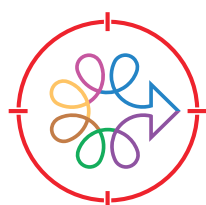


HUMAN RESOURCES FOR HEALTH: foundation for Universal Health Coverage and the post-2015 development agenda

Report of the Third Global Forum on Human Resources for Health

10-13 November 2013 | Recife, Brazil



Third Global Forum on
Human Resources for Health
10 - 13 November 2013
Recife, Brazil



**World Health
Organization**



global health
workforce
alliance

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WHO Library Cataloguing-in-Publication Data

Human resources for health: foundation for universal health coverage and the post-2015 development agenda: report of the Third Global Forum on Human Resources for Health, 10-13 November 2013, Recife, Brazil.

1.Health Personnel. 2.Universal Coverage. 3.Health Manpower. 4.Delivery of Health Care. I.World Health Organization. II.Global Health Workforce Alliance

ISBN 978 92 4 150739 4 (NLM classification: W 76)

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Acknowledgments

This report was prepared by the Global Health Workforce Alliance (GHWA), with support from the World Health Organization (WHO), to summarize the proceedings of the Third Global Forum on Human Resources for Health.

The Forum was convened under the patronage of the Government of Brazil, Pan American Health Organization (PAHO), WHO and GHWA from 10 – 13 November 2013 under the theme Human Resources for Health: foundation for Universal Health Coverage and the post-2015 development agenda.

GHWA and WHO extend their most sincere gratitude to everyone who played a part in making the event a success. We thank the Government of Brazil for welcoming the Forum to Recife, providing political, logistic and high-level participation in the event. We also acknowledge the contribution of Alliance members and partners including those in the development community, international organizations, professional associations, civil society, academia, the private sector who provided in-kind support towards the Forum. We thank the Editor and staff of the WHO Bulletin for publishing a special supplement on HRH, dedicated to the Forum which generated much interest. WHO Member States are acknowledged for their support in the development and finalization of the Forum outcome document. The 3rd Global Forum was organised under the overall leadership and guidance of Dr Rüdiger Krech, Director, Office of the Assistant Director-General, Health Systems and Innovation, World Health Organization. Dr Giorgio Cometto, Advisor to the Executive Director of GHWA was responsible for the coordination of the technical background papers, the commitment framework and served as a resource person in the development of the Recife Political Declaration. Ms Rania Kavar, Technical Officer, Health Workforce at WHO was responsible for the overall coordination of the programme, Dr Amani Siyam, Statistician, Health Workforce, WHO, was responsible for the coordination of the over 35 side events, Ms Sonali Reddy, Communications Officer, GHWA, was responsible for the communication and press work; including the film and photo competitions, Professor Shinjiro Nozaki, External Relations Officer, GHWA, was responsible for the HRH Awards, Ms Romana Rauf, Programme Manager, GHWA, was responsible for the project and resource management of the event, Dr Mohammad Afzal, Technical Officer, GHWA, and Dr Laurence Codjia, Technical Officer, GHWA, were responsible for the overall coordination of eliciting country commitments, Ms Lucy Mshana, WHO, Ms Concepta Ongaro, GHWA, Ms Judie Diah GHWA, and Ms Christine Pastor, WHO, were responsible for the diplomatic protocol and the invitations. We acknowledge and thank the local organizing team in Brazil for their dedicated onsite planning and logistics support.

GHWA and WHO are grateful to the following funding partners – Agence Française de Développement, France; Government of Brazil; Department for International Development, United Kingdom; Deutsche Gesellschaft für Internationale Zusammenarbeit, Germany; Irish Aid, Ireland; Japan; Norwegian Agency for Development Cooperation, Norway; United Nations Population Fund (UNFPA); and the United States Agency for International Development.

GHWA and WHO are grateful to the following members of the Forum Organizing Committee and Forum Working Group for providing guidance, comments and feedback in the development of the forum programme and aspects of the Forum planning.

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Foreword

The Third Global Forum on Human Resources for Health provided an opportunity for an inclusive dialogue with many stakeholders involved in efforts to develop human resources both in countries and globally. The Forum shed light on what universal health coverage really means in relation to human resources for health. Universal health coverage is not a distant and utopian dream; it is a feasible journey, it is wanted and many countries are progressing towards this goal.

We live at a time of socioeconomic, demographic and epidemiological transitions that are transforming the landscape in which we operate and the challenges to be overcome. Accelerating progress towards universal health coverage requires embracing new thinking and a paradigm shift.

Moving beyond an exclusive focus on the numbers of health workers, equal importance should be given to the accessibility, acceptability and quality of the services they provide. Just as important is adopting dynamic planning and forecasting models, based on high-quality data and including labour market analyses, to match workforce supply with demand. The way health professionals are trained needs to change radically, transcending the narrow transfer of clinical competencies and towards models of education that empower health workers as change agents in society. Health services should be organized and delivered to be comprehensive, integrated and people-centred to increase access to health care in rural and remote areas. A greater focus is required on putting incentives in place and ensuring good working conditions that can enhance health workforce productivity, quality and responsiveness. Bringing about lasting change in human resources for health requires the collaboration of sectors and constituencies. The Forum adopted this participatory model and proved the critical importance of having an inclusive dialogue with all stakeholders involved in efforts to develop human resources both globally and within countries.

The highlights of the Third Global Forum were the political statements presented in the Recife Political Declaration on Human Resources for Health as well as more than 80 commitments made by WHO Member States and member organizations of the Global Health Workforce Alliance; we can think of no better measure of the success of the conference in bolstering political commitment for the health workforce agenda.

As leaders in the global health community, we recognize that health workers are the vanguard of universal health coverage, and we will aim higher – and deliver – on our efforts and commitments to ensure that health workforce challenges are addressed. The Third Global Forum on Human Resources for Health was instrumental in showing us the way: let us walk this path together now!

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Executive summary

This report describes the proceedings and main outcomes of the Third Global Forum on Human Resources for Health, which was jointly convened by the Government of Brazil, WHO, the Pan American Health Organization (PAHO) and the Global Health Workforce Alliance in Recife, Brazil, from 10 to 13 November 2013. The event, organized around the theme of Human Resources for Health: Foundation for Universal Health Coverage and the Post-2015 Development Agenda, provided an opportunity to bolster political commitment and to update the human resources for health agenda, to make it more relevant to the current global health policy discourse, including the push towards the health Millennium Development Goals, the universal health coverage objective and the post-2015 agenda. In addition, countries and human resources for health stakeholders were invited to make explicit commitments related to human resources for health to accelerate efforts on their national health development agendas as the basis for an inclusive mutual accountability framework.

With 1800 participants and attendees from 93 Member States, including more than 40 ministers and/or deputy ministers, the Third Global Forum was the largest ever human resources for health event. The conference had a dual nature: a technical event to share new evidence, best practices and lessons learned among experts and planners in human resources for health; and a political one to galvanize the support of policy-makers.

High-level plenaries, technical sessions and satellite meetings with exhibition areas, poster presentations, photo exhibits, awards for excellence and other activities informed and inspired participants to advance the health workforce agenda and provided opportunities for professional development and networking. The following sections of this report summarize the key issues, innovative ideas and solutions emerging in the main areas of human resources for health development around which the programme of the conference was organized:

- health workers and health goals: progress in action for human resources for health in the last decade;
- matching health workforce production to the population's needs and expectations;
- social needs and the regulatory role of the state;
- deployment, retention and management;
- empowerment and incentives; and
- looking towards 2030.

The Third Global Forum showed that the global community must significantly and ambitiously raise the bar in its efforts: aiming much higher in terms of the political will, good governance and financial and other resources committed to address challenges related to human resources for health. A holistic agenda on human resources for health instrumental to attaining universal health coverage will require interconnected efforts at the national and global levels in support of four main areas of action:

- anticipate and adapt to new challenges;
- articulate ambitious targets with a long time horizon (10–15 years), including

producing larger number of health workers and establishing benchmarks for the performance of higher education and employment;

- broaden participation in policy development and response beyond the public health sector by engaging other key constituencies and sectors and create accountability mechanisms to support and oversee implementation; and
- innovate through more efficient and rational planning and use of financial and human resources in the health sector and towards more results-focused implementation.

There is a need to consolidate the lessons from the past years on what works and focus on putting in place and to implement detailed, long-term national strategies that include social compacts with health workers as well as with other sectors; achieving adequate funding will crucially depend on ensuring that investment in human resources for health represents good value for money and that it results in better health outcomes.

The event thus represented an opportunity to take stock of the current situation in developing human resources for health in countries and globally, highlighting that all countries face the challenge of how to attain, sustain or accelerate progress towards universal health coverage: gaps in human resources for health affect virtually all countries – albeit with different connotations and varying level of severity. Further, demographic trends, the growing burden of chronic diseases and long-term care needs and macroeconomic and fiscal constraints triggered by financial restraints imposed in response to a difficult economic climate will make challenges in human resources for health in all resource settings even more acute, rendering it a shared global priority.

At the same time, the Third Global Forum also represented an opportunity to celebrate many advances made in the past decade: for instance, among the countries affected by severe shortages of skilled health professionals, the situation has improved in most of those for which data are available. The needs for human resources for health that stem from the agenda for universal health coverage require renewed attention, strategic intelligence and action. A systemic approach is required to devise and implement sound costed plans for human resources for health as part of broader national health strategies, built based on high-quality data and evidence. This requires long-term strategic planning, realistic forecasting and political commitment, combined with adequate policy dialogue and related funding to make a whole-of-government agenda on universal health coverage a reality. It is critical to foster an inclusive environment conducive to a shared vision with other stakeholders, including the private sector, civil society, academia, labour unions, professional associations and health worker representatives, and other sectors, including education, finance, labour and civil service. The voice, rights and responsibilities of health workers must play a central role in developing and implementing solid policies and strategies towards achieving universal health coverage.

It is necessary to go beyond mere numbers by addressing gaps in distribution, competencies, quality, motivation and performance. Fundamental changes will have to be made in how health workers are educated, managed, regulated

and supported and in the role of the public sector in shaping labour market forces. New competencies will be required as part of a deeper transformation of professional education, aimed not only at equipping trainees with clinical skills but also addressing their contributions to strengthening institutional capacity and contributing to social accountability. Getting the most out of the available health workforce implies achieving optimal distribution, optimizing the use of private-sector partnerships, enhancing health workforce performance and productivity by combining adequate financial and non-financial incentives and developing well-adapted health care models supported by timely and quality data.

Only systemic action can address deep-seated challenges in human resources for health by combining related and complementary actions to strengthen the health workforce towards achieving universal health coverage; only sustained political commitment, in turn, can provide a basis for such actions. Evidence emerging from the conference points to a recurrent feature among countries that are making progress: only high-level political commitment can guarantee the alignment and coordination of various sectors and constituencies in support of a long-term agenda for human resources for health, overcoming piecemeal and short-term approaches.

The Recife Political Declaration on Human Resources for Health, adopted by representatives of Member States attending the Third Global Forum, was the ultimate outcome of the event and enshrined these principles, marking the beginning of a new era in human resources for health. The Recife Declaration recognized the centrality of human resources for health in the drive towards achieving universal health coverage. It reaffirmed the vision that all people everywhere must have access to a skilled, motivated and facilitated health worker within a robust health system; it committed governments to creating the conditions for the inclusive development of a shared vision with other stakeholders; and it reaffirmed the role of the WHO Global Code of Practice on the International Recruitment of Health Personnel as a guide for action to strengthen the health workforce and health systems. Further, it identified a range of actions, including improving planning, education, management, governance, information systems and the adoption of innovative approaches, to be implemented in accordance with countries' contexts and needs. The political statements made in the Recife Declaration, matched by the more than 80 commitments by WHO Member States and Global Health Workforce Alliance member organizations, are the best measure of the success of the Third Global Forum on Human Resources for Health in bolstering political commitment for the health workforce agenda and represent a shared platform and common starting-point for further policy dialogue and action on developing human resources for health in the years ahead.

The Third Global Forum: framing the health workforce agenda for universal health coverage

Universal health coverage is the goal that all people obtain the health services they need without risking financial hardship. This is being increasingly recognized as a framework to encapsulate various global health priorities. Building on the drive

towards people-centred care highlighted by *The world health report 2008*, new evidence, policy options and advocacy in support of universal health coverage have been the focus of *The world health report 2010*, of World Health Assembly resolution WHA64.9 and of numerous global health events and processes.

An adequate and performing health workforce is vital to improve the coverage of health services and health outcomes. In December 2012, the United Nations General Assembly adopted resolution A/RES/63/33, giving further political impetus to universal health coverage and recognizing the need for an “adequate, skilled, well-trained and motivated workforce”. However, *The world health report 2006* and several other analyses and reports since then have highlighted unacceptable variations in availability, distribution, capacity and performance of human resources for health and identified many countries below a critical threshold of health workers, deemed to be generally necessary to achieve high coverage of essential health services.

Given the need to comprehensively address health workforce challenges to attain broader health goals, the World Health Assembly has adopted several resolutions, including the WHO Global Code of Practice on the International Recruitment of Health Personnel in 2010, which is one of the most significant milestones in human resources for health.

Through concerted efforts at the national, regional and global levels, signs of progress are emerging: there are several success stories of how countries are overcoming their challenges in human resources for health, resulting in improved health outcomes. These gains are, however, vulnerable: shortages of human resources for health and inequitable access to health workers are still among the major limiting factors in many countries’ attempts to achieve their national priorities, including those related to the Millennium Development Goals, noncommunicable diseases and universal health coverage.

As leaders worldwide embrace the broader goal of universal health coverage and health systems progressively broaden their scope to cover noncommunicable diseases and other priorities, new demands will be made on existing health workers in support of more comprehensive and equitable access to quality health services. It is therefore critically important to outline a forward-looking agenda in human resources for health that is tailored to achieving this objective and with buy-in and commitment from national and global stakeholders.

The Global Health Workforce Alliance was launched in 2006 to spearhead the response to the crisis in human resources for health at the country and global levels. In support of its mandate, a key responsibility of the Alliance is to convene a Global Forum on Human Resources for Health on a regular basis. The First Global Forum on Human Resources for Health (Uganda, 2008) resulted in the development of a global roadmap for human resources for health development (the Kampala Declaration and Agenda for Global Action); at the Second Global Forum (Thailand, 2011), countries and stakeholders reconvened to review the progress made and renewed their commitments through an outcome statement that called for increased investment, sustained leadership and adoption of effective policies on human resources for health.

This report describes the proceedings and main outcomes of the Third Global Forum on Human Resources for Health, which was jointly convened by the Government of Brazil, WHO, the Pan American Health Organization (PAHO) and the Global Health Workforce Alliance in Recife, Brazil, from 10 to 13 November 2013. The event, organized around the theme of Human Resources for Health: Foundation for Universal Health Coverage and the Post-2015 Development Agenda, provided an opportunity to bolster political commitment to a health workforce agenda instrumental to achieving the objective of universal health coverage. The Third Global Forum aimed at updating the human resources for health agenda, to make it more relevant to the current global health policy discourse, including the push towards the health Millennium Development Goals, the universal health coverage objective and the post-2015 agenda. In addition, countries and human resources for health stakeholders were invited to make explicit commitments related to human resources for health to accelerate efforts on their national health development agendas as the basis for an inclusive mutual accountability framework.

With 1800 participants and attendees from 93 Member States, including more than 40 ministers and/or deputy ministers, the Third Global Forum was the largest ever human resources for health event. The conference had a dual nature: a technical event to share new evidence, best practices and lessons learned among experts and planners in human resources for health; and a political one to galvanize the support of policy-makers.

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- health workers and health goals: progress in action for human resources for health in the last decade;
- matching health workforce production to the population's needs and expectations;
- social needs and the regulatory role of the state;
- deployment, retention and management;
- empowerment and incentives; and
- looking towards 2030.

1.

Health workers and health goals: what can be learned from a decade of action on human resources for health with respect to efforts to achieve the health-related Millennium Development Goals and other important national and global health goals? Are we on the right track towards universal health coverage?



The Third Global Forum reviewed progress in human resources for health in the preceding decade and debated the future directions of efforts to develop the health workforce. Universal health coverage – defined as all people receiving high-quality health services that meet their needs without being exposed to financial hardship – is globally recognized as a fundamental priority. All countries face the challenge to attain, sustain or accelerate progress on universal health coverage, regardless of their level of economic development. Achieving universal health coverage depends critically on human resources for health, without which national health systems cannot function.

The past decade has seen an increased recognition of the central role of human resources for health for achieving national priorities and international goals, such as the Millennium Development Goals. The Joint Learning Initiative report, *The world health report 2006 – Working together for health*, the launch of the Global Health Workforce Alliance in 2006 and the first two global forums on human resources for health convened by the Alliance raised awareness and galvanized a global movement to address the health workforce crisis, particularly in relation to issues of chronic shortages, skill mix and distributional imbalances and poor working conditions. New data, tools and evidence are available that provide a robust guide to action.

A report developed as a background paper for the Forum (Box 1) reframed the discourse on human resources for health away from a predominant focus on the availability of health workers – numbers – and towards according equal importance to accessibility, acceptability, quality and performance. The report showed areas of progress as well as persisting or new challenges (including continuing shortages and maldistribution and a relative neglect of the quality and performance dimensions) and invited national governments and the global community to raise their ambitions, efforts and commitments to strengthen the response on human resources for health.

Human resources for health are central in translating the vision of universal health coverage into reality. Universal health coverage is feasible and is an unavoidable political imperative: this is the direction in which all health systems are moving. The historical, unprecedented economic growth in many countries creates the opportunity to scale up investment in health systems, education and deployment of human resources for health in ways not possible before, if the resources available are backed up by sustained political will to guarantee the alignment of sectors and constituencies and capacity is adequate to plan and implement the development of the health workforce.

Rooting the development of health systems and the health workforce in a primary health care vision has underpinned success in such countries as Cuba, which succeeded not only in meeting its domestic needs but also in training and providing its health workers to other countries facing shortages. Today one of the smartest investments in public health is investing in human capital for health workers close to communities at the frontline of service delivery. Roberto Morales Ojeda, Minister of Public Health, Cuba, says:

“Among the main factors of success in Cuba, it is important to highlight the political will of the highest authorities of the country, which considers health a citizen's right and a responsibility of the state.”

Box 1. Progress in human resources for health in the past decade

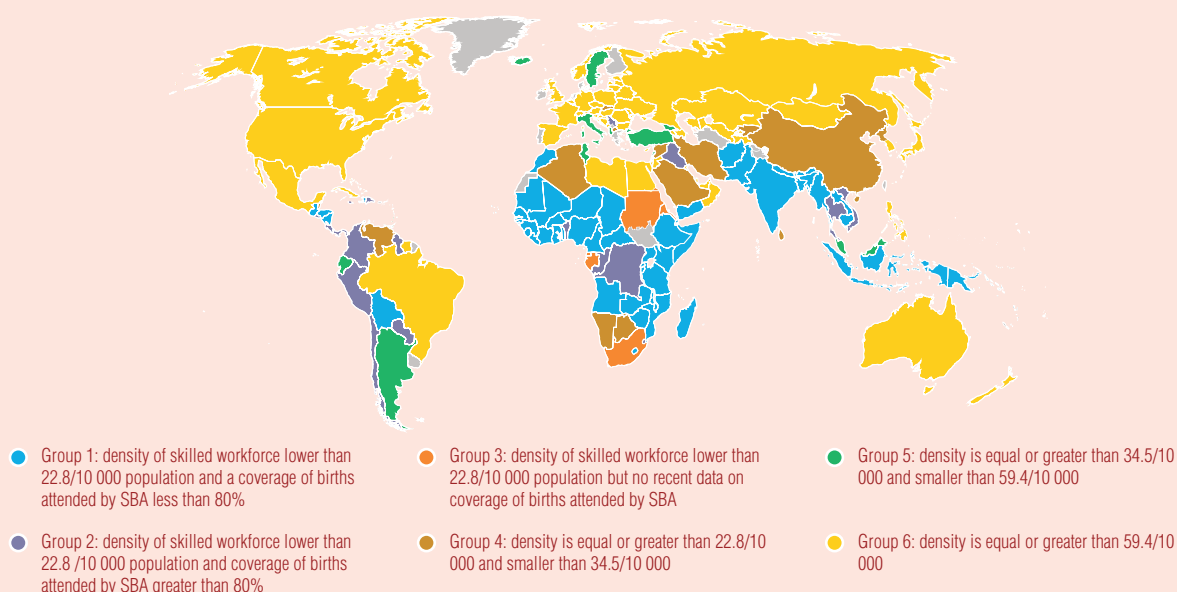
The past decade shows some evidence of progress in human resources for health development, but numerous challenges persist, including:

- shortages of some categories of health workers, with more shortages forecast: 100 countries currently fall below the threshold of 34.5 skilled health professionals per 10 000 population, and the global deficit is estimated to rise to about 12.9 million skilled health professionals (midwives, nurses and physicians) by 2035;
- an ageing health workforce and replacement challenges;
- skill-mix imbalances;
- wide variation in availability and accessibility within countries;
- the need to adapt education content and strategies;
- keeping health workers motivated in an enabling environment;
- insufficient priority afforded to performance assessment and the quality of care;
- varying capacity in estimating future needs and designing longer-term policies; and
- lack of systems for reliable and updated information and data on human resources for health.

The report presents a 10-point agenda.

1. Recognize the centrality of the health workforce in translating the universal health coverage vision into improved health care on the ground.
2. Assess the gap between the need for a health workforce, actual supply and the population's demand for health services.
3. Formulate human resources for health policy objectives that encapsulate the vision for the health system and services.
4. Build the data, evidence base and strategic intelligence required to implement and monitor the policy objectives and to sustain effective management.
5. Build and sustain the technical capacity to design, advocate for and implement policies.
6. Build political support at the highest level to ensure continuity in the pursuit of universal health coverage.
7. Reform the governance and institutional human resources for health environment.
8. Assess the cost of the various scenarios of health workforce reforms.
9. Encourage international partners to focus their support and to report on their official development assistance for building the capacity of health systems.
10. Encourage international partners to address transnational issues and strengthen global human resources for health governance, collaborative platforms and mechanisms.

Workforce to population ratios for 186 countries



Source: Campbell J, Dussault G, Buchan J, Pozo-Martin F, Guerra Arias M, Leone C et al. A universal truth: no health without a workforce. Forum report, Third Global Forum on Human Resources for Health, Recife, Brazil. Geneva: Global Health Workforce Alliance and World Health Organization, 2013.

Progressing towards universal health coverage requires improving the primary health care system to ensure that every person has access to high-quality, person-centred care, improving the health training programmes and aligning them to national objectives related to universal health coverage and guaranteeing the professional and technical advancement of health workers. According to Ariel Pablos-Mendez, Assistant Administrator for Global Health, United States Agency for International Development:

“ The transformative education agenda is changing the way we think about pre-service education and how to not only increase scale-up but to better prepare health workers to meet the needs of their communities and to be change agents. Additionally, focus is shifting to increasing the institutional capacity of pre-service institutions and to increasing involvement of these institutions in health workforce planning. ”

The various types of health workers that make up the workforce need to be better understood: going beyond traditional doctors, nurses, and midwives, much emphasis has been placed on professionalizing health workers such as social welfare workers and supply chain managers and on integrating community health workers and other frontline workers into the formal health system. Experience shows that robust engagement by civil society, the academic and faith-based communities and the rapidly emerging for-profit private sector has been instrumental in making advances in many contexts. New information and communication technology tools can accelerate progress in data collection, training and education, assessing and managing the performance of human resources for health as well as patient management and decision support for health care providers.

Supportive government stewardship to provide adequate funding and systematic oversight of all stakeholders is critical and underpins success in all these areas. Nevertheless, efforts will have to be sustained over a long time frame to bring about the desired changes: 15–20 years in settings characterized by weaker governance, relatively less in countries that have already taken steps in improving their health systems. Pape Gaye, CEO and President, Intrahealth International:

“ I would like to see the timeline accelerated in such a way that children born today do not face the health-related challenges of their parents and can contribute to and flourish in the communities in which they live. As parents, as global public health practitioners and as people, we should not accept less. ”

To achieve universal health coverage, the global health community should better coordinate its efforts, recognizing the difficulty of addressing challenges in an interconnected world, where the global health workforce is mobile and responds to economic incentives. If universal health coverage is to be achieved, national governments need to devote more resources to develop comprehensive strategies and action plans; development partners have a role to play in assisting countries with more limited resources to sustainably and systematically strengthen their health workforce, according to the principles of country ownership and alignment. More attention needs to go into implementing the WHO Global Code of Practice on the International Recruitment of Health Personnel and how that is being reinforced to systematically address migration issues as a global community. Further, a greater sense of urgency around human resources for health issues is needed to obtain the attention required by political leaders and policy-makers.

2.

Matching health workforce production to population needs and expectations: are the right quantities, qualities and skill mix available to move health systems faster towards universal health coverage?



A critical challenge is ensuring that the quantities, qualities and skill mix of the health workforce being produced match the current and future needs and expectations of the population. Health workforce production does not just happen: it requires long-term strategic planning informed by international good practices, realistic forecasting, political commitment combined with adequate policy process and related funding to make a whole-of-government agenda on universal health coverage a reality.

Planning processes for human resources for health allow governments to determine feasible policy options to match health workforce supply to future requirements to move towards universal health coverage. National experiences shared at the Forum indicate that this is as much a political process as a technical one: at its centre is an informed policy dialogue with all relevant actors. This political process is essential for successful decision-making and sustainable long-term investment in producing human resources for health: it requires top-level support to ensure long-term, sustained funding and conducive macroeconomic policies; adapting and innovating in health professional education models to fit with the health reforms; and ensuring an enabling labour market environment. A good policy dialogue needs to be informed by an understanding of the driving forces that affect the supply and demand of the health workforce both in countries and at the global level. According to Agnes Soucat, Director for Human Development, African Development Bank:

“Particularly in Africa, demand for health workers is growing while supply does not match. Most countries have not scaled up with demand, which results in a real shortage.”

In addition to national health policies, strategies and plans, financial, educational and management systems and policy comprise the context for developing human resources for health. Relevant factors to consider as part of a health labour market analysis include wages and allowances, unemployment, the number of working hours, place of work and productivity and performance issues. Government overall wage bill policies have important implications for the health workforce and represent a significant constraint to scaling up in many countries. Another recurrent challenge in matching supply and demand is the difficulty of deploying and retaining health workers in rural areas. Rural recruitment, education and placement are key factors in producing workers for rural areas.

Planning for human resources for health requires building national institutional capacity to develop and review regularly scenarios, according to evolving contextual factors. Health workforce forecasting is a prerequisite for building sustainable strategies towards achieving universal health coverage. Realism and feasibility are key for planning. All scenarios should be challenged by the current and future availability of national resources (public, private and possibly external). Planning is not a one-off exercise: rigid forecasting and planning systems to identify health workforce shortages and oversupply are not adequate to address future needs; horizon planning is needed, as it enables considering the qualitative and systemic parameters that will influence health care in the future. The availability, completeness and quality of health workforce data are crucial factors to enable planning processes. As a key contributor to planning, the coherent classification of professions remains a challenge.

Health workforce planning requires a multisectoral approach. National stakeholders and development partners from the education, finance and labour sectors have critical roles to play: experience shows that costly long-term investments have little chance of being generated in the absence of successful negotiations and a real policy dialogue among key partners. Policy dialogue does not just happen. It is a political process that requires top-level political support and will as well as adequate investment. Civil society and parliaments are powerful voices to harness in the dialogue around decisions on human resources for health. Bringing the private sector to the negotiating table, however, remains a challenge (Box 2).

Political support is key for a successful decision-making process. An area of consensus of the Third Global Forum on Human Resources for Health was that strong political investment is required to bring the human resources for health plan beyond aspirations.

As a prerequisite for implementing human resources for health strategies, ensuring long-term sustained funding for human resources for health must be considered in the context of broader macroeconomic policies and fiscal space for health. Scaling up and maintaining the health workforce to the levels required to progress towards universal health coverage may require significantly increasing resources. Any increase in health workforce spending will have significant implications on the total civil service payroll and overall fiscal framework of governments. Human resources for health strategies therefore need to be adequately developed and costed (both investment and future recurrent costs) in the context of the constraints and possibilities of macroeconomic policy. Policy-makers, in turn, need to explore the policy options to address the fiscal constraints to expanding the health wage bill. Salary top-ups and other bonuses from donor projects create substantial performance incentives but may complicate the institutional sustainability of health systems in low-income countries by creating long-term liabilities for governments. Osamu Kunii, Head of Strategy, Investment and Impact Division, Global Fund to Fight AIDS, Tuberculosis and Malaria:

“The New Funding Model of the Global Fund is more behind country plans and health system building blocks.”

Box 2. Tailoring supply to the health system and population demand in Ethiopia

Ethiopia's Health Extension Program offers a package of basic and essential health services delivered by health extension workers. The Health Extension Program was launched in 2003 and deployed 34 000 government-salaried women health extension workers. They spend about 75% of their time on outreach activities: conducting household visits, educating families to adopt healthy lifestyles, serving as model families in their neighbourhood and organizing communities to participate in expanding Health Extension Program services. A study found that the Health Extension Program improved knowledge of and practices in maternal and newborn health care at scale.¹ According to Amir Aman Hagos, State Minister, Federal Ministry of Health, Ethiopia: “In Ethiopia, at least six ministries were involved in negotiations on the Health Extension Program: Health, Education, Agriculture, Finance, Women and Children and Water. Intense negotiations were necessary to convince them that health was a basic tenet of overall development in Ethiopia and that it should be a priority now.”

¹Source: Karim AM et al. Effect of Ethiopia's health extension program on maternal and newborn health care practices in 101 rural districts: a dose-response study. PLoS ONE. 2013.

National and regional experiences presented at the Forum indicated that a paradigm shift in the health education model is needed to match health professional education and training capacity to the health system and population needs for sufficient quantities of relevant high-quality health professionals. Initiatives such as the Medical Education Partnership Initiative and the Nursing Education Partnership Initiative in Africa and the Asia Pacific Network for Health Professional Education Reform have identified pragmatic and innovative approaches to developing and using new and existing faculty, infrastructure and partnerships to enable a well-balanced, significant increase in education, training and research capacity. Key lessons learned from country experiences include:

- the reforms needed in conceptualizing and planning health workforce education are not solely confined to the health sector;
- innovative tools and approaches are needed to build and strengthen the evidence base, such as developing standardized assessment tools; and
- strengthening investment in basic and evaluation research is required, as well as linking structures for knowledge management to policy processes.

Building on the findings of a *Lancet* commission on medical education and earlier work in the field, new WHO guidelines on health professional education (Box 3)

Box 3. Education guidelines

Transforming and scaling up health professional education is aimed at expanding and reforming education to increase the quantity of health professionals while concurrently improving the quality and relevance of what is taught. The primary objectives are both to meet population health needs and expectations and to strengthen countries' health systems and improve population health outcomes.

The guidelines articulate a vision for transformation that is applicable and are underpinned by 11 recommendations covering issues concerning five domains: education and training institutions; accreditation and regulation; financing and sustainability; monitoring, implementation and evaluation; and governance and planning. The context in which they should be implemented is framed by four good practice recommendations that address areas such as political commitment at the highest levels, formal collaboration and shared accountability across all stakeholders, including government departments that are concerned with health professional education and their deployment, incorporation into national planning, which involves financial commitment, and creating or strengthening mechanisms to support implementation.

These policy and technical guidelines outline 12 basic principles for transformation to take place. Among these principles are country ownership for transformation, producing health professionals who are globally competent and locally relevant, aligning with national health objectives and strategies and human resources for health plans and contributing to universal access to health services. Further, gaps still need to be addressed in the evidence for transformation and a research agenda needs to be clearly articulated to guide partners at the country and global levels.

Specifically, the guidelines aim: to provide sound policy and technical guidance in pre-service education, particularly to countries experiencing shortages of doctors, nurses, midwives and other health professionals; and to guide countries on how to integrate continuing professional development as part of scaling up medical, nursing, midwifery and other health professionals' education to ensure excellence of care, responsive health service delivery and sustainable health systems.

Country ownership in determining priorities and setting policy is required in each of the five guideline domains identified.

show the way on the type of innovation required. Marie-Paule Kieny, Assistant Director-General, WHO:

“Transforming and scaling up health professionals’ education: WHO education guidelines 2013 are conceived for the ultimate benefit of users of health services, whose needs should determine the quantity, quality and relevance of the education of health professionals.”

Improving the planning, funding and production of the health workforce, however, will not translate into better availability, accessibility and quality of health services unless health workers are also deployed and retained where they are needed and adequately motivated to perform. Comprehensive analysis of health labour market dynamics is needed to ensure equitable access to health services and attain universal health coverage: improved data on human resources for health, including on wages and productivity, are required to understand health labour market dynamics. Ultimately, the combination of population needs, demand for services and supply and governance of health workers determines the wages and allowances, the number of health workers employed, the number of hours they work, their geographical location, their employment settings and their productivity and performance (Box 4).

Available health labour market analyses point to the opportunity to use the current workforce more efficiently. An important part of this can be by planning for a more rational and cost-effective skills mix. Task reallocation will require tackling skill mismatch among current human resources for health: innovative approaches, such as harnessing a more diverse skills mix, for instance, by deploying mid-level and community health workers, are needed to address inefficiency and enhance equity in the delivery of services.

Box 4. Retaining health workers in rural areas in Thailand

In Thailand, the rapid expansion of the primary health care infrastructure called not just for an expanded health workforce but also for strategies to ensure health workforce distribution to rural communities. Since 1974, Thailand has had special tracks for recruiting rural students to medical and nursing careers in return for allowing them to work in their home communities. The system was the first national programme of mandatory rural service – for a three-year period – for new medical and nursing graduates. In later years, this rural bonding policy was extended to dentistry and pharmacy graduates.

In 1979 there was one doctor for every 1210 residents of Bangkok, while in the north-eastern part of Thailand, there was one doctor for every 25 713 residents. This 21-fold difference was reduced to a 5-fold difference in 2009. Over the same period, the gap in the number of nurses between Bangkok and the north-eastern part of the country was reduced from 18-fold to 3-fold.¹ According to Mongkol Na Songkhla, Chair of the National Human Resources for Health Commission, Thailand, “In Thailand some of the motivation to stay in rural areas is based on pay, as health workers that have been in rural areas for over 15 years can have a higher pay than a minister.”

¹Source: Tangcharoensathien V et al. Health workforce contributions to health system development: a platform for universal health coverage. Bull WHO. 2013;91:874–80.

3.

Social needs and the regulatory role of the state



A critical role of the state is to promote the overarching principles of justice, solidarity and social inclusion that are embedded in universal health coverage. Achieving this fundamental objective requires strengthening regulatory mechanisms. Since countries plan on scaling up health workforce production to attain universal health coverage, regulation should improve training, ensuring and maintaining the quality and management of health care professionals at all levels of the system. The government is the key player in framing and governing these regulatory mechanisms to ensure health system coherence and responsiveness to universal health coverage. The regulatory framework for human resources for health must be driven by citizens' needs and expectations, with careful consideration of socioeconomic and cultural diversity.

Regulation is not an end in itself but a means to achieve specific goals, such as ensuring a certain level of quality of education institutions (through accreditation standards) or certain level of competencies for graduates and practitioners (through licensing and certification). A comparative analysis of different regulatory frameworks reveals the existence of different models, spanning from totally centralized systems to looser models with a high degree of integration of different actors involved in regulatory functions. Professional associations play a complementary role both in education and in managing human resources for health through reward and recognition mechanisms. Most countries have regulatory bodies or councils for most health professions, typically each with its own specificities reflecting differences in scope of practice and in processes to promote quality standards.

The state represents public interest, but the corporate interests of professional associations or of the private sector can be in contradiction to this; where necessary, governments can adopt regulatory measures to promote public health goals: for instance, as done successfully in many countries by linking access to further training to service in underserved areas. Nevertheless, there is an important financial burden in implementing regulation, and an excessive regulatory burden can stifle innovation and hurt providers. Softer instruments and incentives are therefore also required to complement regulation to attain broader health system objectives. According to Gabriel Yedlin, Secretary of Regulation and Health Policies, Ministry of Health, Argentina,

“What is important is not the number of laws or regulations but that these actually help achieve the goal of people having access to their rights to health – universal access, not just coverage, in primary care.”

A core focus of regulation is education of health workers. Countries share similar objectives of guaranteeing quality while expanding access and promoting equity. A recurrent challenge is striking the right balance between public interest and the reality of health systems with strong private education institutions and health care providers: the benefits of publicly funded training programmes often accrue primarily to corporate stakeholders and private providers. Advances made by education institutions do not always keep pace with the benchmarks set up by governments to regulate health professions: collaboration between health and education sectors and training institutions has been pivotal in making advances.

Given the central role of professional associations in regulation, effective collaboration and synergy among them is crucial in ensuring that the health workforce can effectively operate within the full scope of their education and training. Interprofessional education and collaborative practice in health care are key to achieving universal health coverage, but regulatory structures may sometimes hinder collaborative practice: greater flexibility is necessary for shared responsibility and true team-based care. However, learning and practicing in silos is still the norm: governments need to nurture a policy environment that fosters collaboration among professionals. In turn, health professional associations have a role to play to enhance teamwork and an improved skills mix by engaging in a policy dialogue and advocacy efforts at the national and global levels. According to Lola Dare, CEO of CHESTRAD,

“ Our current discourse on this team concept is very fragmentary, shifting tasks rather than sharing a purpose of improved provider motivation, patient experience and satisfaction Investments in mid-level and community health workers are not a temporary quick fix: they must find placement in a mutually reinforcing, interdependent and tiered health care system. ”

In the past decade, the migration of skilled health workers has become more complex, more global and of growing concern to countries that lose much-needed health workers. People have a right to move and seek the best employment they can get, but some countries suffer disproportionately from the negative effects of migration, and international recruitment is not a sustainable solution in the longer term, including for destination countries facing a relative shortage. International migration of health workers has risen to greater prominence in the global health policy discourse with the adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel in 2010. The voluntary nature of the WHO Code makes it a prominent example of “soft” global regulation. Jean-Marc Braichet, Chef de Cabinet, Ministry of Social Affairs and Health, France, says:

“ The WHO Global Code of Practice on the International Recruitment of Health Personnel was adopted by all Member States, and that consensus was built over a long time. The implementation is a progressive and a long-term process. Each country must get ownership. ”

The WHO Code provides a comprehensive framework to guide policy dialogue on health workforce production, recruitment, deployment, retention and mobility. Key lessons learned in implementing the WHO Code include the need: to raise awareness of it, including at the subnational level; to strive for self-sufficiency in producing human resources for health; to invest in local staff trained with a locally focused curriculum; to address issues of conditions of work, sound management and supervision, and opportunities for professional development and career enhancement to encourage retention; to use accreditation and licensing measures to discourage migration; and to produce more health workers than theoretically needed, anticipating some attrition from outward migration.

The WHO Code is best implemented as part of multistakeholder dialogue and action targeting a sustainable health workforce in all countries. Bilateral agreements

can provide a framework to manage migration that mutually benefits source and destination countries. Actively managing migration can promote migrants' welfare not only abroad (including preventing dropout from the health sector and “brain waste”) but also on their return. Special migration services for health workers may also help to retain productive links with local health institutions while workers are away. Many recipient countries also provide overseas development assistance in health: a coherent approach between domestic and international policies, as the experience of Ireland shows, can entail working towards self-sufficiency at home while ensuring that international support is more directly targeted to expanding the health workforce in beneficiary countries.

4.

Deployment, retention and management: sustaining a high-performing workforce in striving towards universal health coverage



Getting the most out of the available health workforce is as important as producing the right numbers. This practically implies optimal distribution, optimal use of private-sector partnerships, enhanced health workforce performance and productivity through adequate incentives and better working conditions and well-adapted health care models supported by timely and accurate information.

Policy-makers need to take radical measures to ensure retention of their health workers and to better balance their distribution geographically, among the different levels of the health care system and between the public and private sectors. In nearly every country, the geographical distribution of health workers is skewed in favour of urban and wealthier areas. Health workforce imbalances in deployment exacerbate inequities in the health sector. Addressing geographical imbalances in the deployment of the health workforce is a near-universal challenge. There is an emerging consensus that policies for recruitment and retention in rural and remote areas need to be implemented in bundles, addressing different “pull” and “push” factors and combining different packages of interventions according to the variety of elements influencing health workers’ decisions to work in rural or remote areas. These interventions can be divided into five categories: (a) education policies; (b) monetary incentives; (c) nonmonetary incentives; (d) skill substitution; and (e) regulatory policies. Examples of effective policies include compulsory bonding policies, targeted monetary and non-monetary incentives, offsetting the financial opportunity cost from dual practice and rural pipelines for producing and deploying human resources for health. Further, a comprehensive understanding of the health labour market forces that influence health workers’ decisions is essential. According to Carissa Etienne, Director of the Pan-American Health Organization,

“ Multiprofessional teams are critical, particularly to address shortages of human resources for health in rural areas. A diverse skills mix is required to address population needs. There is a continued need to ensure that education and health sector policies are articulated together. Rather than schools of education working in isolation to the health needs, education and training must be designed with population needs in mind. ”

Effective interventions need to match health worker's preferences and expectations: the choice of interventions should be informed by in-depth understanding of the health workforce. This requires, at least, comprehensive situation analysis, including health labour market dynamics, recognizing that health workers and employers are economic actors, with different preferences and interests, making informed trade-offs, and observing the factors that influence the decisions of health workers to relocate to, stay in or leave rural and remote areas.

Policy responses require engagement across all sectors and not only health. Since most countries have health systems characterized by varying combinations of public and private providers and educational institutions (the private sector being dominant in several low- and middle-income countries), an effective response will harness the potential of public, private and not-for-profit institutions.

Health workers are mobile, and often the distinction between public and private provision is not clear-cut, as exemplified by the widespread phenomenon of

dual practice. The evidence on dual practice suggests that policies be aimed at addressing its underlying causes such as incentives and accountability structures. Policies to regulate it will not succeeding in improving health worker performance without efficient management and accountability structures and improved working environments in the public sector.

Examples of successful public-private partnerships (spanning from education and service provision to regulation and research) exist in many contexts, but uncertainty still surrounds the definition and boundaries of the private sector and of public-private collaboration. Most health workers today operate in an environment with both public and private incentives and an increasing interaction between public and private. An equity perspective to the debate is needed to avoid creating two different systems (public for the poor and private for the affluent). Tim Evans, Director, Health, Nutrition and Population of the World Bank, says:

“ The competencies of health sector managers to manage the public-private interface will be critical everywhere. Frameworks for bringing the different components of the health system together – so as not to have fragmented, piecemeal approaches – are required. ”

Health service delivery reforms to improve health system performance, for example by developing networks of integrated health services and people-centred delivery models, lead to more efficiency in deploying human resources for health and better use of the available health workforce. Integrated health service delivery models are systems of health care that provide a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, through the different levels and sites of care within the health system, and according to people's varying needs throughout the life-course. Integrated health service delivery is increasingly important to policy-makers and health planners because it can accelerate progress towards universal health coverage. It does, however, necessitate new ways of training, deploying and supporting the health workforce. Building the right competencies for integrated service delivery and people-centred care requires strengthening pre-service and in-service training.

Box 5. Integrating health services in Canada

Integrated services have been a reality in Canada for a decade. Health is the mandate of the provinces. The Canadian health system is based on primary health care, with more family physicians than other specialties. In Quebec, a single-window access to a network of services has been put in place. Each resident has one phone number for the local health network and university hospitals, and its affiliates work with these local networks.

The introduction of integrated health service delivery models necessitates new ways of training, deploying and managing the health workforce. Building the right competencies for integrated service delivery and people-centred care requires strengthening and/or reforming pre-service and in-service training. Further, these models require a shift in the reorganization of health workers towards multidisciplinary teams, with increased emphasis on non-physician clinicians, including nurses. In Quebec, integration of services has resulted in significant education reforms and a move towards interprofessional collaboration. Medical students now have social science courses, spend time with marginalized communities and receive global health training. Nurse practitioners will be required to do interventions that only doctors were previously allowed to do.

Further, these models require a shift in the organization of health workers towards multidisciplinary teams, with increased emphasis on non-physician clinicians, including nurses.

Integrated health care provision typically requires a context-specific model.

- In Mexico, constitutional reforms and a national strategy advanced integration: 95% of its population were brought under an insurance scheme, and the last 5% are being reached via mobile health units.
- In Quebec, an integrated network of services is bringing health care closer to the people, leading the health system away from hospital-centrism (Box 5). Integration must be accompanied by a profound reorientation of health professional education. A good model is the interprofessional education concept put in place in Japan that has demonstrated good results in transforming attitudes and ways of working.

Policy reforms and associated regulatory updates will be the linchpin for developing and deploying health workers rationally and efficiently. Evidence shows that interprofessional education leads to high-quality health care and reduces costs. A positive policy, funding and regulatory environment is the umbrella under which all these activities can take place.

Another central aspect of improving health workforce management is to develop effective approaches to measure its performance. Health workforce performance

Box 6. Leveraging human resources for health information for effective health workforce governance in Sudan

Facing a lack of effective systems for the collection and analysis of human resources for health data and poor coordination between the main stakeholders, Sudan's national leadership initiated several interventions that catalysed the involvement of many partners in improving human resources for health. A new national human resources for health observatory became a hub for compiling information, and the launch of the "country coordination and facilitation" process further enhanced the role of the observatory in engaging the diverse stakeholders in human resources for health.

The new information system generated comprehensive data on human resources for health, unveiled the challenges facing the health workforce and provided useful evidence for policy- and decision-making. The observatory became the hub for coordination and advocacy for stakeholders in human resources for health, developed capacity for data analysis and management and created a research agenda for human resources for health to produce a knowledge base for guiding future development of human resources for health. In parallel, an enhanced stakeholder forum has enabled the formation of collaborative partnerships across sectors, eliminated duplication and fragmentation and encouraged coordinated implementation.

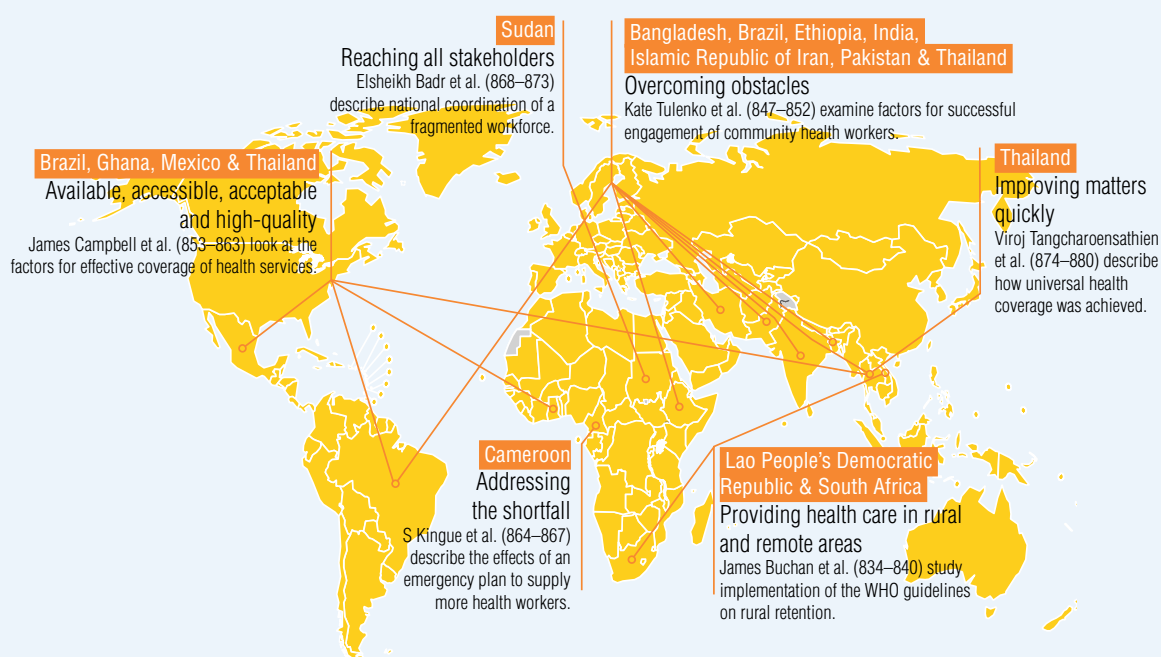
Improved information flows and enhanced governance mechanisms were critical for developing a strategic policy related to human resources for health and designing, funding and implementing a national plan for human resources for health. Effective coordination spearheaded a public-sector commitment to reforming human resources for health that was characterized by high-level involvement and the strategic positioning of issues related to human resources for health. Revitalizing many decentralized training institutions – particularly those for nurses, midwives and allied health professionals – reduced the workforce shortages in underserved rural areas.

Source: Badr E et al. Strengthening human resources for health through information, coordination and accountability mechanisms: the case of the Sudan. Bull WHO. 2013;91:868–73.

and productivity are essential for a well-functioning health system. Chronic absenteeism, lack of motivation and under-the-table payments are among the signs of dysfunctional dynamics in human resources for health. Tackling the problems of workforce inefficiency is essential to achieving universal health coverage. The body

Box 7. Theme issue of the *Bulletin of the World Health Organization*

A collection of articles in a special theme issue of the *Bulletin of the World Health Organization*, dedicated to human resources for universal health coverage, provides concrete examples, success stories and lessons learned of how some countries have structured their efforts in this area and offers analytical tools and new evidence about successful or promising innovative approaches to improve the deployment, retention and management of their health workforce. Other articles contributed to strengthening the policy frameworks and evidence base for human resources for health by: (1) deepening understanding of the labour market forces that affect health workers' motivation, attraction, retention and performance; (2) identifying best practices and lessons learned in tackling the challenges of retaining workers in rural areas and international migration, and specifically in relation to implementing the WHO Global Code of Practice on the International Recruitment of Health Personnel; (3) providing new evidence and recommendations on the effectiveness of and required system support for mid-level and community-based health workers; (4) identifying opportunities for innovation in the education and management support of human resources for health through emerging technologies; (5) investigating levels of domestic spending on human resources for health and exploring how the impact of development assistance in that area can be maximized by targeting it more strategically; and (6) exploring how benchmarks and indicators related to human resources for health could influence and be part of the agenda for universal health coverage and post-2015 development.



How much do doctors cost?

P Hernandez-Peña et al. (808–815) quantify the wage bill for health workers.

Analysing the market

Barbara McPake et al. (841–846) examine factors influencing supply of – and demand for – health workers.

4 million missing

Robert Bollinger et al. (890–891) suggest that information technology can help fill workforce gaps.

Sticking to the code

Amani Siyam et al. (816–823) report use of the *WHO Global Code of Practice on the International Recruitment of Health Personnel*.

Rethinking the health system

Sania Nishtar & Johanna Ralston (895–896) suggest that the health workforce can catalyse change.

Covering all bases

Angelica Sousa et al. (892–894) propose a health labour market framework.

Debating the measures

Giorgio Cometto & Sophie Witter (881–885) weigh the options for benchmarks and monitoring frameworks. Ties Boerma & Amani Siyam (886) argue for definitions, registries and a census of health workers. James Campbell (886–887) advocates for a workforce that's fit for purpose. Xenia Scheil-Adlung (888) points out that health workforce benchmarks should be compatible with sustainable development. Brook K Baker (889) explains why targets need to be patient-centred.

Who delivers better care?

Zohra S Lassi et al. (824–833) review the evidence on mid-level health workers.

of knowledge regarding health workforce performance is quite narrow in focus, and there is a scarcity of comprehensive and comparable measures of health workforce performance, particularly from a health system perspective. A comprehensive performance measurement framework is essential to optimize health workforce efficiency and to assess the impact of new policies and interventions: it should encompass key dimensions, including productivity, availability and quality of care through a composite index. In addition, the framework should identify key factors affecting performance, such as the role of clear job expectations, tools for the job, incentives, supervision and feedback, safety, compensation and the connectivity of the worker. New models for paying the health workforce (such as results-based funding) have the potential of improving the performance of health workers and health systems; however, rigorously assessing their impact requires consistently measuring performance at the individual, facility and system levels.

Systematic ways to collect and make available data on human resources for health are essential for understanding the performance of human resources for health and the dynamics of the health labour market, which in turn are necessary for designing effective policies on human resources for health. Nevertheless, information systems have been unable to provide decision-makers and managers with accurate, timely and useful information on human resources for health. This information concerns several government sectors (education, health, finance and others), which often translates into fragmentation and dispersion of responsibilities. As country experiences show, sound information systems are key to modernizing public management, increasing the availability of data for management and human resources for health planning and forecasting. There is a clear demand for achieving coherent policies and rules, standardizing content, properly managing information resources, introducing appropriate novel technologies and integrating them in routine administrative systems – such as government payrolls – and obtaining clear criteria on the confidentiality and use of data on human resources for health (Boxes 6 and 7).

Establishing national health workforce data repositories with minimum data requirements can improve several dimensions of management of human resources for health, enabling: authenticating and validating health workforce data; aggregating health workforce data required for planning; reducing or eliminating duplicate health workers; reporting data back to the originating source and to other authorized users for required action; and tracking appropriate licenses of health professionals. Performance management and reward mechanisms should incentivize district-level contribution to and use of an information system for human resources for health; health workforce data analysts should be involved in policy dialogue to facilitate management decisions.

5.

Empowerment and incentives:
harnessing health workers' voice, rights
and responsibilities in moving towards
universal health coverage



In many countries, the employment conditions of health workers are not compatible with the attainment of universal health coverage. In some settings, working conditions are characterized by understaffing, excessive workloads, stress, exposure to occupational hazards, unsafe environments, occupational ill health and violence, resulting in inadequate patient care. To address such challenges, governments and health workers should work as partners both in shaping policies and in implementing them. Health workers provide a unique perspective and bring to the policy debate their understanding of community-based and implementation challenges. Such engagement empowers them as key actors in implementing and advancing reforms associated with universal health coverage. It is therefore critical that their voice be heard as policy around universal health coverage is formulated: health workers are directly concerned with the quality of health care, and when they have a voice in policy, real and sustainable improvements may occur in health delivery as well as in the workers' employment and working conditions.

Health workers' empowerment also comes from an enabling environment that allows them to serve their communities: this includes ensuring their safety and security at the workplace, particularly in hardship situations such as conflict, extreme poverty and other emergencies. It also includes promoting cultural, ethnic, racial and religious diversity, gender and social equality and inclusion principles and practices so the health workforce can better meet the needs of the diverse populations they serve.

Ultimately, the voice, rights and responsibilities of health workers must play a central role in developing and implementing solid policies and strategies towards universal health coverage. Governments, trade unions, professional associations and civil society have a joint responsibility in improving and securing the working conditions of their health workers while empowering them in the decision-making process.

Country experiences show that engaging health workers and of the associations that represent them – including civil society, trade unions and professional councils – in health policy processes is important to set strategies that are responsive to the needs and realities of people, communities and health systems. Many countries have successful examples in which health workers and civil society were engaged in formulating effective health policies and strategies, spanning from the involvement of the midwifery association in policy changes on human resources for health in Malawi to the national rural health missions in India overseeing the Accredited Social

Box 8. Australia's professional associations shaping policy towards improved patient care

Australia's universal access to quality health depends on sufficient and appropriately qualified staff. Attempts over the decades to ensure safe staffing using patient dependence tools and other retrospective models have not resulted in the ability for nurses and midwives to provide safe care. Research clearly shows that good patient outcomes correlate directly with the quantity and quality of nursing hours dedicated to patient care. The New South Wales Nurses and Midwives' Association in Australia fought hard to win minimum mandated nurse-to-patient ratios in several health settings in the public hospital system in 2011. Patients and nurses now appreciate the less chaotic hospital atmosphere: knowing how many staff are scheduled for each shift lessens the stress experienced by nurses and improves job satisfaction and retention.

Source: Judith Kiejda, Assistant General Secretary, New South Wales Nurses and Midwives' Association.

Health Activist (ASHA) programme and the inclusive forums for policy dialogue on human resources for health in the United Republic of Tanzania. According to H.E. Manuel Ferreira Teixeira, Secretary of State of Health of Portugal,

“The more complex a policy change the health system is considering, the more important it is to engage health workers. Portugal uses the “triangle” mantra for its health policy decisions: strong political involvement, strong professional involvement and strong involvement of the people. Portugal’s reduction of infant mortality from 38.9 deaths per 1000 live births to 3.4 deaths per 1000 live births in 2012 was driven by the enthusiastic response and participation by health workers and their support for policy changes.”

Among the stakeholders that shape the environment for health workforce policy development, trade unions have a unique role to play in balancing their duty of protecting health workers’ rights and employment conditions with national public health goals. In some settings, working and employment conditions have lost ground since the financial crisis of 2007–2008 and the consequent real economy crisis; austerity budgets have at times limited the growth of the health sector payroll and reduced it in many cases. Health workers are, however, a critical input for universal health coverage: a stable health workforce that provides high-quality services needs good employment conditions. As unions defend the working and employment conditions of their members, they also ensure the stability of a workforce that can deliver high-quality services that are affordable and equitable. Trade unions’ role in promoting adequate funding and employment conditions is critical to ensure appropriate investment in human resources for health, a prerequisite to advance towards universal health coverage (Box 8).

The health workforce is a critical input for meeting health systems’ goals of increased service access, quality, effectiveness and coverage – dimensions of universal health coverage. The path from system inputs to universal health coverage must be cleared of professional, gender, cultural, ethnic, racial, and religious barriers to workforce inclusion and participation. In workforce policy and planning, it is important to proactively manage differences and inequalities relating to gender, ethnicity or other factors because these challenges tend to result in inequalities in the workforce and labour market rigidities. According to Constance Newman, Senior Team Leader for Gender and Health, IntraHealth:

“If left unmanaged, gender differences tend to become inequalities: human resources for health leaders need to be proactive.”

Box 9. Promoting and managing the diversity of health workers for universal health coverage: the case of Uganda

Universal health coverage requires a mix of health workers and addressing gender and other differences and inequalities that can act as barriers to workforce entry and retention. Because gender differences can translate into inequalities, Uganda’s Ministry of Health analysed gender inequalities and disseminated results using participatory methods to promote critical consciousness, capacity-building and action. The analysis identified sexual harassment, unequal work opportunities and discrimination based on stereotypes, and pregnancy and family responsibilities. The Ministry of Health developed gender mainstreaming guidelines for use by district health managers and recruiters to establish policies and procedures to optimize the use of female health workers’ skills and experiences at all levels of the health system.

Addressing these barriers deliberately and systematically by adequately implementing supportive policies will improve system efficiency, expand and better retain the pool of health workers and result in better health system outcomes. Advancing the universal health coverage and human resources for health agenda therefore requires recognizing and harnessing the skills and experiences of a diverse workforce and promoting collaboration between types of health workers; empowering female health workers as leaders and managers through affirmative action and legal and policy protection that guarantee appropriate improvement of working conditions, equal opportunities and equal pay policies; and assuring inclusion, equity and justice for cultural, ethnic, racial and religious minorities (Box 9). Team models should be used to educate, train and manage health workers. Policies to integrate community health workers into professional health teams are needed to maximize their effectiveness. Kate Tulenko, Director, Capacity Plus:

“The more the health team looks like the population, the more the people will use the services.”

Fragile settings, such as those characterized by conflict, extreme poverty and other emergency situations, require a particular focus on the security, safety, well-being and motivation of health workers. The dwindling respect in some of these

Box 10. Awards on human resources for health

The Third Global Forum provided the occasion to assign the 2013 Global Health Workforce Alliance Awards to honour outstanding actors in human resources for health.

Winner in the health worker category: Haruna Lule

Haruna Lule is the principal medical officer and medical superintendent at Gombe Hospital, a 100-bed rural hospital in Butambala district, Uganda. For years, the hospital has faced an inadequate supply of water. As a result, hand hygiene has been difficult for both health workers and patients, leading to high rates of health care-associated infections.

To strengthen hospital infection control, Haruna Lule launched a hand hygiene project. Alcohol-based hand rub was installed in wards, and pocket-size bottles were provided to all staff. Health workers also received training in hand hygiene. Thanks to Haruna Lule's efforts, post-surgery sepsis in the maternity ward has decreased by more than 60%, patients' length of stay has declined from 4.6 to 3.5 days in most wards and cross-infection of diarrhoea cases among the children in paediatrics ward has also reduced drastically.

Winner in the journalist category: Marie Yambo

Marie Yambo is a journalist from Kenya. She is responsible for producing a health segment on Kenyan television called *Health Matters*. The TV programme explores the role of health workers in the national health system.

For instance, the programme has examined the work that traditional birth attendants and community health workers carry out in Kenya to reduce the country's infant and maternal mortality rates.

Marie Yambo believes that Kenya meeting the Millennium Development Goals requires a robust health workforce of doctors, nurses, midwives and community health workers. In her opinion, the media can provide a platform for stakeholders, including policy-makers, to formulate solutions.

Box continued on next page ►

contexts for the neutrality of humanitarian and health workers endangers the delivery of emergency and essential health care services. Safeguarding health care and health workers in conflict and emergency situations requires political commitment and action at the international and national levels: evidence shows that special institutional arrangements are needed that can deal effectively in these environments and for ways to mobilize services and human resources for health quickly to respond to outstanding urgent needs. These situations also present an opportunity to move from managing immediate response towards putting in place the best long-term institutional set-up.

Everyday health care delivery can be complex and hazardous work, especially in the presence of staffing shortages, inadequate supplies as well as biological, chemical, radiation, ergonomic and psychosocial hazards, putting health workers at risk of injury and illness. The right to health and decent work also applies to health workers, and without a safe and healthy working environment, health workers cannot provide quality care. Clear and coherent policies and tools are necessary to improve occupational safety and health and the working conditions of the health workforce.

The responsiveness of health care workers to citizens' expectations is a goal of health systems and a main component of high-quality care. Strengthening the health

► **Box 10 continued**

Winner in the country category: Maria Isabel Rodríguez

Maria Isabel Rodríguez is El Salvador's current Minister of Health. Since her appointment in 2009, Maria Isabel Rodríguez has been leading a process of national health reform to provide universal health care coverage by strengthening the nation's health workforce. This will be achieved thanks to the addition of 3500 health professionals to the workforce.

Maria Isabel Rodríguez's scheme will also see the establishment of the School of Government of the National Institute of Health of El Salvador – a body that will promote the training for national political leadership and ensure the suitability of health personnel in the country – as well as the creation of a national platform for the professional training of specialist physicians in the country.

Previously, as an official for the Pan American Health Organization (PAHO), Maria Isabel Rodríguez led a project for training leaders in international health. The aim was to provide Latin American health professionals with improved abilities to manage international relations in health, develop health funding policies and handle project negotiations. This project has produced a set of professionals who today lead the world of regional public health.

Winner in the member/partner category: African Medical and Research Foundation (AMREF)

AMREF is an international African organization headquartered in Nairobi, Kenya. AMREF's vision is for lasting health change in Africa and they believe that the power for transformation lies within Africa's communities. Every year, AMREF trains more than 10 000 community health workers, who bring health to people's homes in some of Africa's most marginalized communities. They also train doctors, nurses, community midwives, clinical officers, laboratory technicians and pharmacists. AMREF's training takes place in communities, health centres and hospitals in six African countries as well as in AMREF's International Training Center in Nairobi and satellite training centres in Uganda and the United Republic of Tanzania.

One of AMREF's most notable training programmes is an innovative eLearning programme that helps upgrade the skills of 20 000 nurses in Kenya. In partnership with the Government of Uganda, this programme is currently being modified to upgrade the skills of midwives within the country. It is hoped that this programme will be replicated in even more African countries suffering from similar health worker shortages.

workforce requires action on multiple levels and a partnership approach, with the involvement of patients for holistic person-centred care: patients are the clients and should be involved in planning and delivering health services. Patient-centred care can be advanced by community involvement in governance of primary health care interventions, as exemplified by community monitoring and village health sanitation and nutrition committees in India, which have been instrumental in dramatically improving service uptake. A key lesson learned from this and other similar experiences is to involve and engage patients and the community, recognizing them as priority stakeholders (Box 10).

6.

Looking towards 2030 – what is the agenda to make sure the health workforce is the vanguard for universal health coverage?



Despite evidence of progress in the last decade, the world is now at a critical juncture, and an acceleration of efforts to develop human resources for health is key to achieving universal health coverage. According to Timothy Evans, Director, Health, Nutrition and Population of the World Bank,

“ In most systems, the direction of the health workforce is towards greater concentration in urban tertiary care centres. The ultimate challenge to attain universal health coverage therefore is to look at innovative ways at moving towards more credible, marketable, demand-responsive systems of frontline care and developing the conditions, incentives and career opportunities that can nurture and sustain a vibrant frontline workforce. ”

In this respect, the global community must significantly and ambitiously raise the bar in its efforts: aiming much higher in terms of the political will, good governance and financial and other resources committed to address challenges related to human resources for health. A holistic agenda on human resources for health instrumental to attaining universal health coverage will require interconnected efforts at the national and global levels in support of four main areas of action:

- anticipate and adapt to new challenges;
- articulate ambitious targets with a long time horizon (10–15 years), including producing larger number of health workers and establishing benchmarks for the performance of higher education and employment;
- broaden participation in policy development and response beyond the public health sector by engaging other key constituencies and sectors and create accountability mechanisms to support and oversee implementation; and
- innovate through more efficient and rational planning and use of financial and human resources in the health sector and towards more results-focused implementation.

In practice, this means:

- recognizing that the health workforce and health sector is not a consumption sector but rather that it has positive returns on the economy and represents an investment with a great potential to contribute to broader poverty reduction strategies;
- making intersectoral bridges to engage ministries responsible for finance, education and public services;
- moving beyond an exclusive focus on the availability (numbers) of health workers to according equal importance to their accessibility, acceptability, quality and performance, reflecting these objectives related to human resources for health in comprehensive health sector strategies;
- moving towards more dynamic forecasting models that are informed by labour market analyses, that recognize health care systems (and the health workforce within them) as complex and adaptive entities and that can provide the comprehensive understanding of potential losses and efficiency gains across the public and private sectors;
- moving towards explicitly targeting the most disadvantaged segments of society through equity-focused policy objectives and measures of progress;

- transforming health education beyond the traditional informative learning towards a role of health workers as agents of change in society;
- developing better measures of health workforce performance to understand the incentives necessary to improve it;
- promoting supportive management and conducive practice environments for health workers;
- integrating public and private systems to reduce health care costs and regulate for quality; and
- using resources more efficiently through innovative strategies.

There is a need to consolidate the lessons from the past years on what works and focus on putting in place and to implement detailed, long-term national strategies that include social compacts with health workers as well as with other sectors; achieving adequate funding will crucially depend on ensuring that investment in human resources for health represents good value for money and that it results in better health outcomes. Gwen Malegwale Ramokgopa, Deputy Minister of Health, South Africa:

“ More efficient distribution of health resources can be supported by adopting innovative strategies. South Africa has implemented reforms on up- and multi-skilling (such as of nurses, mid-level workers, community health workers), thereby increasing access to rural and other groups. ”

7.

Bolstering political will for human resources for health: the Third Global Forum commitments



An overarching message emerging from the Third Global Forum was that only systemic action can address the deep-seated challenges in human resources for health by combining related and complementary actions to strengthen the health workforce towards universal health coverage.

The reasons why health workforce problems persist are diverse, but a key factor is that often only fragmented or simplistic solutions and quick fixes have been tried, whereas the development of human resources for health continually changes and evolves under the pressure of a variety of factors and forces. Evidence and years of lessons learned show that integrated and coordinated approaches are required that pay adequate attention to every critical step in the supply chain of health workers and that recognize the role that different sectors within government and different constituencies in society play.

Thus, a systems approach needs to be applied to human resources for health. This entails addressing capacity, management and working conditions as well as solid understanding of the health labour market dynamics that affect the production, deployment, absorption into the health system, retention, performance and motivation of human resources for health.

Translating the objective of universal health coverage into reality will require adapting the production and management of human resources for health to the evolving health needs (extending population coverage, expanding the services offered and improving quality) and adopting innovative models of care. Effective strategies that sustainably address deep-seated challenges require a long-term perspective and multistakeholder and multi-constituency collaboration, underpinned by unwavering political commitment. The challenge is not lack of evidence on effective policies: it is to mobilize political will and catalyse action for a contemporary agenda on human resources for health instrumental to achieving universal health coverage.

In support of the objective of focusing political attention and generating political momentum, the Third Global Forum made two critical contributions: eliciting country- or institution-specific commitments in support of national agendas on human resources for health and developing a political declaration reflecting the commitment of the international community to address global and transnational challenges.

In the lead-up to the event, the Global Health Workforce Alliance, WHO, PAHO and the Government of Brazil invited countries and all other relevant stakeholders to identify areas requiring action and to make corresponding commitments on human resources for health at the conference. The Alliance and WHO worked together on developing a framework to assess and organize those commitments in a structured manner, following pathways of interconnected and evidence-informed action on developing the health workforce.

The framework assisted countries and other stakeholders in identifying relevant commitments on human resources for health to be brought to the Forum by mapping out the most effective interventions and their interrelatedness to improve the situation of human resources for health. It drew inspiration from the WHO Global Code of Practice on the International Recruitment of Health Personnel, the policy documents

on human resources for health Member States have endorsed and state-of-the-art evidence. It identified systemic pathways of interventions and organized them along the universal health coverage framework of availability, accessibility, acceptability and quality, which proved to be a useful bridge between the agendas for human resources for health and universal health coverage.

Countries and other entities were invited to identify pathways of interventions that maximized synergy and complemented one another through a systemic approach, recognizing that such interventions, if taken up as stand-alone, might not be equally effective and sustainable. For instance, investment in training new health workers might be lost if a parallel effort is not made to ensure that adequate resources, management systems and incentives are put in place to ensure that the new graduates can find employment in the health sector and, ideally, to work in less well-served areas.

In response to this call, 56 Member States and 27 member organizations of the Alliance or other entities submitted their commitments, which were announced at five dedicated sessions at the Third Global Forum and will strengthen the basis for future collaboration, follow-up and accountability efforts. Many countries outlined their commitments as an interrelated set of actions aimed at bolstering efforts to develop the health workforce according to pathways of systemic interventions. The following are examples of the commitments.

Benin will recruit every year until 2018 at least 775 health workers to address unmet needs in reproductive, maternal, newborn and child health and taking into account projected population growth; this will reduce the access gap in rural areas by 50%, for a cost of 2 043 296 051 CFA francs.

“ South Sudan will promote regulated task-shifting for clinical officers to conduct emergency operations such as Caesarean sections – 28 clinical officers to undergo related training in Zambia and Malawi. ”

“ Somalia will develop curricula for basic and post-basic midwives, establish three new schools and produce at least 100 midwives over the next two years. ”

“ Colombia will strengthen family health by educating 10 000 family physicians over the next 10 years. ”

Domestic, country-specific commitments need to be complemented by the actions that no country could possibly address alone, such as international migration, improved aid effectiveness with regards to developing the health workforce and the existence of data and evidence repositories and of mechanisms for mutual accountability and reviewing progress. Such commitments that are truly global in nature were identified in a global declaration, which reflects the collective will for convergent action of the human resources for health community, revisiting lessons learned in the past decade and proposing a forward-looking agenda inspired by the vision of universal health coverage (see Annex 1 – Recife Political Declaration on Human Resources for Health).

Conclusions

The Third Global Forum on Human Resources for Health represented an opportunity to take stock of the current situation in developing human resources for health in countries and globally. The conference highlighted that all countries face the challenge of how to attain, sustain or accelerate progress towards universal health coverage. Strengthening primary care is the way forward to provide comprehensive, integrated and people-centred services. This requires focusing on building partnerships between health care teams and communities and increasing access for people in rural and remote areas.

Human resources for health are central in translating the vision of universal health coverage into reality. Nevertheless, gaps in human resources for health affect virtually all countries – albeit with different connotations and varying level of severity. Further, demographic trends, the growing burden of chronic diseases and long-term care needs and macroeconomic and fiscal constraints triggered by financial restraints imposed in response to a difficult economic climate will make challenges in human resources for health in all resource settings even more acute, rendering it a shared global priority.

At the same time, the event also represented an opportunity to celebrate many advances made in the past decade: for instance, among the countries affected by severe shortages of skilled health professionals, the situation has improved in most of those for which data are available. Evidence of the progress made and promising new approaches shared at the Third Global Forum provide the inspiration to initiate a decade of innovation on developing the health workforce, following the decade of action called for by *The world health report 2006*: for instance, new opportunities can be opened by harnessing the potential of technology and innovative models for care delivery.

The needs for human resources for health that stem from the agenda for universal health coverage require renewed attention, strategic intelligence and action. A systemic approach is required to devise and implement sound costed plans for human resources for health as part of broader national health strategies, built based on high-quality data and evidence. This requires long-term strategic planning, realistic forecasting and political commitment, combined with adequate policy dialogue and related funding to make a whole-of-government agenda on universal health coverage a reality. It is critical to foster an inclusive environment conducive to a shared vision with other stakeholders, including the private sector, civil society, academia, labour unions, professional associations and health worker representatives, and other sectors, including education, finance, labour and civil service. The voice, rights and responsibilities of health workers must play a central role in developing and implementing solid policies and strategies towards achieving universal health coverage.

It is necessary to go beyond mere numbers by addressing gaps in distribution, competencies, quality, motivation and performance. Fundamental changes will have to be made in how health workers are educated, managed, regulated and supported and in the role of the public sector in shaping labour market

forces. New competencies will be required as part of a deeper transformation of professional education, aimed not only at equipping trainees with clinical skills but also addressing their contributions to strengthening institutional capacity and contributing to social accountability. Placing the health worker at the centre, transformative education methods and continuous professional development opportunities enhance their competencies and improve their performance, deployment and retention. Educational reforms must align with health sector objectives on universal health coverage.

Getting the most out of the available health workforce implies achieving optimal distribution, optimizing the use of private-sector partnerships, enhancing health workforce performance and productivity by combining adequate financial and non-financial incentives and developing well-adapted health care models supported by timely and quality data.

Only systemic action can address deep-seated challenges in human resources for health by combining related and complementary actions to strengthen the health workforce towards achieving universal health coverage; only sustained political commitment, in turn, can provide a basis for such actions. Evidence emerging from the Third Global Forum points to a recurrent feature among countries that are making progress: only high-level political commitment can guarantee the alignment and coordination of various sectors and constituencies in support of a long-term agenda for human resources for health, overcoming piecemeal and short-term approaches.

The Recife Political Declaration on Human Resources for Health (Annex 1), adopted by representatives of Member States attending the conference, was the ultimate outcome of the Third Global Forum and enshrined these principles, marking the beginning of a new era in human resources for health. The Declaration recognized the centrality of human resources for health in the drive towards achieving universal health coverage. It reaffirmed the vision that all people everywhere must have access to a skilled, motivated and facilitated health worker within a robust health system; it committed governments to creating the conditions for the inclusive development of a shared vision with other stakeholders; and it reaffirmed the role of the WHO Global Code of Practice on the International Recruitment of Health Personnel as a guide for action to strengthen the health workforce and health systems. Further, it identified a range of actions, including improving planning, education, management, governance, information systems and the adoption of innovative approaches, to be implemented in accordance with countries' contexts and needs. The Recife Declaration messages will resonate beyond the Third Global Forum, as the document calls for the development priorities for human resources for health outlined at the event to be further discussed by the WHO Executive Board and the World Health Assembly in May 2014 and to be given due consideration in the context of the discussions on the post-2015 development agenda.

The political statements made in the Recife Declaration, matched by the more than 80 commitments by WHO Member States and Global Health Workforce Alliance member organizations, are the best measure of the success of the Third Global

Forum on Human Resources for Health in bolstering political commitment for the health workforce agenda and represent a shared platform and common starting-point for further policy dialogue and action on developing human resources for health in the years ahead.

Annex 1. Recife Political Declaration on Human Resources for Health

1. We, the representatives of governments who gathered in Recife, Brazil, from 10 to 13 November 2013, met with a diverse group of multilateral, bilateral and academic institutions, civil society, the private sector and health workers' professional associations and unions at the Third Global Forum on Human Resources for Health (HRH) to take stock of progress made since the Second Global Forum in 2011, to identify continuing challenges and to renew our shared vision and resolve regarding human resources for health, and adopted this Declaration.

* * *

2. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief or economic or social condition. Poor health is one of the root causes of vulnerability and poverty, while in turn poverty, inequality and social exclusion further contribute to ill health. Healthy populations and well-performing national health systems are fundamental for equitable, inclusive, sustainable development. The attainment of health objectives requires coordinated action and solidarity at international, regional, national and local levels. HRH play an indispensable role in attaining health goals such as the Millennium Development Goals.
3. Some encouraging progress has been made in health workforce development, both in countries and globally. The past decade saw increased recognition of the crucial importance of HRH, as reflected in numerous resolutions of intergovernmental bodies and global action plans endorsed by the United Nations. These provide the mandate, political framework and evidence-based guidance for action on HRH and for according high priority and recognizing the centrality of investment in HRH.
4. We reaffirm the importance of the Kampala Declaration and the Agenda for Global Action, as well as the WHO Global Code of Practice on the International Recruitment of Health Personnel, and recognize the need to revise these commitments in light of new developments, with a view to progressing towards universal health coverage.
5. We take note in particular of the relevant United Nations General Assembly, United Nations Economic and Social Council, World Health Assembly and International Labour Conference resolutions; the United Nations Global Strategy for Women's and Children's Health; and noncommunicable diseases and HIV/AIDS global action plans. These instruments and technical guidance represent solid foundations on which to build.
6. But challenges persist: investment in HRH remains low; fundamental discrepancies exist between health worker supply and demand; HRH planning is often weakened by uncoordinated interventions on single issues, focusing on an individual cadre or illness and not on prevention; and the adoption and implementation of effective policies remains uneven. As a consequence, severe HRH shortages, deficiencies in distribution and performance, gender imbalances and poor working environments for health workers remain matters of major concern.
7. In addition to addressing current challenges, we recognize that future health workforce needs will also be affected by an evolving disease burden,

characterized by a greater need for prevention, treatment and care of noncommunicable diseases; demographic trends, including population ageing; technological advances; and broader development and macro-economic factors, which could potentially constrain public sector budgets but, at the same time, create new opportunities for investment in health.

8. The HRH agenda transcends national borders: geographical maldistribution and international migration affect low-, middle- and high-income countries, in some cases hindering the provision of even essential health services and the attainment of universal health coverage. Given the central role of health services in the relationships between citizens and governments, addressing these problems effectively will reinforce the cohesion of societies and accelerate social and economic development.
9. In particular, international migration of health personnel has reached unprecedented levels in the past few decades. Addressing this issue in accordance with the WHO Global Code of Practice on the International Recruitment of Health Personnel in an effective and ethical manner is truly a shared global priority.
10. In embracing the broader goal of universal health coverage, our collective challenge is to address existing gaps while anticipating the transformative actions that will be required in the future. This will entail planning and investing in HRH in accordance with evolving population and epidemiological dynamics and harnessing the potential of emerging and innovative strategies and technologies in health workforce education and management. Progressing towards universal health coverage must be linked with the involvement of health care providers in health services provision at all levels. Full involvement of these providers will demand the requisite training, updated policies and regulations governing their practice, and inclusion in programme planning and expansion of service delivery.

* * *

CALL TO ACTION

11. We as leaders are committed to attaining universal health coverage and recognize that we need an improved health workforce to achieve it.
12. We therefore commit ourselves to an ambitious agenda for health workforce development at all levels, in particular at country level, and urge all stakeholders and the international community to provide support and foster the required collaboration at all levels, working together towards the shared vision that *“all people, everywhere have access to a skilled, motivated health worker, within a robust health system.”*¹

At country level²

13. Recognizing the on-going need to respond to the challenges of HRH and acknowledging the leading role and primary responsibility of governments,

¹ This is the vision adopted by member organizations of the Global Health Workforce Alliance at the First Global Forum on Human Resources for Health through the Kampala Declaration and Agenda for Global Action. Global Health Workforce Alliance. The Kampala Declaration and Agenda for Global Action. Geneva, World Health Organization, 2008. http://www.who.int/workforcealliance/knowledge/resources/kampala_declaration/en/.

² In accordance with sub-national and national responsibilities

in particular as stewards and regulators of the HRH education system and of the health labour market, as well as the need to engage and cooperate with relevant stakeholders and sectors beyond health, including education, finance, labour, civil service and home affairs, in HRH coordination and planning, we commit to:

- (i) foster an inclusive environment conducive to a shared vision with other stakeholders, including the private sector, civil society, academia, labour unions, professional associations and health worker representatives, and
- (ii) use the WHO Global Code of Practice on the International Recruitment of Health Personnel as a guide to strengthen investment in the health of our peoples through stronger health systems and human resources.

14. Recognizing the need for much greater progress in the HRH field, we agree that the following measures should be implemented, according to national circumstances and needs, while acknowledging the importance of promoting technical cooperation and capacity-building:
- (i) adopt a systemic approach to developing, implementing and monitoring adequately budgeted and funded strategies and plans for a sustainable health workforce;
 - (ii) enhance HRH information systems to facilitate labour market analysis in HRH forecasting and link needs-based planning and projections to innovative practices;
 - (iii) enhance competencies and skills of health personnel through transformative education approaches and continuous professional development opportunities;
 - (iv) prioritize the development of the health workforce at the primary health care level to enhance equity in access;
 - (v) promote equal opportunities in education, development, management and career advancement for all health workers, with no form of discrimination based on gender, race, ethnicity or any other basis;
 - (vi) strengthen HRH governance based on clear accountability and transparent processes, including through decentralization, as appropriate;
 - (vii) enhance HRH performance through, inter alia, innovative, effective, targeted management approaches and incentives;
 - (viii) improve health workforce distribution and retention;
 - (ix) advance research and evidence-based practice to inform and maximize the return on HRH investment, including by enhancing data collection and strengthening information systems; and
 - (x) harness the potential of innovative approaches, including the promotion and use of technology, a more efficient balance of different cadres of health workers, including task-sharing, and innovative models for care delivery.

At the international level

15. National commitment and action are the foundations of any effective response; however, some HRH challenges and issues are transnational and require a global approach underpinned by global commitments, in particular the WHO Global Code of Practice on the International Recruitment of Health Personnel. In

this regard, we will collectively strive to adequately finance WHO, in accordance with the General Programme of Work and the Programme Budget 2014–2015, to facilitate effective implementation of the Code.

16. While recognizing that governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures, we, as members of the international community, inspired by global solidarity, commit to support the promotion of universal health coverage and the realization of the right to the enjoyment of the highest attainable standard of health, through adequate investment at institutional, organizational and individual levels, where resource constraints genuinely affect countries' capacity to invest sufficiently in the development and deployment of their health workforce.
17. We invite international partners to focus their support and development assistance on capacity-building, including in the development of appropriate regulatory frameworks, access to specialized training, technology and skills transfer, strengthening educational institutions as well as continuous monitoring of the health labour market.
18. We commit to addressing transnational issues and work towards strengthening health systems, including global HRH governance and mechanisms, by: (i) disseminating good practices and evidence; (ii) strengthening data collection from all countries; (iii) promoting multi-disciplinary, multi-country research and knowledge exchange; (iv) providing or mobilizing technical assistance where needed; (v) strengthening accountability to identify existing gaps, such as where more public sector interventions and financing are needed; and (vi) promoting and supporting implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel as well as the commitments to HRH and universal health coverage made by countries and their partners.
19. We commit to working together, through bilateral, sub-regional and regional arrangements and other approaches and use the Global Code of Practice on the International Recruitment of Health Personnel as a reference to better manage migration of health personnel for the benefit of both source and destination countries.
20. We call upon the United Nations Member States to ensure that HRH development priorities and universal health coverage are given due consideration in discussions of the post-2015 development agenda.

* * *

21. We urge all stakeholders to collaborate towards realization of the HRH commitments made at Recife.
22. We recognize the leadership role of the WHO, including for HRH, recall the mandate given in this regard by resolution WHA63.16 and invite WHO to take this Declaration into consideration in its future work, in particular during the Sixty-seventh World Health Assembly.
23. We express our gratitude to the Government of Brazil for hosting the Third Global Forum on Human Resources for Health, and we recommend that the content of this Declaration be discussed at the World Health Assembly and the WHO Executive Board.
24. Annex 2. Programme in brief Annex 2. Programme in brief

Annex 2. Forum Programme

Programme at a glance

DAY ONE Sunday, 10 November 2013

17:30 **Opening**

Carissa Etienne, Director, Pan American Health Organization

Mitsuhiro Ushio, Chair, Global Health Workforce Alliance Governing Board, Assistant Minister for Global Health, Ministry of Health, Labour and Welfare, Japan

Marie-Paule Kieny, Assistant Director-General, Health Systems and Innovation, World Health Organization

High-Level Roundtable: Health workers and health goals

Alexandre Padilha, Minister of Health, Brazil – **Words of Welcome by the Host**

20:00 **Reception hosted by the Government of Brazil**

DAY TWO Monday, 11 November 2013

09:00–09:30 **Overview and interviews from previous day and outline of today's events**

Film on human resources for health challenges

09:30–13:00 **High-level roundtable: Matching health workforce production to population needs and expectations**

Parallel track sessions

13:00–14:30 **Special event:** Launch of *Transforming and scaling up health professionals' education: WHO education guidelines 2013*

14:30–18:00 **High-level roundtable: Social needs and the regulatory role of the state**

Parallel track sessions

18:30 **Special events:**

Launch of a report entitled: *A universal truth: no health without a workforce*

Global Health Workforce Alliance Awards 2013 Presentation Ceremony – followed by reception

DAY THREE Tuesday, 12 November 2013

09:00–09:30 **Overview and interviews from previous day and outline of today's events**

09:30–11:00 **High-level roundtable: Deployment, retention and management**

Parallel track sessions

13:00–14:30 **Special event:** Launch of publication: *Moving towards universal health coverage by optimizing skills mix: effectiveness and cost-effectiveness of community-based and mid-level health workers*

14:30–18:00 High-level roundtable: Empowerment and incentives

Parallel track sessions

18:30 **Special event:** Launch of theme issue of the *Bulletin of the World Health Organization*: “From evidence to policy and action: new insights on human resources for universal health coverage”

Reception hosted by IntraHealth

DAY FOUR **Wednesday, 13 November 2013**

09:00–09:30 Overview and interviews from previous day and outline of today’s events

09:30–11:00 High-level roundtable: Looking towards 2030

11:30–13:00 Outcome and closing remarks

DAY FIVE **Thursday, 14 November 2013**

Organized field visits

Full programme¹

DAY ONE - Sunday, 10 November 2013

CHEVROLET HALL

17:30

Opening

Geraldo Couto

Mayor of Recife

Carissa Etienne

Director, Pan American Health Organization

Mitsuhiro Ushio

Chair, Global Health Workforce Alliance Governing Board, Assistant Minister for Global Health,
Ministry of Health, Labour and Welfare, Japan

Marie-Paule Kieny

Assistant Director-General, Health Systems and Innovation, World Health Organization

Alexandre Padilha

Minister of Health, Brazil

Joao Lyra Neto

Governor of Pernambuco

High-Level Roundtable:

Health workers and health goals - what can be learned from a decade of action on Human Resources for Health (HRH) with respect to efforts to achieve the health-related Millennium Development Goals (MDGs) as well as other important national and global health goals? Are we on the right track towards Universal Health Coverage (UHC)?

Mozart Sales, Secretary of Labor and Education Management in Health, Ministry of Health, Brazil

Roberto Tomas Morales Ojeda, Minister of Public Health, Cuba

Mitsuhiro Ushio Chair, Global Health Workforce Alliance Governing Board, Assistant Minister for Global Health, Ministry of Health, Labour and Welfare, Japan

Ariel Pablos-Mendez, Assistant Administrator for Global Health, U.S. Agency for International Development, USA

Pape Gaye, President and CEO IntraHealth, USA

Alexandre Padilha – Words of Welcome by the Host

Minister of Health, Brazil

20:00

Reception hosted by the Government of Brazil

¹ Session details refer to those that had been planned up to the conference starting day, but that last minutes changes may have occurred which are not captured here.

DAY TWO – Monday, 11 November 2013

PLENARY ROOM GUARARAPES AUDITÓRIO

09:00
HIGH-LEVEL
ROUNDTABLE
09:30 – 11:00

Overview and interviews from previous day and outline of today's events – Ghida Fakhry, former News and Programmes Anchor for Film on human resources for health challenges Al Jazeera English

Matching health workforce production to population needs and expectations: do we have the right quantities, qualities and skill mix to move health systems faster towards universal health coverage?

Hussein Mwinyi, Minister of Health and Social Welfare, United Republic of Tanzania;
Fred Jachan Omach, Minister of State for Finance Planning and Economic Development, Uganda;
Mongkol Na Songkhla, Chair, National Human Resources for Health Commission, Thailand;
Agnes Soucat, Director for Human Development, African Development Bank, Tunisia
Lead Organizer: WHO/GHWA; Moderator: Ghida Fakhry, former News and Programmes Anchor for Al Jazeera English

Room	AUDITÓRIO TABOÇAS 1	AUDITÓRIO TABOÇAS 2	AUDITÓRIO BRUM	TEATRO BEBERIBE	AUDITÓRIO RIBEIRA	
SESSIONS 11:30 – 13:00	Planning and forecasting health workforce requirements for UHC <i>Organizers: WHO</i>	Multisectoral partnerships, investment and policy dialogue towards strategic HRH decision-making <i>Organizers: WHO</i>	Towards sustainability in financing: macroeconomic policies, the role of external aid and the implications on HRH <i>Organizers: World Bank</i>	Transforming and scaling up health professional education and training <i>Organizers: Prince Mahidol Award Conference</i>	Applying a labour market lens to HRH <i>Organizers: WHO and World Bank</i>	Commitments WHO Member States, agencies, entities and institutions will present their Human Resources for Health (HRH) commitments' pathways to advance the HRH agenda in countries. <i>Moderator: Carissa Etienne, Director, PAHO</i>
Lead Organizer: WHO						
Moderator	James Campbell Director, ICS INTEGRARE (Instituto de Cooperación Social Integrare), Spain	Timothy Evans Director, Health, Nutrition and Population, World Bank	Agnes Soucat Director for Human Development, African Development Bank, Tunisia	Vicharn Panich Health Professional Education Reform, Chairman of Mahidol University Council, Thailand	Ok Pannenberg Chairman, Supporting Medical & Health Professionals' Schools, USAID/CapacityPlus	
Speakers	Epiphane Ngumbu Mabanza Director, HRH, Ministry of Public Health, Democratic Republic of the Congo Marieta Cutiño Rodríguez Deputy Minister, Ministry of Cuban Public Health, Cuba Michel Van Hoegaerden Programme Manager, EU Joint Action on Health Workforce Planning and Forecasting, Belgium Charles Godue Unit Chief, Human Resources for Health, Pan American Health Organization	Amir Aman Hagos State Minister, Federal Ministry of Health, Ethiopia Fred Omach Minister of State for Finance, Uganda Osamu Kunii Head of Strategy, Investment and Impact Division, The Global Fund Patrick Kadama Executive Director a.i, African Platform on Human Resources for Health, Uganda	Abdul Baser Sarwar Deputy Minister of Financial and Administration, Ministry of Public Health, Afghanistan Ambassador Leslie Rowe Ambassador, Global Health Diplomacy, U.S. State Department, USA Remco van de Pas Health Policy Adviser, Wemos, Netherlands André Mama Fouda Minister of Public Health, Cameroon Joana Godinho Sector Manager for Health, Latin America and Caribe, World Bank	Wanicha Cheunkongkaew Health Professional, Faculty of Medicine Siriraj Hospital, Vice President for Education, Mahidol University, ANHER, Thailand Patricia J Garcia Dean of the School of Public Health and Administration, Cayetano Heredia University, Peru Marie-Paule Kieny Assistant Director-General, Health Systems and Innovation, WHO Mabel Nangami Senior Lecturer, Africa Health Leadership and Management Network, Kenya Francis Omaswa Executive Director, ACHEST, Uganda	Mutinta Musonda Technical Support Specialist, Ministry of Health, Zambia Gustavo Nigenda Fellow at the International Development Research Center of Canada Edson Araujo Economist, Health, Nutrition and Population, World Bank Michael Schoenstein Economist, Directorate for Employment, Labour and Social Affairs, OECD Ties Boerma Director, Health Statistics and Information Systems, WHO	<ul style="list-style-type: none"> • Argentina • Belize • Brazil • Costa Rica • Dominican Republic • El Salvador • Guatemala • Haiti • Panama • Paraguay • Suriname • Uruguay • Consejo de Ministros de Salud de Centroamérica y República Dominicana • Chile • Colombia • Ecuador • Peru • Organismo Andino de Salud Convenio Hipólito Unzué <p>* This list might be amended with additional presentations of commitments if required.</p>
13:00 – 14:30	Lunch Break	LAUNCH OF THE WHO GUIDELINES "Transforming and scaling up health professionals' education and training"				

HIGH-LEVEL ROUNDTABLE	Social needs and the regulatory role of the State					
14:30 – 16:00	Mozart Sales, Secretary of Labor and Education Management in Health, Ministry of Health, Brazil; Gabriel Yedlin, Secretary of Regulation, Health Policies, Ministry of Health, Argentina; Jean-Marc Braichet, Chef de Cabinet, Ministry of Social Affairs and Health, France; Giovanni Leonardi, Director General, Directorate General for Health Professions and Human Resources, National Health Service, Ministry of Health, Italy; Lead Organizer: WHO/GHWA; Moderator: Ghida Fakhry, former News and Programmes Anchor for Al Jazeera English					
Room	AUDITÓRIO BRUM	TEATRO BEBERIBE	AUDITÓRIO RIBEIRA	AUDITÓRIO TABOCAS 1	AUDITÓRIO TABOCAS 2	
SESSIONS 16:30 – 18:00	Comparative analysis of regulatory frameworks <i>Organizers: Brazil</i>	Cultivating excellence: regulation of the institutions in charge of education and training of health workers <i>Organizers: Brazil</i>	Professional autonomy and social expectations <i>Organizers: Brazil</i>	Building collaborations and synergies between health professions: practice within full scope of education and training <i>Organizers: World Health Professions Alliance</i>	The balancing act of regulating HRH migration <i>Organizers: WHO</i>	Commitments WHO Member States, agencies, entities & institutions will present their Human Resources for Health (HRH) commitments' pathways to advance the HRH agenda in countries.
Lead Organizer:	Govt of Brazil					
Moderator	Sameen Siddiqi Director Health Systems and Services, Eastern Mediterranean Regional Office, WHO	Peter Johnson Director of Global Learning Office, JHPEIGO, USA	Nisia Lima Vice President, Oswaldo Cruz Foundation, FIOCRUZ	Brenda Myers Secretary General, World Confederation for Physical Therapy, United Kingdom	Peggy Clark Executive Director, Aspen Global Health and Development, USA	Moderator: Sigrun Møgedal, Special Adviser, Norwegian Knowledge Centre for the Health Services, Norway
Speakers	Roberto Tomas Morales Ojeda Minister of Public Health, Cuba Fernando Menezes Deputy Secretary of Labour and Education Management in Health, SGTES-MS, Brazil Teresa Campos Garcia Advisor, International Projects on Innovation and Professional Development and Training, Andalusia, Spain Felix Rigoli Chief of Health Systems, Pan American Health Organization, Brazil	Yit Sunnara Undersecretary of State, Ministry of Health, Kingdom of Cambodia Francisco Campos Executive Secretary, Open University of Brazil's National Health System, Board Member Global Health Workforce Alliance Stefan Lindgren President, World Federation of Medical Education, Denmark Carlos Rodrigues da Silva Filho Professor, Faculty of Medicine of Marília, Brazil Jorge Alejandro Villavicencio Alvarez Minister of Public Health and Social Assistance, Guatemala	Hannah Kimemiah Director of Human Resources Management, Ministry of Health, Kenya David Benton CEO, International Council of Nurses, Switzerland Nicolau Sábado Girardi Centre for Education in Public Health, Federal University of Minas Gerais, Brazil Charles Godue Unit Chief, Human Resources for Health, Pan American Health Organization	Luc Besançon General Secretary and CEO, International Pharmaceutical Federation, Netherlands José Luiz Gomes do Amaral World Medical Association, Brazil Jean-Marie Moore Director, Center for Health Workforce Studies, State University of New York at Albany, USA Judith Shamian President, International council of Nurses, Canada Nermin Yamalik Counselor, World Dental Federation, Turkey	Ivy Lynn Bourgeault Executive Secretary, Canadian Institutes of Health Research, University of Ottawa, Canada Zafar Ullah Chaudhry President, College of Physicians and Surgeons, Pakistan Irene Glinos Technical Officer, WHO European Centre for Health Policy, Belgium David Weakliam Programme Lead, HSE Global Health Programme, Health Service Executive (HSE), Ireland Linda Mans WEMOS Foundation	<ul style="list-style-type: none"> • Djibouti • Egypt • Iran • Lebanon • Libya • Oman • Pakistan • Palestinian Authorities • Somalia • Yemen • College of Physicians & Surgeons, Pakistan • Bangladesh • Bhutan • Indonesia • Maldives • Myanmar • Nepal • Sri Lanka <p>* This list might be amended with additional presentations of commitments, if required.</p>
18:30	LAUNCH OF THE REPORT: "A universal truth: no health without a workforce – a flagship report outlining progress and challenges to date, and a forward-looking vision for HRH development over the next decades Ceremony – followed by a reception Global Health Workforce Alliance Awards 2013 Presentation					

DAY THREE –Tuesday, 12 November 2013

PLENARY ROOM GUARARAPESAUDITÓRIO

09:00 Overview and interviews from previous day and outline of today's events – Ghida Fakhry, former News and Programmes Anchor for Al Jazeera English

HIGH-LEVEL
ROUNDTABLE **Deployment, retention and management: sustaining a high performing workforce in the stride towards UHC**

09:30 – 11:00 Jonathan Quick, President and CEO, Management Sciences for Health, USA;
Kedar Bahadu Adhikari, Joint Secretary, Ministry of Health and Population Government of the Federal Democratic Republic of Nepal;
Dilorom Sadykova, Advisor of the Minister of Health, Ministry of Health, Tajikistan;
Carissa Etienne, Director, Pan American Health Organization;
Miriam Were, Co-Founder and Trustee, Uzima Foundation, Board Member Global Health Workforce Alliance, Kenya;
Naoyuki Kobayashi, Deputy Director, General Human Development Department, JICA, Japan
Lead Organizer: WHO/GHWA; Moderator: Ghida Fakhry, former News and Programmes Anchor for Al Jazeera English

Room	TEATRO BEBERIBE	AUDITÓRIO TABOCAS 1	AUDITÓRIO BRUM	AURITORIO RIBEIRA	AUDITÓRIO TABOCAS 2	
SESSIONS 11:30 – 13:00	Health workforce deployment –addressing geographical imbalances <i>Organizer: World Bank</i>	Harnessing the potential of public, private and not-for-profit institutions' interaction to advance HRH <i>Organizer: World Bank</i>	Measuring health workforce performance <i>Organizer: World Bank</i>	Integrated service delivery models: implications on human resources for health <i>Organizers: WHO</i>	Innovations in HRH information systems <i>Organizers: WHO</i>	Commitments WHO Member States, agencies, entities & institutions will present their Human Resources for Health (HRH) commitments' pathways to advance the HRH agenda in countries. <i>Moderator: David Sanders, Professor and founding Director of the School of Public Health at the University of the Western Cape, (UWC), South Africa</i>
Lead Organizer: World Bank						
Moderator	Ok Pannenberg Chairman, Supporting Medical & Health Professionals' Schools, USAID/CapacityPlus	Timothy Evans Director, Health, Nutrition and Population, World Bank	Magnus Lindelow Economist, World Bank	Jim Campbell Director, ICS INTEGRARE (Instituto de Cooperacion Social Integrare), Spain	Ties Boerma Director, Health Statistics and Information Systems, WHO	<ul style="list-style-type: none"> • Cambodia • Ireland • Republic of Moldova • Afghanistan • Sudan • Nigeria • Ivory Coast • Senegal • IntraHealth • Community Health Workers (CHWs) • French speaking midwives project • International Pharmaceutical Federation (FIP) • Swasti
Speakers	<p>Nicolau Sábado Girardi Medical Doctor, Centre for Education in Public Health, Federal University of Minas Gerais, Brazil</p> <p>Luis Huicho National University of San Marcos, Peru</p> <p>Alfredo Vergara Branch Chief, Health System Strengthening, CDC and Prevention, Mozambique</p> <p>Mame Abdoulaye Gueye Deputy Minister, Ministry of Health, Senegal</p> <p>Carmen Dolea Technical Officer, Health Systems Governance and Financing, WHO</p> <p>Christopher Herbst Health Specialist, World Bank</p>	<p>Jean Marc Braichet Chef de Cabinet, Ministry of Social Affairs and Health, France</p> <p>Junhua Zhang Deputy Director-General, Health Human Resources Development Center, Ministry of Health, China</p> <p>Jose Luiz Bonamigo Brazilian Medical Association, Brazil</p> <p>Peter Ngatia Director, Capacity Building, African Medical and Research Foundation, Kenya</p> <p>Agnes Soucat Director for Human Development, African Development Bank, Tunisia</p> <p>Mary O'Neil Management Sciences for Health</p>	<p>Dorothee Akoko Kinde Gazard Minister of Health, Benin</p> <p>Alice Belita Research Officer, Kenya Medical Research Institute, Kenya</p> <p>Alfredo Fort Director, Monitoring and Evaluation, IntraHealth, USA</p> <p>Edson Araujo Economist, Health, Nutrition and Population, World Bank</p> <p>Angelica Sousa Technical Officer, Health Systems Policies and Workforce, WHO</p>	<p>Marilyn DeLuca Adjunct Associate Professor, University of New York, USA</p> <p>Luiz Ruben Duran Fontes Undersecretary for Integration and Development of Mexican Health System, Ministry of Health, Mexico</p> <p>Jacques Girard Associate Dean, Population Health, Laval University, Canada</p> <p>Hideomi Watanabe Dean, Gunma University Graduate School of Health Sciences, Japan</p> <p>Sigrun Møgedal Special Adviser at Norwegian Knowledge Centre for the Health Services, Norway</p>	<p>Martinho Dgedge Inspector General of Health, National Director of Human Resources for Health, Ministry of Health, Mozambique</p> <p>José Concha Góngora School of Public Health, University of Chile, Chile</p> <p>Boun Nhem Ekkarat Medical Doctor, Department of Health Personnel, Management Division, Ministry of Health, Lao People's Democratic Republic</p> <p>Dykki Settle Director, Health Workforce Informatics, IntraHealth, USA</p> <p>Ansa Ogu Director Health Workforce Planning, Research and Statistics, Federal Ministry of Health, Nigeria</p>	<p>This sessions will continue after lunch, 14:30-16:30</p> <ul style="list-style-type: none"> • AMREF • AEMRN network • CHESTRAD • Health Workers for All • Health Workers Count • HIFA Health Information for All Institute for Collaborative Development • Mothers2Mothers • The voices of women health workers in India • THET • World Vision • Wonca Working Party on Rural Practice <p>* this list might be amended with additional presentations of commitments, if required.</p>

13:00 – 14:30	Lunch Break LAUNCH OF PUBLICATION “Moving towards universal health coverage by optimizing skills mix: effectiveness and cost-effectiveness of community-based and mid-level health workers”					
HIGH-LEVEL ROUNDTABLE	Empowerment and incentives: harnessing health workers’ voice, rights and responsibilities in moving towards UHC					
14:30 – 16:00	Michael Kidd, President, World Organization of Family Doctors, Thailand; Francis Omaswa, Executive Director, African Centre for Global Health and Social Transformation, Uganda; María Isabel Rodriguez, Minister of Health, El-Salvador; Mariangela Simao, Director of Rights, Gender, Prevention and Community Mobilization, UNAIDS; Margaret Mungherera, President World Medical Association, Uganda Lead Organizer: WHO/GHWA; Moderator: Ghida Fakhry, former News and Programmes Anchor for Al Jazeera English					
Room	TEATRO BEBERIBE	AUDITÓRIO BRUM	AUDITÓRIO TABOCAS 1	AUDITÓRIO TABOCAS 2	AUDITÓRIO RIBEIRA	
SESSIONS 16:30 – 18:00 Lead Organizer: IntraHealth	Health workers’ role in shaping policies <i>Organizers: Frontline Health Workers Coalition</i>	The roles and responsibilities of trade unions in advancing the agenda towards UHC <i>Organizers: Public Services International</i>	Promoting and managing diversity of health workers for UHC <i>Organizers: IntraHealth/ Makerere University</i>	Security, safety, wellbeing and motivation of health workers in difficult contexts <i>Organizers: ILO and WHO</i>	A health workforce responding to citizens’ rights and expectations: paving the way towards UHC <i>Organizers: AMREF and WMA</i>	Commitments WHO Member States, agencies, entities and institutions will present their Human Resources for Health (HRH) commitments’ pathways to advance the HRH agenda in countries. Moderator: Francis Omaswa, Executive Director, African Centre for Global Health and Social Transformation (ACHEST)
Moderator	Mary Beth Powers Campaign Chief, Newborn and Child Survival Campaign, Save the Children	Odile Frank Health Services Officer, Public Services International, France	Kate Tulenko Director, CapacityPlus/ IntraHealth, USA	Elizabeth Adams Director, Professional Development, Irish Nurses & Midwives Organisation, Ireland	Peter Ngatia Director, Capacity Building, African Medical and Research Foundation, Kenya	<ul style="list-style-type: none">• Benin• Burkina Faso• Burundi• Ethiopia• Guinea• Kenya• Liberia• Malawi• Mali• Mozambique• South Sudan• Tanzania• Tanzanian Training Centre For International Health• Togo• Uganda
Speakers	Manuel Ferreira Teixeira Secretary of State for Health, Ministry of Health, Portugal Frances Day-Stirk President, International Confederation of Midwives, Netherlands Shiv Mathur Chair, Asia Pacific Action Alliance on Human Resources for Health (AAAH), India Anne-marie Curat Midwifery National Council, France Ellen Mkondya Senkoro Chief Executive Officer, Benjamin William Mkapa HIV/AIDS Foundation, Tanzania	Judith Kiejda Assistant General Secretary, New South Wales Nurses and Midwives’ Association, Australia Ayuba Wabba President, Medical and Health Workers’ Union of Nigeria Francis Ntalazi Assistant Commissioner for Human Resources for Health, Ministry of Health, Uganda Solange Caetano President, National Federation of Nurses, Brazil	Hagos Godefay Tigray Region Health Bureau Head, Federal Ministry of Health, Ethiopia Ivone Evangelista Cabral Coordinator of the Intersectoral Commission on Human Resources, Brazil Estelle Quain Senior Technical Advisor, Office of HIV/AIDS USAID, USA Constance Newman Senior Team Leader, Gender and Health, IntraHealth, USA	Martin Muita Senior Public Health Coordinator, UNHCR, South Sudan Len Rubenstein Senior Scholar, Johns Hopkins Bloomberg School of Public Health, USA Christiane Wiskow Health Services Specialist, International Labour Organization Edward Kilimba District Medical Officer, United Republic of Tanzania	Emil Agustiono Deputy to the Minister of Coordination for People Welfare, Indonesia Yoswa M Dambisya Senior Professor, University of Limpopo, South Africa Anuradha Jain Advisor, Save the Children, India Julia Tainijoki-Seyer Medical Advisor, World Medical Association, France Eva Maria Ruiz de Castilla International Alliance of Patients’ Organizations, Peru Board Member, Global Health Workforce Alliance	<ul style="list-style-type: none">* this list might be amended with additional presentations of commitments, if required.
18:30	LAUNCH OF WHO BULLETIN THEME ISSUE “From evidence to policy and action: new insights on human resources for universal health coverage” Reception hosted by IntraHealth					

DAY FOUR – Wednesday, 13 November 2013

09:00	Overview and interviews from previous day and outline of today's events- Ghida Fakhry, former News and Programmes Anchor for Al Jazeera English
HIGH-LEVEL ROUNDTABLE	Looking towards 2030 – what is the agenda to make sure the health workforce is the vanguard for UHC?
09:30-11:00	Timothy Evans, Director, Health, Nutrition and Population, World Bank
<i>Lead Organizer: WHO/ GHWA</i>	Lola Dare, Public Health Physician, CEO and Secretary of the Governing Council, Centre for Health Sciences Training, Research and Development (CHESTRAD)
	Gwen Malegwale Ramokgopa, Deputy Minister of Health, South Africa
	Gaylor Hoskins, Clinical Research Fellow and Save the Children Campaigner
11:00-11:30	Break
11:30-13:00	Outcome document and closing remarks
	Marie-Paule Kieny, Assistant Director-General, Health Systems and Innovation, World Health Organization
	Mitsuhiro Ushio, Chair, Global Health Workforce Alliance Governing Board, Assistant Minister for Global Health, Minister's Secretariat, Ministry of Health, Labour and Welfare, Japan
	Ministry of Health Brazil
	Pape Gaye, President and CEO, IntraHealth, USA
	Ruediger Krech, Director, Office of the Assistant Director-General, Health Systems and Innovation, World Health Organization

DAY FIVE – Thursday, 14 November 2013

Organized Field Visits

Annex 3. List of side events

9-Nov

SE36: International health workforce mobility and recruitment: Can bilateral agreements help managing? World Health Organization Regional offices for Europe and Western Pacific	SE3: HRH for UHC: Where are the CSOs in the Debate? Health Workforce Advocacy Initiative	SE9: Addressing the eye health workforce crisis in PALP - Sightsavers	SE13: Human Resources for Health Policies for Universal Health Coverage: Understanding Health Workforce Responses in a Dynamic Labour Market Context - World Bank	SE-BRAZIL-1: Contributions Policy Popular Education in Health Policy for the Management of Labor and Health Education in SUS: New Methodology for the democratization of labor relations – Secretary of Management and Education in Health / Ministry of Health of Brazil	SE14: Strengthening Health Worker Skills through Partnership Models - Save the Children
SE2: Universal health coverage – improving access and outcomes through responsible medicines use - International Pharmaceutical Federation	SE6: Achieving HRH Commitments: Lessons learned and resources from CapacityPlus - CapacityPlus / The HRH agenda: How is it advancing progress in Africa? IntraHealth International	SE10: Increasing the Quantity, Quality, and Relevance of the Health Workforce for Universal Health Care: Country examples of transformative scale up of health professional education - Jhpiego	SE15: Developing Leadership for Managing and Governing Universal Health Care (UHC): Innovations and Evidence from the Field - Management Sciences for Health	SE-BRAZIL-2: Discussing Policies of Labor Management in Health: The challenges of the implementation of the NHS Careers – Secretary of Management and Education in Health / Ministry of Health of Brazil	SE22: Health Workforce Diagnostic Platform: responding to HRH challenges - World Health Organization
SE4-SE5: Strengthening the role of Community Health Workers in Achieving Universal Healthcare Coverage: Moving from Fragmentation to Synergy - USAID / Frontline Health Workers Coalition	SE7: The CLEAR toolkit: Helping health workers tackle the social causes of poor health - The CLEAR Collaboration	SE17: Presentation of European Union financed Action: “Migration of Health Professionals between Latin America and Europe. Analysis and Generation of Opportunities for Shared Development - MPDC”. Presentation of the Iberoamerican Network on the Migration of Health Professionals – RIMPS - Andalusian School of Public Health (Escuela Andaluza de Salud Pública – EASP)	SE20: HealthWISE - Work Improvement in Health Services - International Labour Organization / World Health Organization	SE-BRAZIL-3: Strengthening the quality of clinical practice and training from health workforce to enable developing universal health coverage (UHC) – British Medical Journal / Ministry of Health of Brazil	SE18: The global challenge of health workforce education, training and migration: The role of a new generation of Health Workers - International Federation of Medical Students' Associations
SE4-SE5: Strengthening the role of Community Health Workers in Achieving Universal Healthcare Coverage: Moving from Fragmentation to Synergy - USAID / Frontline Health Workers Coalition	SE8: Promising Practices/New Tools: Strengthening the Health Workforce - Johnson & Johnson / Improving the Health Care Workforce: The Role of Academic Institutions - Johnson & Johnson	SE32: Challenges of Midwifery training: lessons learnt from improving the midwifery training in the French speaking countries in Africa - Maternal, Newborn and Child health worker - HRHCoP SE31: The mobile (r) evolution: learning on the run for health workers in Africa - AMREF	SE20: HealthWISE - Work Improvement in Health Services - International Labour Organization / World Health Organization	SE-BRAZIL-4: Health Professionals and Millenium Development Goals – Brazilian Association of Public Health - ABRASCO	SE19: The strengthened African Platform on Human Resources for Health (APHRH); – A business Meeting - African Platform for Human Resources for Health (APHRH) / Scale up of Medical Education in Africa towards a responsive skill mix for Universal Health Coverage - APHRH

10-Nov

SE21: Achieving Universal Health Coverage? Not Without Associate Clinicians. Time to Leverage North - South Partnerships - [New York University](#)

SE23: Forecasting and planning of HRH to achieve universal coverage of maternal and neonatal services - [Royal Tropical Institute](#)

SE26: Getting things moving: the key role of the rehabilitation workforce in the changing health landscape - [Handicap International](#)

SE24: Making the most of your HRH investments: Using the WISN tool for determining evidence-based staffing requirements to support HRH planners and policy makers - [World Health Organization](#)

SE-BRAZIL-5: PMAQ – Qualification Strategy for Primary Care in SUS: Dialogues between Models of Health Care Policy and Management Health Work – [Secretary of Management and Education in Health / Ministry of Health of Brazil](#)

SE16: Rising to the challenge of improving human resources for health supply chains – [The People that Deliver initiative](#)

SE25: Reforming Medical Professional Training and Regulations in Libya post revolution - EU - [Libyan Healthcare System Strengthening Programme \(EU-LHSS\)](#)

SE27: Sound PBF Management as a Step to Universal Health Coverage - Elizabeth Glaser Pediatric AIDS Foundation; Motivating and Retaining Staff to Achieve Universal Health Coverage - a Performance-Based Approach - [Institute for Collaborative Development \(ICD\)](#)

SE28: How to Recruit and Retain Health Workers in Rural and Remote Areas in Developing Countries – using discrete choice experiment to inform policy design and implementation - [World Health Organization / World Bank](#)

SE-BRAZIL-6: The National Board of Permanent Trade SUS (MNNP-SUS) as a tool for democratization of labor relations in the Brazilian Health System (SUS) and the role of protocols MNNP-SUS in the implementation of the Policies of Labor Management in Health – [Secretary of Management and Education in Health / Ministry of Health of Brazil](#)

13-Nov

SE29: PEPFAR's Contribution to HRH for Universal Health Coverage: Strengthening HRH through a "Vertical" Program - [Office of the U.S. Global AIDS](#)

SE30: Improving health worker in-service training effectiveness, efficiency and sustainability: Harvesting good practices and lessons learnt - [USAID/URC](#)

SE37: Closing the Mental Health Gap: Strengthening Human Resources for Health to Advance Universal Health Coverage - [International Medical Corps](#)

SE33-SE34: Strengthening the Role of Human Resources in Nursing and Midwifery in Achieving Universal Health Coverage: Challenges and Possibilities - [Pan American Health Organization / World Health Organization](#)

SE12: Advances in strengthening health workforce information, monitoring and evaluation at the national level - [Health Workforce Information Reference Group](#)

SE35: SwitchPoint for Human Resources for Health: Private Sector Innovations - [IntraHealth International, Inc.](#)

SE38: Launch of the the French-Speaking Midwives Network (Réseau des Sages-femmes Francophones) - [Maternal, Newborn and Child health worker / HRHCoP](#)

SE11: Improving the maternal newborn services by retaining skilled birth health workers in the rural and remote areas [JICA](#)

SE33-SE34: Strengthening the Role of Human Resources in Nursing and Midwifery in Achieving Universal Health Coverage: Challenges and Possibilities - [Pan American Health Organization / World Health Organization](#)

SE12: Advances in strengthening health workforce information, monitoring and evaluation at the national level - [Health Workforce Information Reference Group](#)

Forum snapshots¹



¹ All photos under Forum snapshots are from the GHWA collection.











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