholders, regional bodies, partners and members with a comprehensive process from which to work. It offers an opportunity to work together in a coordinated, collaborative and synergistic manner. It does so by combining a set of principles and good practices that help countries strengthen coordination processes. It embraces all activities related to HRH, from undertaking a situation analysis to developing costed HRH plans and accessing financing. In other words, it provides countries with the expertise and mechanisms to build their HRH systems from the ground up. It enhances the ability of a country to elicit commitment from its stakeholders, which in turn will determine the leadership role that local actors take on to produce results within the national health system. This alliance building under national stewardship will counter fragmentation and build synergy, a vital ingredient towards ensuring effective change in countries.

CCF was introduced through a series of regional meetings in Ghana (26–29 October 2009), Burkina Faso (9–13 November

2009) and Viet Nam (21–22 November 2009). These gathered hundreds of participants from more than 30 African countries and seven Asian countries, and numerous other stakeholders from around the world. National participants included representatives from the public sector (ministries of health, labour, education and finance, and public service commissions), the private sector, civil society, health professional associations, and multilateral and bilateral organizations. Additional meetings are planned for the Region of the Americas (in El Salvador) and the Eastern Mediterranean Region (in Pakistan) in 2010.

The CCF process holds great promise. Seventeen countries are at various stages of developing their own costed HRH plans utilizing CCF mechanisms. Work is under way to link with regional bodies such as the West African Health Organization (WAHO), the East, Central and Southern African Health Community (ECSA), and the African Platform on Human Resources for Health, who hold promise in further promoting and disseminating CCF among its members.

Costed HRH plans

One of the reasons behind the HRH crisis is that countries often do not possess the necessary information to properly plan and manage HRH. In most countries existing information systems are inadequately managed and poorly linked, which lead to ineffective decisions. This, coupled with a lack of critical baseline data, has diminished the ability of countries to develop comprehensive, costed plans for HRH.

The Alliance launched a new tool to assist countries to better identify the financing required to reverse the global health workforce crisis under the rubric of CCF at the annual ministerial review of the United Nations Economic and Social Council (ECOSOC) in July 2009. The Resource Requirements Tool (RRT) is a hands-on, Excel-based tool that assists countries to estimate and project the resources needed for their HRH plans, analyse affordability, simulate “what if” scenarios, facilitate monitoring of scaling up and contribute to the development

Box 1 Catalytic funding

In 2009 the Alliance extended catalytic funding for HRH activities to a number of countries after piloting in eight countries (Angola, Benin, Cameroon, Ethiopia, Haiti, Sudan, Viet Nam, Zambia). These funds enabled them to undertake a situation analysis to examine HRH needs, plan development and undertake training activities. Some examples are:

- **Djibouti:** to establish its first medical college;
- **Pakistan:** to develop a national HRH plan to develop the health leadership skills of medical students and graduates;
- **Somalia:** to strengthen capacity and to develop a national HRH plan, and sustain health professional and nursing educational institutions;
- **Sudan (Southern):** to undertake a rapid assessment in all of Southern Sudan’s 10 states and to assist in the maintenance of health professional educational institutions, strengthen existing nursing, midwifery and allied health worker institutions and sustain community health workers;
- **Zambia:** to develop a national strategy on community health workers

of HRH information systems. It addresses ministries of health, education and finance as well as parliaments and donors. Developed by the Financing Task Force of the Alliance, this tool is already being utilized in Ethiopia, Liberia, Mozambique, the Philippines and Uganda. A number of other countries have shown keen interest.

In other country work, the Alliance supported proposals from 18 African States to develop comprehensive, costed HRH plans while strengthening their HRH information systems and establishing HRH observatories (Box 1). WHO supported HRH observatories are cooperative mechanisms through which information and evidence is shared to inform policy making. By the end of 2009, 14 had tabled progress reports and all aimed to finalize their HRH plans by 2010.

HRH profiling of crisis countries

In 2009, the Alliance worked in partnership with ministries of health, WHO headquarters, and WHO regional and country offices to support the development of a series of HRH country profiles with the aim of accelerating the availability of synthesized and accurate information. The aim was to provide a forum in which stakeholders could work together more closely, build relationships, collect data and advocate for HRH issues. The profiles are designed to:

- provide an overall view of the HRH situation and general information available in a given country for a given period;
- provide general HRH information on stock, production, utilization, work environment and governance;
- summarize information available on the HRH situation analysis, plan and monitoring system.

In 2009, 33 countries in Africa began developing their HRH country profiles. Eight countries finalized their HRH country

profiles, 11 were in the process of finalizing, five had initial drafts, and nine countries were at various stages of planning and drafting (Table 1). The target is to complete HRH profiles in most of the crisis countries by the end of 2010.

The HRH country profiles have already proven to be extremely useful in identifying information available in countries and highlighting actions that need to be taken to improve them. The profiles are showing their potential to influence policy processes and be a powerful tool for the CCF process. In collaboration with WHO and other Alliance partners, the Alliance Secretariat has also initiated the consolidation and synthesis of all country profiles. This will contribute to monitoring progress in relation to the Kampala Declaration and Agenda for Global Action.

Community health workers: global systematic review

Community health workers represent a largely untapped potential solution to help alleviate the global HRH crisis. Community health workers, if trained properly, can take on some of the more routine duties – for example immunization and maternal health service delivery – currently undertaken by professionals such as doctors, nurses and midwives. This in turn enables the latter to focus on more complex and acute cases while, at the same time, ensuring that the population is well served by a skilled workforce that is based in the community and who are less likely to migrate for more lucrative offers elsewhere. Although in many countries they provide up to 50% of all primary health care services, the contributions of community health workers still remain largely ignored.

In 2009, the Alliance, with support from the United States Agency for International Development, conducted a global systematic review and eight in-depth country case studies

Table 1 African HRH country profile status

Completed (8)	Being edited (11)	Initial draft (5)	Being drafted (6)	Planned (3)
Cameroon	Angola	Burkina Faso	Democratic Republic of the Congo	Burundi
Congo	Benin	Côte d’Ivoire	Kenya	Madagascar
Gambia	Cape Verde	Sierra Leone	Liberia	Rwanda
Malawi	Central African Republic	Togo	Niger	
Mauritania	Chad	United Republic of Tanzania	Senegal	
Nigeria	Ethiopia		Zimbabwe	
Sudan	Ghana			
Uganda	Guinea-Bissau			
	Mali			
	Mozambique			
	Sao Tome and Principe			

Source: HRH country profile report, as presented to the Alliance ninth Board meeting, February 2010

in sub-Saharan Africa (Ethiopia, Mozambique, Uganda), South-East Asia (Bangladesh, Pakistan, Thailand) and Latin America (Brazil, Haiti). The aim was to identify and share best practices that could be adapted to crisis and priority country contexts to assist attainment of the Millennium Development Goals.

The overarching goal was to share evidence with policy-makers and to inform them of how to expand the cadre of community health workers in resource-strapped settings. The study focused on maternal and child health, HIV/AIDS,

tuberculosis and malaria, and also covered mental health and noncommunicable diseases.

The community health worker case studies and global systematic review have yielded a wealth of knowledge. The Alliance is now disseminating the findings to country-level policy-makers, health care delivery organizations and those in charge of developing HRH programmes. It is also planning a series of consultations designed to catalyse discussion about the potential critical role of community health workers and how they can be deployed to help alleviate the HRH crisis (Boxes 2 and 8).

Box 2 Best practice: Pakistan

With a population of more than 160 million and a per capita national gross domestic product of only US\$ 1085, Pakistan has faced serious problems retaining skilled health care practitioners. Although more public and private sector colleges are training doctors and other health care workers, demand far exceeds supply. Particularly hard hit are the rural areas. This is because most skilled workers tend to either cluster in the cities where conditions are better or migrate to wealthier countries where they can earn more.

Enter the “lady health worker”. In an attempt to staunch the outflow of skilled personnel, in 1994, the Government of Pakistan came up with an ingenious solution: the Ministry of Health decided to train up a cadre of female health workers tasked with providing essential primary health care services (health promotion, disease prevention, curative and rehabilitative services and family planning) to the communities where they live. The rationale was that, because these women were not formally accredited as doctors or nurses, they would be far less likely to migrate and would opt instead to stay in their communities. Working in tandem with local health authorities and clinics, each lady health worker is responsible for 1000 individuals living within her area. The target is to deploy 150 000 lady health workers by the end of 2011.

So far, the Lady Health Worker Programme has been a resounding success, contributing towards marked improvement in health outcomes in the areas these workers serve. The total cost per year? Only US\$ 745 per lady health worker. That translates to less than 75 cents for every individual that the lady health worker is responsible for. This experience from Pakistan was one of the 10 country cases that the Alliance studied in detail to distil recommendations for scaling up the health workforce.

Complementing this effort, in 2009, the Alliance, along with three medical colleges in Pakistan, initiated a leadership and management skills development project for medical graduates to enhance the managerial, social and public health competencies that would complement their clinical skills. Medical graduates made excellent clinicians but were felt to be inadequately prepared to deal with field situations or have a broader public health perspective. This initiative met a strongly felt need.



2009: The year in review

CONTINUING ADVOCACY

When it comes to HRH the importance of advocacy cannot be overstated. Action on HRH requires the collaboration, and time commitment, of so many stakeholders – including government agencies and educational and occupational institutions – that it is imperative that it be sustained over the long haul. Without advocacy interest wanes, funding dries up and with it, the resources necessary to address the crisis. The stakes are huge and it is imperative to impress upon all stakeholders the need to sustain and expand advocacy efforts.



In 2009, the Alliance continued to make advocacy and communications a high priority. It worked with donors and countries to raise global and national awareness of how the health workforce crisis was affecting poverty alleviation efforts around the world.

In *Moving forward from Kampala*, the Alliance identified the following expected result under this strategic priority for 2009:

- Governments, international organizations, civil society, the private sector and other stakeholders are mobilized to expand and implement national and international political programmes and funding commitments – translating commitments into concrete actions.

Draft code of practice on the international recruitment of health personnel

The migration of skilled health personnel from poorer countries with a high disease burden to wealthier nations is one, but very significant, reason behind why developing countries are facing such a severe HRH crisis. However, wealthier nations also face their own challenges, which is why they continue to recruit developing country workers with offers of higher salaries, more attractive benefits and vastly superior working conditions.

Because the issues are complex and transnational in nature, the Alliance, Realizing Rights and WHO have established the Health Worker Migration Policy Initiative bringing together the Health Worker Migration Global Policy Advisory Council², and the WHO led Migration Technical Working Group.

In 2009 the Advisory Council continued supporting the efforts of WHO in drafting and securing approval of the voluntary draft code of practice on the international recruitment of health personnel. The code is global in scope, applies to all health personnel and lays out a set of principles and voluntary standards in order to promote an equitable balance

Box 3 Health Workforce Advocacy Initiative

Keeping HRH on global agendas requires sustained and evidence-based advocacy. The Alliance supported the launch of the Health Workforce Advocacy Initiative (HWAI) in 2007 to drive civil society-led initiatives in HRH advocacy. HWAI has led research, policy analysis and evidence-based advocacy focused on opportunities offered by the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States President's Emergency Plan for AIDS Relief (PEPFAR), the International Health Partnership and related initiatives (IHP+) and the G8, among others. In 2009, apart from its significant influence on the G8 process, HWAI contributed to the civil society response to the High-Level Task Force on Innovative International Financing for Health Systems and developed a training module *Effective advocacy strategies to reach HRH goals*, which was presented at the CCF consultation in Burkina Faso, November 2009. It also produced *Incorporating the right to health into health workforce planning*, a practical reference on how human rights should contribute to an effective health workforce. Throughout 2009, HWAI engaged with global initiatives through various activities including developing a statement of principles for the proposed Joint Platform on Health Systems Strengthening and a survey of Global Fund country experiences regarding health systems strengthening and HRH.

of interests among the health workforces of source and destination countries. It also covers the need for effective HRH planning, collection of national and international data, research and information sharing.

In January 2009, WHO presented the first draft of the code of practice to the WHO Executive Board. This was followed by further consultations in August and October of 2009. At the time of writing, comments and suggested amendments were being collected from WHO Member States, to be consolidated and made available for participants at the sixty-third World Health Assembly in May 2010.

To strengthen these efforts further, on 1 June 2009 the Advisory Council met to discuss the role of the United States of America in ethically managing the steadily accelerating flow of skilled workers to wealthier countries. Participants of this meeting drafted a memorandum to President Obama outlining recommendations for a United States policy response to the challenges posed by health worker migration, linking United States domestic health reform with global health outcomes.

G8 Leaders Declaration

Of particular importance in 2009 was the acknowledgement of the health workforce issue, and the active role played by the Global Health Workforce Alliance, in the G8 Leaders Declaration: *Responsible leadership for a sustainable future*³, delivered at the G8 Summit in L'Aquila, Italy, July 2009. At that summit, the G8 Leaders also endorsed the Health Experts Group report *Promoting global health*, which highlighted the necessity of addressing the scarcity of health workers in developing countries and acknowledged the role of health systems strengthening in ensuring

² See http://www.realizingrights.org/index.php?option=com_content&task=view&id=16&Itemid=49#hwmgpac.

³ See http://www.g8italia2009.it/static/G8_Allegato/G8_Declaration_08_07_09_final.0.pdf (para 121).

universal access to health services and in attaining the Millennium Development Goals.

In the run-up to the G8 Summit, the Alliance participated in a round-table discussion on a new matrix for global health at the Global Health Forum, Rome, 12–13 February 2009, organized by the Aspen Institute, United States, and the Health Policy Institute, Japan. The round table discussed crucial issues regarding the “health challenges”, including the fight against major pandemics, current priorities and the strengthening of health systems. A closing session with representatives from the G8 discussed the innovative financing mechanisms.

The Alliance-supported Health Workforce Advocacy Initiative, a civil society-led coalition specializing in policy analysis and evidence-based advocacy for health worker shortages, developed recommendations on HRH for the 2009 G8 Summit and shared them with the meeting of the Health Experts Group (Box 3).

Alliance advocates and champions

In 2009, the Alliance expanded the number of spokespersons to include new categories of representatives who could speak out on behalf of health workforce issues. It secured Princess Haya Bint Al Hussein of Dubai as Special Advocate (Box 4).

The Alliance also selected four other champions. These high-profile individuals are already well known in the health and development community and will be able to influence the political agenda at the policy level. The Alliance's new advocates are:

Professor Sheila Tlou, former Health Minister, Botswana. As a distinguished advocate on HRH issues, Professor Tlou

is widely recognized as a visionary leader and champion, particularly through her initiatives on HIV/AIDS, gender and women's health. Recipient of several international awards including the 2003 Florence Nightingale Medal by the International Committee of the Red Cross and the 2008 Presidential Award for Outstanding Contribution to Global Health by the Academy of Nursing, Professor Tlou has made an outstanding contribution to the nursing profession in her country and abroad.

Lord Nigel Crisp, former Chief Executive of the National Health Service, United Kingdom. A prominent public health leader and advocate, Lord Crisp co-chaired the Alliance Task Force on Education and Training during 2007–2008 and co-authored the report *Training the health workforce: scaling up, saving lives*. He followed this up by co-founding the Zambia UK Health Workforce Alliance to implement the recommendations of the Task Force.

Professor Keizo Takemi, former State Secretary for Foreign Affairs of Japan. An internationally renowned advocate on global health and development issues, Professor Takemi led, in 2008, a high-level working group dedicated to advocating collective action on global health, particularly on health system strengthening, within the G8 Summit, hosted by Japan. Both the pre-Summit proposal and the follow-up report succeeded in ensuring strong commitment by the G8 to recognize and address the global health workforce crisis.

Dr Marc Danzon, former Regional Director of the WHO Regional Office for Europe. Dr Danzon is a medical doctor and an eminent advocate of public health issues, specializing in health administration and economics. During his term at the WHO, he led such major health initiatives as the First European Conference on Tobacco Policy (Madrid, November 1998) and the WHO Ministerial Conference on Health Systems, Health and Wealth (Tallinn, Estonia, June 2008).

Box 4 Special Advocate Princess Haya Bint Al Hussein

In 2009, Her Royal Highness Princess Haya Bint Al Hussein agreed to work with the Alliance, in the capacity of Special Advocate, to raise awareness of the global health workforce crisis and to help partners work towards a solution. Although she sits on the boards of many cultural and artistic foundations, it is her humanitarian work for which she is most renowned.

Maternal health, child health and midwifery are particular passions for Her Royal Highness, and she has completed a number of field visits to public and private regional health care institutions to acquire greater awareness of and show her support for the issue. She is also President of the United Arab Emirates Nursing and Midwifery Council. Her other work on health focuses on child health and nutrition, training and education of national health specialists, awareness raising and health education, and support for the health and rehabilitation of children with special needs.

In 2003 she founded Tkiyet Um Ali, the first food aid nongovernmental organization in the Arab world. In September 2007, former United Nations Secretary-General Ban Ki-moon appointed her as a United Nations Messenger of Peace and then selected her to become a founding member of the Geneva-based Global Humanitarian Forum, an international organization aimed at addressing humanitarian problems. From 2005 to 2007, Princess Haya represented the United Nations as a Goodwill Ambassador for the World Food Programme.

Meeting on advocacy and communications priorities for 2010–2011

In 2009, the Alliance, in collaboration with the Health Workforce Advocacy Initiative, convened an informal consultation on advocacy and communications priorities for 2010–2011. The meeting was attended by 30 HRH advocates and communicators from Alliance member civil society groups, health care professional associations, the media and international organizations.

The objectives were to:

- share updates on the issue and actions taken by the Alliance Secretariat and by the Alliance partners and members;
- determine common communications and advocacy objectives for Alliance partners and members for 2010–2011;
- brainstorm on target audiences and on messaging and positioning with regard to the health workforce crisis;
- share a calendar of events and explore collaboration on priority joint activities, events, campaigns and products.

The meeting represented a good example of how the Alliance's convener role can lead to enhanced communication and sharing between stakeholders. At the close, delegates had agreed upon common advocacy objectives, messages and an updated media calendar of events and activities for 2010–2011.

Alliance website

In 2009, the Alliance reorganized and recalibrated its website, making it easier to navigate, and initiated work on a new multilingual website and an enhanced knowledge centre. The website has a fresh focus on engaging partners and members by offering more dynamic, accessible and informative data and material. The aim is to make the site more user friendly, introduce partners and members, and highlight what each contributes to the global HRH response.

Over the last three years the Alliance website use has increased dramatically. From an average of 8000 visitor sessions in 2007, it rose to 11 000 in 2008, and to a steady average of 15 000 in the second half of 2009, with a peak in October 2009 of over 20 000 sessions.

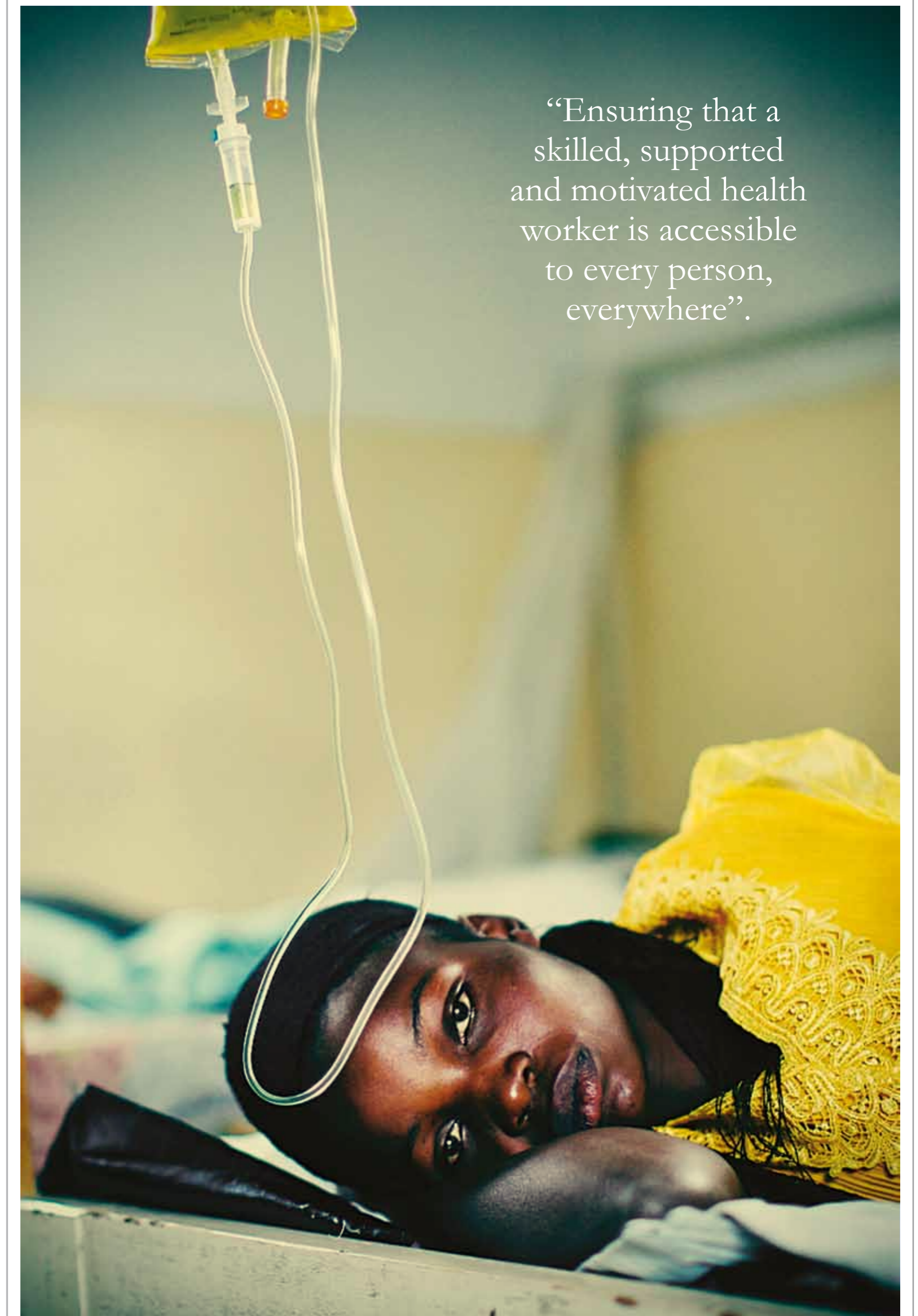
Box 5 *Doctors and Nurses*

In 2009 Rockhopper TV produced *Doctors and Nurses*, a 22-minute documentary that was aired as part of the BBC's 2010 Kill or cure series, which explored the global health workforce crisis, challenges and potential solutions.

The film portrays a real-life journey of Dr Brian Kubwalo, a Malawian doctor working in Manchester, United Kingdom, who embarks on a personal quest to find out whether he should go back to his native country, where his skills are sorely missed, or stay in Manchester, where he can provide a better future for his children.

In the film, Dr Mubashar Sheikh, the Alliance Executive Director, calls upon donors to invest more in the global health workforce in a bid to retain staff and better manage the migration of vitally needed personnel. "It is critical that the countries that are facing shortages of health workers invest more and produce more health workers to create an environment where the health workers can stay," says Dr Sheikh.

BBC World News first broadcast *Doctors and Nurses* on 19–22 January 2010, with additional broadcasts. The film can also be viewed on the Alliance YouTube channel. DVD copies for advocacy and educational purposes can be ordered at ghwa@who.int.



“Ensuring that a skilled, supported and motivated health worker is accessible to every person, everywhere”.

BROKERING KNOWLEDGE

Generating and sharing knowledge is a key strategy of the Alliance to facilitate strengthening of HRH. Policies need a sound evidence base. The Alliance assists stakeholders to generate knowledge, disseminate it and put it into practice. Brokering knowledge requires sharing evidence and examples of good practice in order to contribute to a skilled and motivated workforce. Decision-makers need to be linked to researchers to better influence each other's work, forge stronger partnerships and promote evidence-based decision-making.

Knowledge exchange represents the very core of the Alliance's work with partners, donors and recipient countries. In 2009, in keeping with the expected result as outlined in *Moving forward from Kampala*, the Alliance worked with its partners to:

- Generate, gather and disseminate knowledge targeting a wide variety of constituents with the aim of strengthening and improving HRH.

Task forces and technical working groups

Responding to the need to address global HRH policy issues that have not been systematically explored and in keeping with its strategic objectives, the Alliance established mission-oriented, time-bound task forces and technical working groups. Towards this end, it convened experts from eminent organizations across the world to bring to bear collective thinking on evidence-based solutions to specific aspects of the global HRH crisis (see Annex 5 for an overview of task forces and technical working groups). In 2009, many of the Alliance-supported task forces and technical working groups delivered significant outputs.

Task Force on Financing Human Resources for Health

Financing human resources for health represents a critical challenge to resourced and underresourced countries alike. In poorer countries, human resources on average represent more than 60% of health care budgets. Because poorer countries are already so stretched owing to competing demands on scarce resources, it is imperative to address the economic factors that influence financing of health workforce plans so that populations may access trained and motivated health workers.

The Task Force on Financing Human Resources for Health was set up to address precisely this issue and contribute to the effectiveness of HRH financing policies in countries. The task force is co-chaired by David de Ferranti, former World Bank Vice President for Latin America, and K.Y. Amaoko, former Executive Secretary of the United Nations Economic Commission for Africa. In 2009 the task force produced the Resource Requirements Tool (RRT), a decision-making tool for country planners that enables them to estimate and project the costs of scaling up HRH. It allows countries to analyse a plan's affordability, facilitate monitoring of the scaling-up process and contribute to the costing component of HRH information systems. The task force has also produced:

- a framework paper, *Financing and economic aspects of health workforce scale-up and improvement*, which synthesizes the literature and experiences on HRH financing;
- an action paper, *What countries can do now: twenty-nine actions to scale up and improve the health workforce*, which provides recommendations to policy-makers on immediate steps that can be taken on HRH financing independent of any long-term interventions;

- three lessons learnt reports, on findings from field applications of the RRT in Ethiopia, Liberia and the Philippines.

Task Force on Migration - the Health Worker Migration Policy Initiative

To address the worsening problem of migration of health workers from developing to developed countries and even within countries from rural to urban areas, the Health Worker Migration Policy Initiative was set up in 2007 bringing together two groups: the Health Worker Global Policy Advisory Council, under the leadership of Mary Robinson of Realizing Rights and Dr Francis Omaswa, former Executive Director of the Alliance, and a Migration Technical Working Group under the leadership of WHO. The Initiative made a significant impact on influencing policy to maximize the development benefits while minimizing the negative impacts of international migration of health workers. Towards the broader objective of supporting the draft code of practice to be discussed at the sixty-third World Health Assembly in 2010, the Advisory Council partnered with the Commonwealth Secretariat to host a meeting to reflect on successes and failures of the Commonwealth code of practice on health worker migration.

The Advisory Council also convened on 1 June 2009 in Washington, DC, to specifically address United States domestic policies related to health worker employment, given its status as the largest global employer of health workers. The Advisory Council presented research on the reliance of the United States on foreign health workers, as well as its research on bilateral arrangements associated with this issue. The Advisory Council has compiled 10 such agreements analysing procedural and substantive elements of codes of practice, memoranda of understanding and regional agreements related to HRH migration.

Task Force on the Private Sector

The private health sector, comprising nongovernmental actors in the health sector, represents an untapped opportunity to increase the supply of new workers, improve efficiency and reduce attrition. The Task Force on the Private Sector was established in 2008 to identify additional and innovative sources of health workers from the non-State sector. Based at the Duke Global Health Institute, Duke University, United States, its aim is to contribute towards the acceleration of scaling up and cross-border implementation of innovative private sector initiatives, so as to increase health worker supply and retention.

In 2009, the task force undertook an assessment in three countries, Kenya, Mali and Zambia, for the development of a health workforce incubator – a pilot model that offers technical capability, access to business expertise, and private and public

financing. It also helps identify and develop partnerships with local affiliates, technical partners and potential investors. Under this initiative, the Alliance supported the expansion of a distance learning initiative, which accelerates the certification of nurses in Kenya for deployment into other sub-Saharan countries.

Technical Working Group on HRH Implications of scaling up towards Universal Access to HIV/AIDS Prevention, Treatment, Care and Support

Recognizing that health worker shortages are a major obstacle to universal access to HIV/AIDS-related services, this technical working group was launched in Kampala in March 2008. Chaired by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and Centers for Disease Control and Prevention (CDC)-Ethiopia, it aims to review new and innovative strategies for scaling up and to synthesize existing evidence and concrete experiences in order to identify approaches needed to respond to the HRH requirements for expanding HIV/AIDS-related services in a country. In 2009, members initiated five country-based studies in Côte d'Ivoire, Ethiopia, Mozambique, Thailand and Zambia. A report currently under preparation will recommend how different stakeholders can assist countries to reach universal access targets for HIV/AIDS prevention, treatment, care and support. The report will emphasize the need for greater high-level leadership with respect to HRH strengthening and more attention to HIV/AIDS prevention, care and support, in contrast to the current emphasis in most HRH plans on treatment access.

Health Workforce Information Reference Group

Reliable data and evidence are the backbone of effective policy building in countries. Despite the view that rigorous statistics are scarce, diverse sources of information can be potentially used to produce relevant information, even in low-income countries. The Health Workforce Information Reference Group (HIRG) was created to address the challenges in improving HRH information.

In response to a decision taken at its seventh Board meeting, the Alliance, in collaboration with the WHO Department of Human Resources for Health and the Health Metrics Network (HMN), convened the Health Workforce Information Reference Group (HIRG) in order to initiate discussion about how to promote a coordinated, harmonized and standardized approach to strengthening the global evidence base on HRH. The ultimate goal was to establish and bolster country health workforce monitoring systems to support policy, planning and research.

In 2009, the HIRG developed the basis for a 2010–2011 biennium action plan to develop and implement a global strategy to promote standardized approaches to monitoring health workforce development; build institutional and individual capacities for HRH data collection, analysis, presentation,

sharing, synthesis and use; and mobilize technical and financial support for countries to monitor their health workforce.

Alliance Reference Group

The creation of task forces and technical working groups strongly added value in advocating the importance of strengthening HRH systems and in bringing important stakeholders to the table. However, it had less impact on country leadership in supporting national HRH planning and management. A Reference Group, composed of academic institutions, global alliances, nongovernmental organizations, professional associations, private sector entities and country partners, was therefore proposed to consider integrated and comprehensive modes of work that would accelerate country HRH action.

On 16–17 December 2009, the Alliance organized the first meeting of the Reference Group in Geneva. It aimed to initiate discussion about how the products, tools, results and policy recommendations of the Alliance task forces and technical working groups could be transferred or adapted to the HRH needs of national health programmes of priority countries. The participants recommended that the Reference Group act as a think tank, and recommend innovative approaches with respect to knowledge brokering. The aim is to achieve the coordinated, cost-effective, efficient and sustainable use of HRH-related products and tools and methodologies at country level.

Positive Practice Environments Campaign

Underinvestment in the health sector, coupled with poor employment conditions and policies, have resulted in a deterioration of working conditions for health professionals in many countries. Occupational hazards such as stress, physical and psychological violence, insufficient remuneration coupled with unreasonable workloads, and limited career development opportunities are only a few of the reasons why workers migrate elsewhere. At the same time, patients and people have a right to have access to the best performing health care professionals, and this is possible in a workplace environment that sustains a motivated workforce.

In April 2008, the Alliance supported a group of its members – the International Council of Nurses, the International Pharmaceutical Federation, the World Dental Federation, the World Medical Association, the International Hospital Federation and the World Confederation for Physical Therapy – to initiate the global Positive Practice Environments (PPE) Campaign. This campaign aims to raise awareness, identify good practice, develop tools and conduct national and local demonstration projects to improve environments. The long-term aim is to generate political will towards establishing positive practice environments that ensure the health and safety of staff, support quality patient care, and improve individual and organizational motivation and productivity.

In 2009, the PPE Campaign undertook three country case studies focusing on Morocco, Uganda and Zambia. It finalized key campaign documents, established two national steering committees in Uganda and Zambia and opened preliminary discussions with professional organizations in Taiwan. It also convened meetings with potential international collaborating partners, disseminated hundreds of electronic and printed campaign kits and posters, and issued an electronic newsletter.

Human Resources for Health Exchange community of practice

The exchange of knowledge and experiences within the HRH community is yet another aspect of the knowledge brokering function of the Alliance. A virtual community of practice, known as the Human Resources for Health Exchange, has been created to enhance interaction and exchange among health professionals and policy-makers from all parts of the world. It aims to keep HRH issues at the centre of health policy development discussions in countries worldwide.

In keeping with its mandate, the Alliance Secretariat runs and moderates the communities of practice on a regular basis. Members and partners, other organizations and individuals interested in participating are encouraged to register and join the discussions. The 2009 community of practice discussions revealed that with each round the membership of the Human Resources for Health Exchange grew significantly and increased in diversity, indicating its potential to be a true hub of exchange between health professionals and lead to fruitful collaborations.

Two online communities of practice were conducted in 2009. The first was held between 28 April and 8 May 2009 and focused on task shifting, i.e. delegating responsibilities to less-specialized health workers from more skilled professionals, expanding access to health care for those living in impoverished settings. Those participating numbered 246 members representing 56 countries, generating 92 contributions from 21 countries. The far-ranging discussions touched on various aspects of this complex issue and concluded with a set of recommendations, notably that grass-roots participation was critical to ensuring that task shifting was undertaken within a broader set of planned interventions to increase capacity.

The second community of practice, 3–12 August 2009, focused on essential HRH elements in funding proposals, and engaged over 290 members from 61 countries in deliberating over the considerations in making HRH a key part of Global Health Initiative (GHI) funding proposals. The community of practice identified its role in providing specialist inputs that could be of practical value to stakeholders involved with global health initiative funding. The discussions raised several key issues that fed into the development of a checklist that could

inform and guide proposal development. The outcomes of the discussions were also published in the *Africa Health Journal*.

Knowledge centres

A knowledge centre is where health professionals can go to build skills. It can be either physical or virtual and offers information exchange, e-learning, theoretical development, research opportunities and capacity building. In 2009, the Alliance supported Ethiopia's Ministry of Health to bring new and innovative technologies to facilitate the expansion of HRH quickly and effectively in two rural areas in Ethiopia. The aim was to bring up-to-date health care information and learning to populations living in some of the most remote and inaccessible communities on earth. Two centres will open in Ethiopia in 2010 – one in Bishooftuu Health Centre in the Oromia region, around 75 kilometres south-east of Addis Ababa, and the other in Durame Hospital in the Southern region, approximately 400 kilometres from Addis Ababa.

The Alliance recognizes that creation of knowledge centres alone will not automatically guarantee that individuals will use them or result in increased HRH capacity or transform evidence into practice. It is therefore working with the Knowledge Management Sharing Department at WHO headquarters and the Implementing Best Practices Knowledge Gateway staff to establish mechanisms to ensure that all local health workers use the centre on a regular basis and benefit from e-learning and distance teaching.

E-Portuguese initiative

The Alliance supported the WHO-led E-Portuguese initiative in Angola, Brazil, Cape Verde, Guinea-Bissau, Mozambique, Portugal, Sao Tome and Principe and Timor Leste to promote and strengthen collaboration among Portuguese-speaking countries. It contributes to the training and capacity building of the health workforce in these countries while enabling governments to have their own technical and scientific portal with a local directory of health events, health sites and health legislation. During the year all countries developed their own national health libraries and strengthened HRH capacity by using information and communication technology (ICT) tools such as distance learning platforms and strengthened collaboration with other strategic initiatives such as the Evidence-Informed Policy Network (EVIPNet), a WHO-hosted site that encourages policy-makers to use evidence to improve health systems planning.

Publications

Brokering knowledge also means publishing articles, recommendations and reports. In 2009, the Alliance published several documents (Box 6), many of which were also made available in multiple languages.

Box 6 Publications in 2009

Task force products

- Resource Requirements Tool (RRT): Product of the Alliance Task Force on Financing Human Resources for Health (English, French and Spanish). This includes:
 - the tool
 - user guide
 - data collection guide
 - frequently asked questions (FAQs)
 - one-page description.
 - Financing and economic aspects of health workforce scale-up and improvement (Framework paper)
 - What countries can do now: twenty-nine actions to scale up and improve the health workforce (Action paper)
- Scaling up, saving lives: summary and recommendations of the report of the Task Force for Scaling Up Education and Training for Health Workers (Arabic, French, Portuguese, Russian, Spanish)
- Scaling up, saving lives: Report of the Task Force for Scaling Up Education and Training for Health Workers (Spanish and Arabic)
- Scaling up education and training of human resources for health in Ethiopia: moving towards achieving the MDGs

Africa Health Journal articles

- Developing a knowledge strategy: GHWA identifies the priorities. January 2009: GHWA, Erica Wheeler
- Managing a health workforce in the global era: South Africa's experience. March 2009: Reiko Matsuyama, International Organization for Migration
- Migration trends of Ghanaian nurses and midwives: impact of a recent policy implementation. May 2009: Veronica Darko et al.
- A mobilization strategy for community-based interventions: the ART literacy project experience. July 2009: W. Mthembu et al.
- Maximizing funding opportunities to upgrade – and retain – the health workforce in Africa. September 2009: J. Campbell et al.
- Calculating human resource need. GHWA toolkit developed for use and trialled in Liberia. November 2009: Results for Development

Case studies

- Pakistan's Lady Health Worker Programme (French)
- Ethiopia's Human Resources for Health Programme (French)
- Ghana: implementing a national human resources for health plan (French)
- Malawi's Emergency Human Resources Programme (French)

Strategic documents

- Kampala Declaration and Agenda for Global Action (Chinese, Russian and Arabic)
- Moving forward from Kampala: strategic priorities and directions of the Global Health Workforce Alliance: 2009–2011 (English and French)
- Knowledge Strategy of the Global Health Workforce Alliance: 2009–2011 (English, French and Spanish)
- Communications Strategy of the Global Health Workforce Alliance: 2009–2011 (English, French and Spanish)
- Biennial report of the Global Health Workforce Alliance: 2006–2007 (English)



2009: The year in review

PROMOTING SYNERGY BETWEEN PARTNERS

“Synergy” is the term used to describe how the combined efforts of the many are more effective than those undertaken by a single individual or group. Promoting synergy is critical to resource mobilization and the sustainable expansion of HRH at the community, country, regional and international levels.



In *Moving forward from Kampala*, the expected outcome related to this strategic action was:

- Partnerships of entities involved in human resources for health are strengthened, and their coordinated actions become more effective at national, regional and global levels.

Second Global Forum on Human Resources for Health

The First Global Forum on Human Resources for Health, held in Kampala, Uganda, generated unprecedented momentum on the issue of the health worker crisis. The Kampala Declaration, endorsed by the 1500 participants of the Forum, has since become the definitive global reference point in the action on HRH. One of the recommendations of the Kampala Declaration was to reconvene the Forum in two years to report against progress.

Key decisions on the strategic focus, leadership, structure and thematic focus of the Second Forum were made during 2009. In a bid to ensure broader ownership, it was decided that the Second Forum would be co-hosted by the Alliance, the Prince Mahidol Award Conference, WHO and the Japan International Cooperation Agency. It was also felt that the Forum should not be a stand-alone event, but intrinsically linked to and a part of a continuum of action on related issues, such as primary health care, equity and emerging global challenges, while staying rooted in the tenets of the Kampala Declaration. The Forum was envisioned to be a venue for meaningful dialogue and interaction to renew and inspire commitment among stakeholders towards forging solutions to the HRH crisis. It was to strike a balance between policy, political and technical imperatives, and encourage regional and country participation, including through scholarships and funding support. The structure of the Second Forum would contain the following elements: pre-conference activities, such as field visits; main conference activities, including HRH forum awards; post-conference follow-up; and parallel activities. The objective would be to help sustain a movement on HRH, reviewing progress made and strategizing around new and emerging challenges.

These decisions were taken through a joint planning workshop among the co-hosts in December 2009, which was preceded by a small group consultation on the thematic focus on 14 July 2009, and an extensive online discussion on the Human Resources for Health Exchange community of practice during August and September 2009.

Collaborations with global health initiatives

The Alliance engaged with the Global Health Initiatives and other international stakeholders to build synergy across different partners at country and global levels on HRH issues. Throughout 2009, it attempted to work with international entities to build consistency and streamline assistance, especially at country level, through mapping and analysing partner activities, sharing information, building connections between entities, encouraging participation in each other's activities and reinforcing and encouraging positive practices.

While the Alliance participated in a number of significant events in 2009 (see Annex 2), it developed special relationships with WHO (Box 8), the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Japan International Cooperation Agency. It collaborated actively with IHP+ and the World Bank on a number of strategic initiatives. Through its concerted advocacy efforts with other partners, including the Health Workforce Advocacy Initiative, commitments for training new health workers were announced by PEPFAR, and the Governments of Japan and the United Kingdom. The Alliance also actively supported the High-Level Task Force on Innovative International Financing for Health Systems, and sponsored the High-Level Dialogue on Maximizing Positive Synergies between Global Health Initiatives and Health Systems, Venice, Italy, 22–23 June 2009. The Global Health Workforce Alliance partnered with the Alliance for Health Policy and Systems Research in co-funding a research project examining rural retention issues in India. The Global Health Workforce Alliance is also engaged in discussions with regional entities, including the African Union, the European Commission, the Asia-Pacific Action Alliance on Human Resources for Health (AAAH), and the African Platform on Human Resources for Health in facilitating implementation of national HRH strategic plans.

Supporting key events

Building synergies between and among partners has also been achieved through participating in and organizing events on specific issues. In 2009, the Alliance extended technical contribution to 19 external events and directly supported or organized seven events (see Annex 2 for a list of significant events). Through this active participation and dialogue, the Alliance succeeded in placing HRH high on the global and national agendas.

Box 7 Partnership with WHO

The Alliance and WHO enjoy a special relationship. Not only does WHO host the Alliance, but it is also a valuable partner, collaborator and repository of considerable HRH expertise. In 2009 the Alliance worked closely with the WHO Department of Human Resources for Health at headquarters and in the regions across a number of salient activities:

WHO headquarters

- establishing the community of practice knowledge portal;
- establishing the HRH tracking survey with the Royal Tropical Institute (KIT), Netherlands;
- supporting participation at the High-Level Dialogue on Maximizing Positive Synergies between Global Health Initiatives and Health Systems, Venice, Italy, 22–23 June 2009;
- providing support to develop HRH country profiles.

WHO Regional Office for the Americas and Pan American Health Organization

- establishing the "Training Grounds for HRH Planners";
- carrying out a study on the determinants of success and failure for the recruitment and retention of HRH in the Americas;
- continuing collaboration on the draft code of practice on the international recruitment of health personnel.

WHO Regional Office for Europe

- holding a workshop on HRH migration to encourage dialogue between source and destination countries;
- building a database to strengthen information, improve quality and harmonize definitions for health professionals.

WHO Regional Office for Africa

- developing a regional and country-level human resources information system and HRH observatories;
- developing policy plans and management strategies on Millennium Development Goals 4 and 5.

WHO Regional Office for the Eastern Mediterranean

- developing HRH strategic planning, management and monitoring tools and guidelines;
- exchanging regional best practices, innovative experiences and lessons learnt.

MONITORING THE EFFECTIVENESS OF INTERVENTIONS

Monitoring the Kampala Declaration and Agenda for Action is critical to measuring progress, holding partners accountable to their commitments and ensuring that interventions are cost-effective, efficient and pragmatic.

The expected result stated in *Moving forward from Kampala* was:

- The effectiveness of policies and interventions, financial flows as well as the development of HRH in countries are monitored and evaluated.

Monitoring the Kampala Declaration

In March 2008, the Kampala Declaration and Agenda for Global Action laid out a road map through which all stakeholders could resolve the HRH crisis over the next decade. Since September 2008, the Alliance has been engaged in developing a robust mechanism to regularly monitor the implementation of the Kampala Declaration and Agenda for Global Action in crisis countries and worldwide. A set of 31 indicators were identified against which to measure progress in the 57 crisis countries. In 2009, WHO with the support of the Alliance commissioned a desk study to the Royal Tropical Institute (KIT), Netherlands, to review policies and practices related to HRH in the 57 countries in order to create a baseline. This was the first attempt at objectively measuring the implementation of the Kampala Declaration. The Alliance Secretariat conducted further analysis based on this database from the tracking survey.

The baseline threw up interesting results. Despite the partial information captured by the baseline, it showed clearly that while most countries had mechanisms in place for providing government leadership, such as an HRH plan or an HRH unit for addressing HRH issues, most did not have adequately functioning HRH information systems. While countries had received donor support, there was not much evidence of coordination mechanisms to harmonize this support. While the majority of countries had incorporated pre-service education as part of their HRH plans, and were therefore planning for scale-up of health workers, very few had policies in place for ensuring retention. Only six countries of the 57 – Afghanistan, Ghana, Malawi, Peru, Rwanda and Zimbabwe – had implemented plans for incentives, working environments and deployment and distribution of health workers.

Work will continue on gaining further information to fill in the missing elements of the indicators and produce a report on the baseline for implementation of the Kampala Declaration and Agenda for Global Action. Qualitative methods will supplement the quantitative data, and some indicators will be revisited and revised if needed.

Box 8 Best practice: Ethiopia

The Alliance set out to capture best practices to showcase how some crisis countries are addressing their own HRH shortages. The aim was to provide partners with a series of examples from which they can adapt their own programmes.

In 2009, the Alliance focused on Ethiopia, which is beset by an acute shortage of health workers at every level. Up to 85% of the population resides in rural areas, which remain largely devoid of skilled health workers. The Ministry of Health calculates that 60–80% of the country's annual mortality rate is due to preventable communicable diseases such as malaria, pneumonia and tuberculosis. HIV/AIDS is a growing problem.

In order to bridge the gap, the Health Extension Programme aims to train 30 000 new health extension workers to provide a package of essential interventions at rural health posts. The government is adopting a training-of-trainers approach. More than five years ago it began deploying 85 master trainers to instruct 700 faculty members during a series of regional workshops. These faculty members are now delivering the one-year course offered at a national network of 37 existing vocational institutes.

By 2009, the Ministry of Health had trained an additional 5000 health officers. These in turn will supervise the health extension workers and provide more specialized care for those requiring referral. Twenty hospitals are currently involved in hands-on training programmes for the health officers. Additionally, the programme is being expanded to include pre-service education and training capacity targeting doctors and nurses. Ethiopia is committed to increasing its annual medical student intake from 250 to 1000, and is training an additional 5000 health officers.

PROGRAMME MANAGEMENT AND COORDINATION

A Board made up of a broad representation of stakeholders oversees the governance of the Alliance. The Alliance Secretariat is housed within and hosted by WHO and is made up of a small core group of professionals who drive and coordinate the implementation of the Alliance strategic priorities and the Kampala Declaration and Agenda of Global Action.

The Secretariat reports directly to the Board for programmatic results and follows WHO rules with respect to administration, personnel and financial matters. WHO neither funds nor controls Alliance operations, but is a founding member and partner with a permanent seat on the Board, alongside professional associations, nongovernmental organizations, donor governments and other constituencies.

For programme management and coordination, the expected result in *Moving forward from Kampala* was:

- The Alliance continues to fulfil its obligations based on the Memorandum of Understanding with WHO.

Governance handbook

Effective governance represents a combination of policies, systems, structures, and operational strategies that an organization must deploy in order to assure appropriate decision-making and accountability. A governance handbook was developed to help orient new Board members and provide new members with governance information about the Alliance. The aim was to support leadership that focuses on vision, strategic issues and policy-making, delegating authority and empowering staff to make operational decisions. Although each partner and member agency has its own governance rules

and regulations, this particular handbook covers interactions between Alliance partners.

A consultant developed drafts of the handbook, which underwent several reviews and consultations, and received inputs from the eighth meeting of the Board. Additionally, the Standing Committee of the Board in December 2009 specified that compliance with the Memorandum of Understanding with WHO be ensured. The final draft was prepared for presentation to the ninth meeting of the Board in February 2010.

Human resources

Teamwork represents the backbone of the Alliance and continued to do so in 2009. This applies as much to the five constituent units of the Secretariat as it does to the Secretariat as a whole.

In order to maximize the performance of the Secretariat over the course of 2010, a new team approach was institutionalized in 2009. This new approach emphasizes building of technical and communication skills, including language skills, according to each staff member's development plans. In 2009, eight new staff joined the Alliance, bringing the Secretariat total to 20. Information about partners and members of the Alliance is given in Box 9.

Box 9 Partners and members of the Alliance

The Alliance derives its strength from its members and partners. While members are individuals and organizations with an interest in HRH and a general commitment to the strategy and objectives of the Alliance, and who apply voluntarily for membership, partners are those engaged in global, regional or national change in HRH and who have a defined relationship with the Alliance.

Members are expected to be active in HRH and endorse the values and principles of the Alliance, while actively supporting the attainment of the Kampala Declaration and Agenda for Global Action. They must actively initiate and participate in collaborative Alliance-related activities, including contributing funding, technical expertise, staff time and assistance with advocacy, and sharing knowledge on experiences that help accelerate action on HRH. The members are profiled on the Alliance website and are also invited to participate in various activities of the Alliance, and have access to all knowledge and information products of the Alliance.

As of December 2009, the Alliance had 229 members and partners, as follows:

- 70 academic and research institutions
- 13 foundations
- 14 national governments
- 61 nongovernmental and civil society organizations
- 20 private corporations
- 18 professional associations
- 7 United Nations agencies
- 26 other categories, such as hospitals, networks, and unions.

2009: The year in review

THINKING GLOBALLY, ACTING LOCALLY: 2010 AND BEYOND

Even as the Alliance delivers on its first year of commitments to the strategic directions outlined in *Moving forward from Kampala*, it remains well cognizant of the unfinished agenda and the increasingly complex environment within which it will continue to function.

Undoubtedly, in its four years of existence, the Alliance has made a mark. It has established human resources for health as a global issue meriting attention at the highest levels because of its potential ability to impact the attainment of internationally agreed goals, such as the Millennium Development Goals. In its unceasing effort to drive change, it has partnered with natural and non-traditional allies to synergize energies and agendas. It has entered as an equal partner in the global development arena and, with its unique niche, has offered value-added collaborations. It has ceaselessly advocated, brought to bear evidence and tools, and is now demonstrating its value at country level.

The Alliance's commitment to the Kampala Declaration and the Agenda for Global Action remains strong and preparations for the landmark Second Global Forum on Human Resources for Health are well under way. The first year of implementation of the 2009–2011 workplan presented in *Moving forward from Kampala* has been successful and the Alliance is on target to reach all objectives by the end of the workplan's three-year period.

And yet, while its goals and objectives remain the same, the global context within which the Alliance finds itself has changed dramatically since 2006. New threats to health, security and development continue to emerge. The Alliance is increasingly aware of the growing complexity of its environment created by emerging and re-emerging health issues and their demands on the health workforce. In this closely interconnected world, new threats such as pandemic influenza, the food and water

crises and the epidemiological transition in disease patterns are creating unprecedented pressure on health care providers, and the undeniable impact of climate change and often related humanitarian disasters, not to mention the financial crisis, are further straining the already fragile human resources for health. The Alliance owes it to its leadership function to think beyond 2011, and address the emerging challenges head on. In line with its role as a political advocate it will raise awareness of the impact of this complex set of intertwined issues and use its political influence to catalyse effective and urgent action. The Alliance and all its constituent partners and members, and its Board and Secretariat, are also aware of the need to influence real change in-country and where it is most needed. The Alliance understands that this needs to be done urgently as time slips past between now and the end of the MDGs, between now and lives lost because of people's inadequate access to quality health care.

The Alliance will do this with and through its constituents and together with its collaborators, and will strive to bring harmonization in the face of fragmentation. It will also mobilize its strategic resources to best utilize the political and funding opportunities that present themselves in this climate. It will ensure it works towards equity and justice.

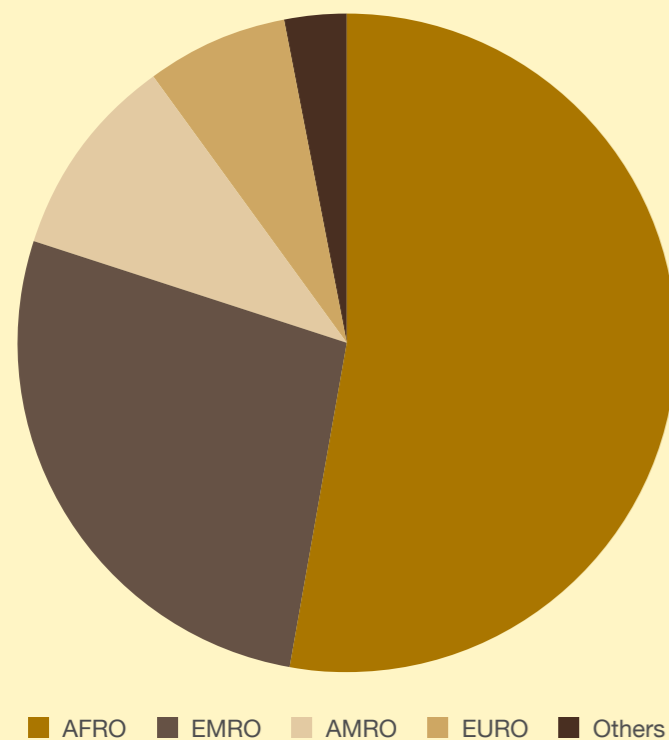
With an eye on the horizon, in close partnership with the like-minded but firmly rooted in its mandate, the Alliance will continue to strive for the best way forward for ensuring that "a skilled, supported and motivated health worker is accessible to every person, everywhere".

ANNEXES

Annex 1. Alliance financial statement for 2009

Financial overview 2009	US\$
Funds available 1 January to 31 December 2009	16 094 733
Total expenditures and encumbrances	8 188 537
Closing balance as of 31 December 2009	7 906 196*

The Alliance distributions and catalytic support to regions and countries in 2009



Alliance expenditures and encumbrances 1 January to 31 December 2009		US\$
		Expenditures and encumbrances
Communication and advocacy		443 505
Publications, communication material, translation		392 613
Advocating HRH solutions		50 892
Accelerating country actions		2 284 224
Country Collaboration and Facilitation (CCF), including Ghana and Burkina Faso		433 065
Support to countries (HRH planning, improving country databases and country profile development)		138 955
Regional and country expenditures		1 712 204
Partnerships, monitoring and evaluation		190 988
Alliance Second Global Forum		93 488
Convening partners (including multisectoral meetings)		46 340
Tracking survey (Kampala Declaration and Agenda for Global Action)		51 160
Knowledge generation, management and sharing		1 686 535
Working group on tools and guidelines		10 992
Task force on scaling up education and training		141 798
Technical working group on scaling up education and training		17 962
Working group on advocacy		26 324
Working group on universal access		652 619
Working group on financing		124 533
Working group on migration (policy)		245 000
Reference group		34 568
African Platform and stakeholders (including Steering Committee meeting in July 2009)		9 583
South-East Asia and Western Pacific Platform (Asia-Pacific Action Alliance on Human Resources for Health)		139 332
Positive practice environment		500 000
Research grants		22 590
Technical brief on primary health care		10 300
Secretariat		3 041 510
Staff salaries (year-end salaries in process)		1 858 278
Operating expenses		97 511
Office equipment		84 681
Consultancies		328 256
Board meeting		85 164
Key event attendance		587 620
Programme support costs		541 775
Total expenditure and encumbrances		8 188 537*

*Subject to WHO biennium financial closure (adjustments, if applicable)

Annex 2. Key events supported by the Alliance in 2009

Leaders in Healthcare Conference, Dubai, United Arab Emirates, 26 January 2009

As part of the Arab Health Congress 2009, the Alliance participated in the Leaders in Healthcare Conference in Dubai and presented at the session on future healthcare human resources, which considered the need for transforming the 2008 pledges into concrete action in the context of the global financial crisis.

High-Level Task Force on Innovative International Financing for Health Systems, London, United Kingdom, 13 March 2009

The Alliance, a number of its key members and the Health Workforce Advocacy Initiative participated in the follow-up meeting of the Task Force on Innovative International Financing for Health Systems. The task force's independent working group expressed concern that unless donors and developing countries met international targets for increasing support to health, the funding gap would be an estimated US\$ 30 billion a year by 2015 and the health-related Millennium Development Goals would not be met.

Humanitarian Action Summit, Boston, United States, 26–28 March 2009

The Alliance participated at this important summit, which examined how best to utilize humanitarian health workers before, during and after emergencies. Delegates established a working group in order to develop a set of skills and competencies and called upon the Alliance to coordinate and convene further action. A number of bilateral meetings were held in parallel featuring representatives from the Bill & Melinda Gates Foundation, the Rockefeller Foundation, Médecins sans Frontières, Oxfam International, Merlin, Microsoft Corporation, the University of Colombia, the University of George Washington and Harvard University.

World Health Day 2009 celebrations, Amsterdam, the Netherlands, 6–7 April 2009

At the invitation of the Wemos Foundation, the Alliance participated in the 2009 World Health Day celebrations in Amsterdam and communicated with Dutch Parliamentarians and Government about the need for strengthening the global health workforce. The Secretariat participated in two major advocacy events and a number of bilateral meetings to brief national policy-makers about the mandate and priorities of the Alliance, with particular emphasis on the Kampala Declaration and Agenda for Global Action.

Orientation and capacity-building meeting on the use of tools and guidelines to scale up health nursing and midwifery service delivery in the context of primary health care renewal, Nairobi, Kenya, 20–24 April 2009

Senior nursing and midwifery officials from 21 African countries participated in this Alliance-supported event. The aim was to expand the use of tools and guidelines necessary to scale up health, nursing and midwifery service delivery in the context of primary health care.

Twelfth World Congress on Public Health (World Federation of Public Health Associations), Istanbul, Turkey, 27 April–1 May 2009

Representatives of public health associations, ministries of health, the European Commission, the Council on Health Research for Development, the Medical Knowledge Institute and the International Federation of Pharmaceutical Manufacturers and Associations came together to share ideas, experiences and research on public health. The Alliance took the opportunity to present the Scaling up, saving lives recommendations of the Task Force on Education and Training at panels on international health worker migration issues and partnerships.

Fourth session of the African Union Conference of Ministers of Health, Addis Ababa, Ethiopia, 4–8 May, 2009

The Alliance participated as an observer at the fourth session of the African Union Conference of Ministers of Health in Addis Ababa and used the opportunity to discuss with the delegations the HRH strategies and requirements for their countries. Delegates from 34 African Union Member States attended the meeting, which focused on maternal, neonatal and child health.

HRH Action Framework (HAF): taking stock meeting, Amsterdam, the Netherlands, 5–7 May 2009

The Alliance convened this meeting with a view to strengthening partnerships among subregional stakeholders and HAF users and reviewing the progress made in implementing HAF at regional and country levels.

Human Resources for Health Results Research Symposium, Addis Ababa, Ethiopia, 11–14 May 2009

The Alliance and the World Bank co-organized this meeting, which was seen as the culmination of the Africa Human

Resources for Health Program, funded by the Bill & Melinda Gates Foundation and the Government of Norway. The Alliance organized a side meeting and presented its activities, and discussed the role of the WHO Regional Office for Africa, the African Platform and regional bodies in scaling up HRH strategies in Africa.

High-Level Dialogue on Maximizing Positive Synergies between Global Health Initiatives and Health Systems, Venice, Italy, 22–23 June 2009

The Alliance participated in the High-Level Dialogue on Maximizing Positive Synergies between Global Health Initiatives and Health Systems and took this unique opportunity to address the health workforce crisis. The draft concluding statement include a call to “recognize the urgent need to develop and strengthen the health workforce through increased education and training as well as strategies to sustain and retain all categories of health workers”.

Human Resources for Maternal Survival: Task-Shifting to Non-Physician Clinicians, Addis Ababa, 29 June–2 July 2009

The Alliance was involved in the ministerial conference attended by health ministers, deputy health ministers and permanent secretaries of 30 African countries. Alliance staff also participated in a panel discussion on enhancing maternal and newborn survival.

United Nations Economic and Social Council, Geneva, Switzerland, 6–9 July 2009

The Alliance hosted a special session at the Economic and Social Council Innovation Fair to launch the Resource Requirements Tool (RRT) developed by the Alliance Task Force on Financing Human Resources for Health. The launch raised interesting and innovative discussions among the country and mission representatives and the global health initiatives that attended.

Meeting with countries and partners on good practices for Country Coordination and Facilitation (CCF), Accra, Ghana, 26–29 October, 2009

The meeting, first in a series of consensus-building meetings organized by the Alliance, presented Human resources for health: good practices for Country Coordination and Facilitation to key stakeholders. The meeting brought together a wide variety of stakeholders from Anglophone African countries working on HRH issues.

Consensus-Building Workshop on Country Coordination and Facilitation (CCF) and the Planning of Human Resources for Health, Ouagadougou, Burkina Faso, 9–13 November, 2009

The second consultation on CCF was organized for francophone African countries in Burkina Faso. Participants of the meeting recognized the urgent need to synergize efforts on HRH issues as a critical approach to address the shortages of health personnel in their countries.

Consensus-Building Workshop on Country Coordination and Facilitation (CCF) and the Planning of Human Resources for Health, Hanoi, Viet Nam, 22 November, 2009

The third Alliance consensus-building meeting brought together key stakeholders in the South-East Asia and Western Pacific Regions. Asian countries expressed their recommendations that more players need to be involved in the implementation of HRH activities, with stronger coordination and facilitation by the ministry of health.

Alliance Reference Group Meeting, Geneva, Switzerland, December 2009

Organized by the Alliance, the meeting initiated discussion on how results and policy recommendations of the Alliance task forces and technical working groups could be adapted to the needs of national health programmes in the HRH priority countries.

Annex 3. Alliance Board of Directors in 2009

Eric Buch
Health Policy and Management
University of Pretoria, South Africa

Kathy Cahill
Bill & Melinda Gates Foundation
Seattle, USA

Lincoln Chen
Harvard Kennedy School of Government
USA

Mark Dybul
U.S. Global AIDS Coordinator
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Senior Technical Adviser Human Capacity Development,
Office of HIV/AIDS
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Francisco Eduardo de Campos
Secretário da Gestão do Trabalho e da Educação na Saúde
Ministério da Saúde
Brasília, Brasil

Carissa Etienne
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Director, Human Resources for Health
World Health Organization, Geneva Switzerland

Eric Friedman
Physicians for Human Rights
Washington, DC, USA

Basile Kollo
Director, Human Resources and Vice-Chair of Inter Agency
Coordination Committee for Immunization, Ministry of Health
Yaoundé, Cameroon

Sigrun Møgedal (Chair)
Ambassador, Ministry of Foreign Affairs
Norway

Bjarne Garden (Alternative)
Department of Human Development and Service Delivery,
Health Unit, NORAD
Norway

Marie Odile Waty
Agence française de développement
Paris, France

Judith A. Oulton
International Council of Nurses
Geneva
Switzerland

Christine Reissmann
ACDI-CIDA
Québec, Canada

Julian Schweitzer
Director, Health, Nutrition and Population
World Bank, Washington, DC, USA

Mubashar Sheikh (Ex-officio)
Executive Director, Global Health Workforce Alliance
World Health Organization, Geneva, Switzerland

Miriam Were
AMREF headquarters
Nairobi, Kenya

Suwit Wibulpolprasert
Senior Adviser on Disease Control
Ministry of Public Health, Bangkok, Thailand

Junhua Zhang (Alternative)
Assistant Director-General
WHO Collaborating Centre for Human Resources for Health
Ministry of Health, China

Annex 4. Overview of task forces, technical working groups and reference groups

Task forces & technical working groups	Established / duration	Issues addressed	Secretariat	Membership
1. Task Force on Financing Human Resources for Health	January 2008, concluded mid-2009	Economic factors influencing health workers	Results for Development	Abt Ass. Inc., USA, Zambia; Action Aid; Action Group for Health, Human Rights and HIV/AIDS, Uganda; Africa Public Health Rights Alliance and the "15% Now!" Campaign; African Centre for Economic Transformation, Ghana; African Centre for Global Health and Social Transformation; African Council for Sustainable Health Development; African Medical and Research Foundation, Kenya; African Union Commissioner for Social Affairs; AfricaRecruit/FindaJobinAfrica.com; Afro-European Medical and Research Network; Aga Khan Development Network, Mali; Aga Khan University, Nairobi; AMREF; Anglo American plc.; Aspen Institute; Becton Dickinson and Co.; Canadian Society for International Health; Capacity Project; CDC, Ethiopia; Centres for Disease Control and Prevention; China Medical Board; CIDA; Commonwealth Secretariat; Cordaid; Department of Health, South Africa; Department of Health, UK; Dept of Epidemiology and Public Health, Ireland; Development Bank of the Philippines; DHRH Project, Uganda; Earth Institute, Columbia University; East, Central and Southern African Health Community; EQUINET; Ethiopian Public Health Association; World Dental Federation; Federal Office of Public Health, Switzerland; Fuqua School of Business, Duke University; Ghana Health Service; Global AIDS Alliance; Global Health Workforce Alliance; Global Healthcare Information Network; Health Alliance International; Health Care Without Harm; Health GAP, USA; Health Metrics Network; Health Ministry, Uganda; Health, Education, Labor and Pensions Committee; HIFA 2015; IMT, Portugal; Innovations in Global Health and Poverty; International AIDS Society; International Commission on Occupational Health; International Council of Nurses; International Hospital Federation; International Labour Organization; International Management and Health Consultants, Nigeria; International Monetary Fund; International Organization for Migration; International Pharmaceutical Federation; Intra-Health International; Kenya Health Service; KfW Entwicklungsbank; LATH, UK; London School of Hygiene & Tropical Medicine, Thailand; Master Trainers Consultants, Zambia; Médecins Sans Frontières, Malawi (MSF-Malawi); Medical Emergency Relief International; Merck & Co; Merlin, UK; Ministry of Finance, Colombia; Ministry of Foreign Affairs, Norway; Ministry of Health, Indonesia; Ministry of Health, Brazil; Ministry of Health, Malawi; Ministry of Health, Nigeria; Ministry of Health, Oman; Ministry of Health, Republic of Ghana; Ministry of Health, Republic of Mali; Ministry of Health, Sudan; Ministry of Health, United Republic of Tanzania; Ministry of Medical Services, Kenya; Ministry of the Environment and International Development, Norway; MSH, USA; Norwegian Agency for Development Cooperation; Office of the Global AIDS Coordinator, US Department of State; Pan American Health Organization/World Health Organization; Partners in Health; Physicians for Human Rights, USA; Public Health Foundation of India; Public Health Institute; Public Services International; RAND Corporation.; Realizing Rights; Results for Development Institute, Washington, DC; SurGlobal; Swedish International Development Cooperation Agency; Bill and Melinda Gates Foundation; Duke Global Health Institute; Rockefeller Foundation; World Bank; World Bank, Africa Region; Touch Foundation; United Nations Economic Commission for Africa; UNAIDS; UNICEF; United States Senate; Universidade Federal de Minas Gerais, Brazil; University of Botswana; University of Iowa; University of Limpopo, South Africa; University of Ottawa; University of the West Indies; University of the Western Cape, South Africa; US Department of State; USAID; Voluntary Services Overseas, United Kingdom; WEMOS; WHO; WHO Regional Office for Africa; WHO Regional Office for Europe; WHO Regional Office for the Western Pacific; World Federation for Physical Therapy; World Federation of Occupational Therapists; World Medical Association; Yale University.
2. Task Force on Migration: Health Worker Migration Policy Initiative	May 2007 to December 2009	Health worker migration	Realizing Rights	
3. Task Force on the Private Sector	May 2009 to 2011	Increased health worker supply, effectiveness or retention	Duke University	
4. Technical Working Group on HRH Implications of scaling up towards Universal Access to HIV/AIDS Prevention, Treatment, Care and Support	September 2009 to January 2011	Scaling up national responses to HIV/AIDS	Capacity Project	
5. Health Workforce Information Reference Group	December 2009, ongoing	Implement results of task forces and technical working groups at country level		
6. Alliance Reference Group	December 2009, ongoing	Improve availability, quality and use of data on human resources in health systems		
7. Task Force for Scaling up Education and Training for Health Workers	2007	Champion increased investment in education and training of health workers	Department for Health	
8. Tools and Guidelines Working Group	2005–2007	Collate, review and update existing tools for planning and implementation of HRH policies	WHO	
9. Positive Practice Environments (PPE) Campaign	May 2009 to May 2014	Improved working conditions and environments within health systems	International Council of Nurses	
10. Health Workforce Advocacy Initiative (HWA)	2007, ongoing	Evidence-based advocacy	Physicians for Human Rights	



“The Alliance will
continue to strive for
the best way forward”

**The Alliance is grateful to the following
donors for their support**

Bill & Melinda Gates Foundation
Canadian International Development Agency (CIDA)
Commission of the European Communities
French Development Agency/Agence Française de Développement (AFD)
Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), GmbH
Irish Aid, Department of Foreign Affairs, Ireland
Norwegian Agency for Development Cooperation (NORAD)
UK Department for International Development (DFID)
United States Agency for International Development (USAID)

Launched in 2006, the Global Health Workforce Alliance is a partnership dedicated to identifying and coordinating solutions to the health workforce crisis. It brings together a variety of actors, including national governments, civil society, finance institutions, workers, international agencies, academic institutions and professional associations. The Alliance is hosted by the World Health Organization.

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