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Swiss Contributions to Human Resources for Health Development in Low- and Middle-Income Countries

Current Practices and Possible Future Orientations

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Preamble

In 2006, Switzerland established a foreign policy on health matters with the aim of coordinating national and international health policy (EDI and EDA, 2006). The policy addresses international migration of health personnel, to satisfy the demand of labour markets in high-income countries and emerging economies without harming human resource and health sector development in low- and middle income countries. The international migration of health workers is increasingly recognised as a priority issue underlined by the World Health Assembly's adoption of a code of conduct for the ethical recruitment of health workers in May 2010.

In 2008, the inter-departmental conference of the Swiss Confederation on foreign health policy (IK-GAP) grounded an inter-departmental working group to evaluate the situation in Switzerland and determine to what extent Switzerland contributes to global health workforce shortages. The group unanimously agreed that there is a great need for more information.

Consequently, in October 2009, IK-GAP mandated three different institutions to take an in-depth look into the situation from three distinct angles. A first report, established by the Swiss Health Observatory (Obsan), provides a statistical and quantitative description of the immigration of health professional to Switzerland (Jaccard Ruedin and Widmer, 2010). This corresponds to a preamble on the topic of migration of health workers. The results of this study revealed the magnitude of the problem in Switzerland and allowed the active participation of Switzerland in the elaboration of international guidelines for the collection of statistical data.

The other two mandates worked under the assumption that even if Switzerland decreases its dependency on health workers trained abroad, the country will continue to rely - in the mid term - on immigrant workers to supplement its workforce. The duration of training health professionals in Switzerland is long and numbers of staff currently trained is too low to satisfy the need.

These two mandates also considered the principles listed in the WHO code of conduct for the ethical recruitment of health workers which outlines that both health systems of source and destination countries should benefit from international migration of health staff.

This report thus documents international cooperation practices of Switzerland aiming to strengthen human resource for health development in low- and middle-income countries. The third report, drafted by the Swiss Conference of Cantonal Health Directorates analyses, through a qualitative study, opinions and positions of employers and immigrant health workers (Huber and Mariéthoz, 2010).

The three reports are available on the websites of the Swiss Federal Administration (http://www.deza.admin.ch/de/Home/Themen/Gesundheit), the Swiss Conference of Cantonal Health Directorates (http://www.gdk-cds.ch/296.0.html) and Obsan (http://www.obsan.admin.ch/bfs/obsan/de/index/05/publikationsdatenbank.html?publicationID=4081) . A fact-sheet focusing on key issues and conclusions of the three studies is also available at http://www.deza.admin.ch/de/Home/Themen/Gesundheit.

Abbreviations

AMO	Assistant Medical Officer
BiH	Bosnia & Herzegovina
BBT	Bundesamt für Berufsbildung und Technologie
BMZ	Federal Ministry for Economic Cooperation and Development
CHF	Swiss Currency
CHPS	Centre for Health Policies and Services
COST	European Cooperation in Science and Technology
CRED	Centrul Romano-Elvetian pentru Dezvoltarea Sistemului de Sanatate (Centre for Health Sector Development)
CSRS	Centre Suisse de Recherches Scientifiques Abidjan
DHD	District Health Departments
DMO	District Medical Officer
DPG Health	Development Partners Group for Health
ERA	European Research Area
ERC	European Research Council
EU	European Union
EVD	Eidgenössisches Volkswirtschaftsdepartement
FDFA	Federal Department of Foreign Affairs
FOM	Federal Office for Migration
FOPH	Federal Office of Public Health
FP	European Framework Programme
HAS	Hôpital Albert Schweitzer
HRH	Human Resources in Health
HRH Task Force	Human Resources for Health Task Force
ICN	International Council of Nurses
IHP	International Health Partnership
IMCI	Integrated Management of Childhood Illness
KTI	Kommission für Technologie und Innovation
MD	Medical Doctor
MDGs	Millennium Development Goals
MMNS	Medicus Mundi Network Switzerland
MOHSW	Ministry of Health and Social Welfare
NGO	Non-Governmental Organisation
Norad	Norwegian Agency for Development Cooperation
ODMT	Operational District Management Team
OECD	Organisation for Economic Co-operation and Development
PBCLSM	Pius Branzeu Centre of Laporoscopic Surgery and Microsurgery
ReMMSy	Regional Emergency Medical Services Systems
RNP	Research Networking Programme
RoNeonat	Romanian-Swiss Neonatology Project
SCIH	Swiss Centre for International Health
sciexNMSch	Scientific Exchange Programme between Switzerland and the New Member States of the EU
SCOPES	Scientific cooperation between Eastern Europe and Switzerland
SDC	Swiss Agency for Development and Cooperation
SECO	State Secretariat for Economic Affaires
SNSF	Swiss National Science Foundation
SRC	Swiss Red Cross
STI	Swiss Tropical Institute
TTCIH	Training Centre for International Health in Ifakara, Tanzania
VHSG	Village Health Support Groups
WHO	World Health Organisation

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Executive Summary/Zusammenfassung

Executive Summary

Recent years have seen a dramatic increase in international commitment to health in low and middle income countries and the momentum derived from the MDGs has, in turn, helped generate an expansion of resources for the health sector. Aid disbursements for health nearly doubled between 2003 and 2006, reflecting both increased commitments from bilateral donors and contributions through Global Health Initiatives (GHIs). Although this tendency may be reversed in the coming years due to the global financial crisis and bilateral donors decreasing their allocations to health sector development, the availability and performance of human resources for health (HRH) have emerged as key factors in further development of the health sector. It is widely acknowledged that chronic shortage of well-trained health workers in low- and middle-income countries affect the efficiency and equity with which available resources are used and, in some cases, posing an absolute constraint to service expansion. At the same time, there is growing concerns that high-income countries are will not be able to respond to the growing demand for doctors and nurses in the next 20 years.

With this background, the **objectives of this review are to**:

- Establish an inventory of the cooperation practices of Switzerland with middle- and low-income countries in the area of human resource development, including two short country case studies of Swiss cooperation practices in Romania and Tanzania
- Review human resource development cooperation practices of two European countries (Germany and Norway) in light of their similarity to Switzerland
- Establish recommendations on cooperation approaches for the retention of health workers in their country of origin and "next steps" for Swiss human resource development cooperation practices

To provide answers for these objectives four **methods** were used: (i) review and analyses of related background and key documents, including the screening of web information and other documentation sources on Swiss development cooperation to establish an inventory of health and HRH activities; (ii) structured telephone interviews with key representatives of the Swiss development cooperation covering NGOs as well as governmental actors of relevant agencies; (iii) open telephone interview with key representatives of the Norwegian (NORAD) and German Development Cooperation (GTZ) (Federal Ministry for Economic Cooperation and Development (BMZ)); and (iv) questionnaires sent to representatives of the coordination offices of the Swiss Agency for Development and Cooperation (SDC).

Swiss governmental and non-governmental actors mentioned the following five problems areas in HRH development most frequently: (1) low salary levels and lack of monetary incentives; (2) poor working conditions; (3) inadequate staffing of health services; (4) ‘brain drain’ and migration from low- and middle-income countries; and (5) absence of, or weak HRH policies.

The inventory of Swiss cooperation practices shows that Switzerland, through its development assistance, supports a substantial number of small- and large-scale initiatives, and projects which focus on changing the conditions for health care workers in their source countries. This includes improving working conditions and career development prospects, enhancing training capacities both at graduate and post-graduate level and through continuous education measures, and bettering physical working environments and infrastructures. The study is however, not in a position to

quantify absolute and relative financial investments of Swiss actors and institutions in HRH development in source countries, as budgets of development projects typically spread over different calendar years, are often not tied to fiscal years and are typically part of broader health systems strengthening projects and programs which do not specifically disclose budget lines related to human resources.

Key findings/messages emerging from this study:

1. The importance of investing in human resource development in low- and middle-income countries as an integral part of efforts to strengthen health systems and prevent health worker migration is acknowledged by a broad range of Swiss governmental and non-governmental actors.
2. Swiss investments in human resource development are substantial and an integral element of broader health systems strengthening efforts. Typically there are however no stand-alone investments in human resource development or the prevention of migration.
3. Swiss investments in human resource development are channelled through different mechanisms (SDC, SNSF, Swiss Cohesion Funds, SECO, NGOs, etc.). They are not well integrated into a broader and comprehensive Swiss health policy for cooperating with low- and middle-income countries or into an overall strategy for combating health worker migration.
4. The Norwegian and German experience indicate to Switzerland:
    a. the importance of promoting synergies and close collaboration of the different agencies and their aid modalities for a given country
    b. the importance of multi-ministerial approaches for policy coherence between domestic and foreign development policies and development of action plans
    c. the need for a strong presence in the international forum (e.g. Global Health Workforce Alliance, World Health Organization)
    d. the relevance for defining HRH problems as a global health priority in countries' development policies

    If more emphasis is given to this, the effectiveness, efficiency and sustainability of Swiss investments can be enhanced
5. While long term investments in health sector development are a major strength of Switzerland, it runs the risk of being less visible than other donors and agencies. In an increasingly competitive environment creating a clear Swiss development cooperation profile that makes the varying strengths of the different governmental and non-governmental organizations more widely known is important.
6. As there is little evidence available on which of the "Swiss" strategies really work for human resource development in the health sector, there is potential to focus on a systematic capitalisation and dissemination of country-based and regional experiences, and to monitor and better measure the impacts of Swiss domestic and foreign investments.

If Switzerland is committed to streamlining cooperation approaches to the retention of health workers in their country of origin, then Switzerland needs to assure coherence among its actors be inserted into a broader and comprehensive Swiss health policy for cooperating and an overall strategy for combating health worker migration and retention in the source country. Bilateral treaties to steer health worker flows that are more beneficial to source countries could be promoted. Although, not an explicit form of cooperation modality today, the Swiss development cooperation can support circulatory migration, acknowledging that costs of running such schemes are high and typically only target specific categories of health professionals. The Swiss development cooperation may also more systematically engage health staff to return (temporarily) to their country of origin under special arrangements that will not penalize them upon their return to Switzerland.

Zusammenfassung

In den vergangenen Jahren und angesichts der Milleniumsziel konnte ein verstärktes internationales Engagement im Gesundheitssektor der Niedrigeinkommensländer (LIC) und Länder mit mittleren Einkommen (MIC) beobachtet werden. Mittelzuwendungen für den Bereich Gesundheit haben sich von 2003 bis 2006 fast verdoppelt und spiegeln sowohl die wachsende Verantwortung der bilateralen Geber als auch die Beiträge der Global Health Initiative (GHIs) wieder. Obgleich sich dieser Trend in den kommenden Jahren aufgrund der globalen Finanzkrise und durch geringere Investitionen der bilateralen Geber in den Gesundheitssektor möglicherweise gegenläufig entwickeln wird, stellen die Verfügbarkeit und Leistungsfähigkeit von Gesundheitspersonal zentrale Schlüsselfaktoren für eine weitere Entwicklung und Stärkung des Gesundheitssektors dar. Es herrscht weitgehende Übereinstimmung darüber, dass ein chronischer Fachkräftemangel an gut ausgebildetem Gesundheitspersonal in Ländern mit niedrigen und mittleren Einkommen eine effiziente und gerechte Nutzung von vorhandenen Ressourcen einschränkt und in manchen Fällen sogar eine Ausdehnung der Gesundheitsdienstleistungen erheblich behindert. Gleichzeitig wird mit zunehmender Besorgnis beobachtet, dass einkommensstarke Länder in den nächsten 20 Jahren möglicherweise nicht mehr in der Lage sein werden, den wachsenden Bedarf and Ärzten und Krankenschwestern zu decken.

Vor diesem Hintergrund sind die Ziele der vorliegenden Studie:

- Erstellung einer Bestandsaufnahme der Kooperationsmodalitäten zwischen der Schweiz und ressourcenschwachen Ländern im Bereich Entwicklung und Stärkung von Gesundheitspersonal. Diese Bestandsaufnahme schliesst auch zwei Länderstudien (Rumänien und Tansania) ein.
- Analyse von Kooperationsstrategien im Bereich Entwicklung von Gesundheitspersonal anhand von zwei europäischen Länderstudien (Deutschland und Norwegen), um Rückschlüsse auf ihre Umsetzbarkeit im Rahmen des Schweizer Kontexts ziehen zu können.
- Formulierung von Empfehlungen für Kooperationsmodalitäten, die sowohl einen Verbleib von medizinischen Fachkräften in den Herkunftsländern sowie zukunftsträchtige Kooperationsstrategien der Schweiz im Bereich Entwicklung von Gesundheitspersonal berücksichtigen.

Um diese Zielsetzungen zu erfüllen, wurden vier Methoden angewendet: (i) Literaturrecherche und -analyse von relevantem Informationsmaterial und Schlüsseldokumenten (inkl. web-basierten Informationen sowie Dokumenten von relevanten Akteuren der schweizerischen Entwicklungszusammenarbeit), um ein Inventar ihrer Aktivitäten im Gesundheitsbereich zu erstellen; (ii) strukturierte Telefoninterviews mit Repräsentanten von relevanten Akteuren der schweizerischen Entwicklungszusammenarbeit unter Einbeziehung von staatlichen und nichtstaatlichen Akteuren, (iii) Telefoninterviews mit Repräsentanten von Schlüsselakteuren der norwegischen (NORAD) und der deutschen Entwicklungszusammenarbeit (Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung BMZ)); und (iv) Auswertung eines zugestellten Fragebogens für Repräsentanten von relevanten Organisationen der schweizerischen Entwicklungszusammenarbeit.

Die Umfrageergebnisse zeigen auf, dass die folgenden Kernprobleme des Gesundheitssektors am häufigsten von den befragten schweizerischen staatlichen und nicht-staatlichen Akteuren genannt wurden: (1) niedrige Löhne und fehlende monetäre Anreize; (2) schlechte Arbeitsbedingungen; (3) Personalmangel; (4) Braindrain und Migration; und eine (5) fehlende oder schwache HRH Politik.

Die Analyse der untersuchten Schweizer Kooperationsmodalitäten verdeutlicht, dass die Schweiz eine erhebliche Anzahl an Klein- und Großinitiativen bzw. Projekten unterstützt, die die Arbeitsbedingungen von Gesundheitspersonal in Herkunftsländern verbessern. Diese Zielsetzung soll insbe-

sondere durch attraktivere Berufsperspektiven und Ausbildungskapazitäten auf gradualer und postgradualer Ebene, einem umfangreicheren Weiterbildungsangebot sowie durch eine modernisierte Infrastruktur erreicht werden. Die Studie erlaubt es jedoch nicht, Rückschlüsse über den Umfang von absoluten und relativen Finanzinvestitionen zur Förderung von HRH in den Herkunftsländern durch Schweizer Akteure und Institutionen, zu ziehen. Die Gründe hierfür liegen einerseits in der Budgetverteilung für Projekte der Entwicklungszusammenarbeit, die sich häufig über mehrere Kalenderjahre erstrecken und andererseits in der besonderen Thematik der HRH Förderung. HRH Förderung stellt normalerweise nur eine Teilaktivität eines breit gefassten Gesundheitssystemprojektes dar wofür es häufig keine spezifische Haushaltslinie gibt.

Schlüsselergebnisse dieser Studie sind:

1. Schweizer Investitionen zur Förderung der HRH in Ländern mit niedrigem und mittlerem Einkommen werden als wichtige und integrale Bemühungen zur Stärkung von Gesundheitssystemen und zur Prävention von Abwanderung von medizinischem Fachpersonal gesehen. Eine Vielzahl von staatlichen und nicht-staatlichen Schweizer Akteuren räumen ihnen deshalb einen hohen Stellenwert ein.
2. Schweizer Investitionen zur Förderung von HRH sind substantiell, werden aber eher selten als Einzelinvestitionen zur Migrationsprävention von Gesundheitspersonal getätigt. Sie stellen in den meisten Fällen ein integrales Element eines breit angelegten Engagements zur Stärkung von Gesundheitssystemen dar.
3. Schweizer Investitionen zur Förderung von HRH werden durch verschiedene Organisationen (DEZA, SNF, Schweizer Kohäsionsfonds, seco, NGOs etc.) getätigt. Sie sind nur bedingt in eine umfassende Schweizer Gesundheitspolitik, die eine enge Kooperation mit Niedriglohnländern und Ländern mit mittlerem Einkommen vorsieht, sowie bedingt in eine übergreifend Strategie zur Bekämpfung von Abwanderung von Gesundheitspersonal, eingebettet.
4. Die norwegischen und deutschen Erfahrungswerte verdeutlichen, dass:
    a) die Förderung von Synergien und eine enge Zusammenarbeit der verschiedenen Akteure sowie eine gezielte Mittelaufwendung von grosser Bedeutung sind.
    b) ministerienübergreifende Strategien für eine Politikkohärenz zwischen innenpolitischen und außenpolitischen / entwicklungspolitischen Ansätzen sowie für die Entwicklung von Aktionsplänen wichtig sind.
    c) eine starke Präsenz in internationalen Foren (z.B. Global Health Workforce Alliance, World Health Organisation) gewährleistet sein sollte.
    d) HRH Probleme als eine Priorität der globalen Gesundheit erkannt und also solche in der Entwicklungspolitik der einzelnen Länder verankert sein sollten.

    Wenn diese Punkte mit mehr Nachdruck verfolgt würden, könnte die Wirksamkeit, Effizienz und Nachhaltigkeit der Schweizer Investitionen erhöht werden.
5. Obwohl langfristige Investitionen in der Entwicklung des Gesundheitswesens ein Hauptelement der Schweizer Bemühungen darstellen, besteht das Risiko, dass diese weniger wahrgenommen werden als vergleichbare Handlungen anderer Geberländer und Institutionen. In einem zunehmend wettbewerbsmäßig geprägten Umfeld ist deshalb ein klares Profil der Schweizer Entwicklungszusammenarbeit wichtig, welches die mannigfaltigen Stärken der verschiedenen Regierungs- und Nichtregierungsorganisationen mehr in den Blickpunkt der Öffentlichkeit rückt.
6. Da wenig Referenzdaten zur Verfügung stehen, die eine Auswahl von funktionierenden „Schweizer“ Strategien zur Förderung von HRH erlauben, besteht Entwicklungspotential für eine systematische Kapitalisierung und Verbreitung regionaler und länderspezifischer Erfahrungen sowie für Maßnahmen, die die Auswirkungen von In- und Auslandsinvestitionen besser einschätzen und überwachen können.

Wenn sich die Schweiz für besser aufeinander abgestimmte Kooperationsmodalitäten, die den Verbleib von medizinischen Fachpersonal in Herkunftsländern fördern, einsetzen möchte, dann sollte sich die Schweiz vermehrt dafür stark machen, dass (i) einerseits kohärente Kooperationsstrategien für alle Schweizer Akteure in eine breite und umfassende Schweizer Gesundheitspolitik eingegliedert werden und dass (ii) eine allgemeingültige Strategie gegen Abwanderungsbewegungen von Gesundheitspersonal sowie für deren Verbleib in Herkunftsländern definiert wird. Bilaterale Verträge zur Steuerung von Migrationsbewegungen von medizinischem Fachpersonal, die sich als Vorteilhaft für Herkunftsländer erweisen, könnten gefördert werden. Obwohl es gegenwärtig keine eindeutig definierten Kooperationsmodalitäten gibt, könnte die Schweizer Entwicklungskooperation zirkuläre Wanderungsbewegungen unterstützen. Hierbei muss jedoch berücksichtig werden, dass die damit verbunden Kosten hoch sind und sich diese Massnahmen typischerweise nur an ganz bestimmte Berufsgruppen zum Beispiel Spezialisten richten. Die Schweizer Entwicklungskooperation kann auch Mechanismen fördern, die Gesundheitspersonal aus dem Ausland ermöglicht zeitweise in ihr Herkunftsland zurückzukehren um Beiträge bei der Stärkung von Gesundheitssystemen von Ländern mit niedrigem und mittlerem Einkommen zu leisten.

1 Background

Over the last years, funding for health in low- and middle-income countries has substantially increased principally through a number of new initiatives and instruments such as the Global Alliance for Vaccines and Immunization (GAVI) or the Global Fund to Fight HIV/AIDS Tuberculosis and Malaria and reached unprecedented levels, in particular for the control of HIV/AIDS, malaria and tuberculosis. For example, it has been estimated that official development assistance (ODA) grew from US$8.5 billion in 2000 to US$13.5 billion in 2004, corresponding to a 60% increase (Kates et al. 2006). Albeit, the global financial crisis is likely to lead to a reduction of Governmental allocations earmarked to assistance to health sector development (Feachem et al, 2010) in the coming years, there has been a substantial increase in private funding for global health, which is said to now account for about a quarter of all development aid for health (Bloom 2007). From 1995 to 2006, public financing of health in constant US$ from domestic sources increased by nearly 100%. Overall, this increase was the product of rising GDP, slight decreases in the share of GDP spent by government, and increases in the share of government spending on health. At the country level, while shares of government expenditures to health increased in many regions, they decreased in many sub-Saharan African countries (Lu et al., 2010).

There are a number of consequences including among others that HRH related problems have become more apparent and moved into the spotlight of interest. At the same time concerns have been formulated that the additional funding is primarily made available to disease oriented control programs and does not sufficiently well contribute to broader health systems strengthening (Marchall et al., 2009). The availability of appropriately trained, well-deployed and motivated human resources is critical for a well-functioning, sustainable health system. Health workers with the “capacity” to deliver health interventions to their populations are the key to improving health outcomes.

It is widely acknowledged that the world is experiencing a chronic shortage of well-trained health workers, a crisis felt most acutely in those countries that are experiencing the greatest public health threats, referred to as “source or donor countries” in this report. For low- and middle-income countries, it estimated that 57 countries have an absolute shortage of 2.3 million physicians, nurses and midwives (Scheffler et al, 2008).These shortages suggest that many countries have insufficient numbers of health professionals to deliver essential health interventions, such as skilled attendance at birth and immunization programs.

At the same time, there is growing concerns that high-income countries are not any longer able to respond to the growing demand for doctors and nurses over the next 20 years (OECD, 2008). For Switzerland a number of recent reports have pointed out present and upcoming shortages. Annually, Switzerland has a production deficit of around 1’500 physicians which is compensated through the recruitment of foreign doctors, principally from the European Union (SWR, 2007). It is further estimated that in the upcoming years there is an annual deficit in the production of nursing staff in the range of 4’500 staff per year (GDK and OdASanté, 2009). As a response to partially counteract a lack of nursing staff in Switzerland, the federal government together with the cantonal level and the OdASanté have defined a set of strategies in the Masterplan “Bildung Pflegeberufe 2010-2015” (EVD 2010). The Masterplan outlines specific measures which are supposed to reduce the dependency on foreign health professionals such as the provision of a needs based number of training and apprenticeship positions in Switzerland.

As one strategy to address world-wide human resource problems, the World Health Assembly adopted in 2004 a resolution which called for the development of a Code of Practice on the International Recruitment of Health Personnel. The corresponding code has been discussed and adapted

at the World Health Assembly of May 2010. The code of practice sets out the action which WHO member states should take in order to address the worsening human resources problems related to migration and is expected to be an instrument in the global response to the health worker migration issue (Taylor and Gostin, 2010). Designed to be global in scope, it is directed towards all persons concerned with the international recruitment of health personnel, including WHO Member States as well as health workers, recruiters, employers and civil society.

Consequently it was pointed out that Switzerland and other OECD countries should adopt a comprehensive approach to the looming shortage of health workers, reinforce international cooperation and better monitor health workforce policies and international migration of doctors and nurses (OECD, 2008). These measures should be accompanied in both sending and receiving countries by policies aimed at improving retention and integration into the health workforce, developing the skill mix and coordinated care and increasing productivity. At the same time, others argue that migrants boost economic output, at little or no cost to locals and with few exceptions emigration is unlikely to shape the development prospects of an entire nation (UNDP, 2009). What so ever, in 2006, Switzerland has established a foreign policy relating to health matters which especially aims at coordinating national and international health policy and emphasises the attention to be given to problems related to international migration of health workers (EDI and EDA, 2006).

Against this background, the present study aims to review Swiss contributions to Human Resources Development in low-and middle-income countries and staff retention in countries of origin. More precisely, the **objectives of this review are to**:

1. Establish an inventory of cooperation practices of Switzerland with middle- and low-income countries in the area of human resource development whereby focusing on
    - the role of different actors involved and modalities of collaboration
    - consequences/results of these practices in terms of motivation and migration
    - approaches of present practices relating to circulatory migration of professionals
    - identification of possible interfaces between private and governmental actors
    - two short country case studies of Swiss cooperation practices (Romania and Tanzania)
2. Review cooperation practices in the area of human resource development of two European countries (Germany and Norway) in the light of their validity for Switzerland.
3. Based on identified "best practices" and enabling and disabling factors for the success of initiated initiatives formulation of
    - Recommendations on cooperation approaches aiming at the retention of health workers in their country of origin
    - Recommendation on "next steps" of Swiss cooperation practices in the area of human resource development

To address these objectives, the Swiss FOPH and the SDC mandated a team of public health professionals with HRH expertise, project management, to conduct a survey to identify “best practices” and evaluate the Swiss cooperation strategies to strengthen HRH. In particular, the view of key actors of the Swiss Development Cooperation, including governmental and non-governmental organisations, were questioned regarding their role, level of involvement, types of activities, best practice examples and collaboration modalities to support the development and stabilisation of the HRH situation in source countries. The term source countries used within this mandate, with a special country focus on Tanzania and Romania, refers to developing countries as well as Eastern European countries. HRH related investments of Swiss actors abroad represented the focus of the study. Hence, Switzerland based activities such as the promotion of application oriented research by Swiss universities as practised by the Swiss Commission for technology and information (KIT) were not considered.

Approach and methods used

1.1 Approach by objective

The approach to provide answers to the objectives of the study has been fourfold:

1. **Review and analyses of related background** and key documents, including the screening of web information and other documentation sources of key actors of the Swiss Development Cooperation to establish an inventory of health and HRH activities (see section 2.2.1)
2. **Structured telephone interviews** with representatives of key actors of the Swiss Development Cooperation covering NGOs (mainly from the Medicus Mundi Network) as well as governmental actors (SDC, State Secretariat for Economic Affaires (SECO), FOM, Swiss National Science Foundation (SNSF) (see section 2.2.2)
3. **Open telephone interviews** with representatives of key actors of the Norwegian (NORAD) and German Development Cooperation (Federal Ministry for Economic Cooperation and Development (BMZ)) (see section 2.2.3)
4. **Questionnaire** which was sent to representatives of the coordination offices of SDC. (see section 2.2.4)

Figure 1. Stages of health workforce development (source WHR, 2006)

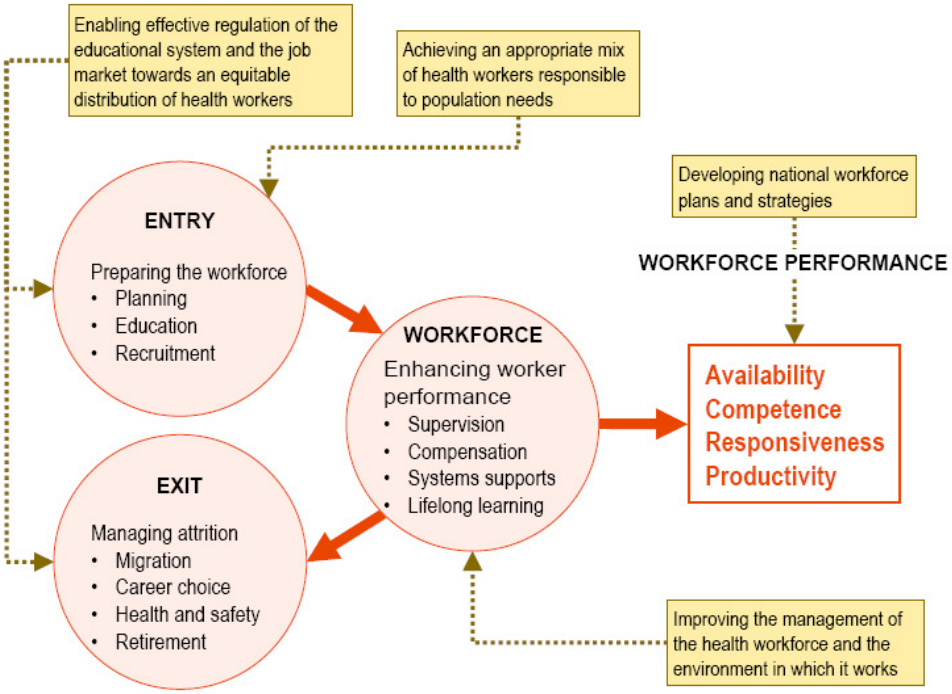

Figure 1 provides a general overview on stages of health workforce development (WHR, 2006). A similar model was used by two studies which were conducted in parallel (Huber and Mariéthoz, 2010; Jaccard Ruedin and Widmer, 2010). Table 1 provides an overview of the methods used to address the four objectives of this study. Thereby the main emphasis was given to the inventory of cooperation practices and to investments of SDC as the main Swiss actor in the area of development cooperation. The two country studies focusing on Tanzania and on Romania as well as the

analysis of cooperation practices of Germany and of Norway were deliberately kept short so not to overload the present report. Nevertheless the comparison of Swiss activities was also made with the efforts of the Norwegian and German Development Cooperation to strengthen the HRH situation in source countries in order to identify possible alternative collaboration modalities which could be applied to the Swiss Development Cooperation.

Table 1. Methods used by this study by objective

	Objective	Method used	Comments
1	Inventory of cooperation practices of Switzerland and with middle- and low-income countries in the area of human resource development whereby focusing on i. role of different actors involved ii. modalities of collaboration with individuals and partner countries iii. consequences/results of these practices for the staff in the countries of origin in terms of motivation and migration iv. approaches of present practices relating to circulatory migration of professionals in low-income countries v. identification of possible interfaces between private and governmental initiatives vi. establishment of two short country case studies of Swiss cooperation practices (Romania and Tanzania)	• Review of documentation • 8 Telephone interviews with governmental actors including with SDC (headquarters and in-country offices) • 15 Telephone interviews with NGOs • 10 E-mail questionnaire responses from SDC country offices	• Main focus of the study • Main focus on SDC • No financial analysis of Swiss investments
2	Analysis of cooperation practices in the area of human resource development of two European countries (Germany and Norway) in the light of their validity for Switzerland	• Review of documentation • Telephone interviews: 3 with NORAD; 3 with BMZ/GTZ	• German BMZ includes main German instruments (GTZ, InWent, DAAD, etc.)
3	Based on identified "best practices" and enabling and disabling factors for the success of initiated initiatives formulation of recommendations on i. Cooperation approaches aiming at the retention of health workers in their country of origin ii. "Next steps" of Swiss cooperation practices in the area of human resource development		

1.2 Methods

1.2.1 Review of Key Documents

Available published and grey literature has been consulted and reviewed in the period November 2009 to February 2010. An internet literature-based review through Google was conducted. Further, documents made available to the review team, including those sent by different agencies of the Swiss Development Cooperation, were collected. These documents were then analysed with regard to international evidence, observations and recommendations on human resource development as well as for evidence, observations and recommendations for priority action at priority country level.

Inventories in the form of project summary tables of health projects and where possible of HRH activities were created for each Swiss key governmental actor in order to develop an overview of the HRH components per organisation and to facilitate data analyses.

1.2.2 Structured telephone interviews

For telephone interviews targeting the Swiss Development Cooperation, key representatives of governmental and non-governmental actors were identified and invited to participate. In total, 9 interviews were held with governmental actors representing the following agencies: SDC, SECO, Federal Office for Migration and Swiss National Science Foundation (SNSF).

The Non Governmental Organisations (NGO) actors were selected from the Medicus Mundi Network (http://www.medicusmundi.ch/mms-en/network), whereby all those with activities in the health context in sources countries were approached. In total 15 NGOs out of a total of 23 NGOs replied. For one NGO, two interviews were held, amounting to a total of 16 interviews with NGO actors. Those NGOs targeted but not included in the final analyses were either not in a position to respond to HRH questions or could not be reached at all.

In order to structure the interview an interview guide was sent out before the telephone interviews were held. The guide was the same one as used for the structured questionnaire sent out by email (see section 2.2.4). The telephone interview consisted of open and few closed ended questions allowing for a qualitative as well as quantitative analysis of the responses. The focus was however placed on the qualitative dimension in order to probe for in-depth information about the main HRH problems faced in donor countries, related HRH activities of the various organisations, strengths and limitations of the Swiss Development Cooperation as well as their future HRH strategies. The interview was kept anonymous.

As in the case of the Email questionnaire, interviews were then transcribed and analysed along a pre-established grid (see section 2.2.4)

1.2.3 Telephone Interview with Norwegian and German actors

Telephone interviews with selected representatives of the main Norwegian and German actors in the field of development cooperation were conducted in order to identify alternative cooperation modalities and best-practice and to share experiences which could be taken up in the future Swiss HRH agenda. In total 3 Norwegian and 3 German key actors were interviewed. The same reference document for the telephone interview was used as for the Swiss actors (see section 2.2.3), by adapting it as necessary to the Norwegian and German context. Furthermore, the same approach was used.

1.2.4 Semi-structured questionnaire

For the telephone interviews as well as for those SDC country coordination offices which were contacted by Email a semi-structured questionnaire was used (see annex 2). The questionnaire focused on the perspectives of representatives of key actors of the Swiss Development Cooperation regarding:

- The most pronounced HRH problems in sources countries

- The main HRH strengthening activities of their organisation in source countries
- The cooperation modalities with project partners
- Their organisation's efforts to counteract push factors[1] (e.g. low pay, lack of incentives, poor working conditions) and minimise brain drain
- Strengths and limitations of the Swiss Development Cooperation in the field of HRH strengthening
- Priorities for future HRH strategies of the Swiss Development Cooperation

1.3 Analytical approach

Based on an earlier analysis of HRH related constraints (Wyss, 2003), an analytical evaluation grid was developed to assess trends of the level of involvement of Swiss actors to counteract HR constraints, the so called push factors. The analytical framework of push factors was used to structure the interviews and to assess the Swiss involvement in donor countries at five levels: 1) individual level, 2) training capacity, 3) health service level, 4) health sector level and socio-political and country level.

Table 2 provides the list on push factors which have been of interest in the present study and which were used to structure the analysis of interviews and opinions on investments in human resource development by Swiss governmental and non-governmental actors. A more detailed overview presenting also the questions of interest for assessing Swiss investments in HRH development in low- and middle-income countries can be found in annexe 3.

Table 2. Overview of potential push factors for migration used to analyse answers of respondents

Potential push factors for migration
Individual level
• Career development prospects
• Salary level/Income and monetary and non-monetary incentives
• Gender/Cultural/Social class and ethnic Determinants
• Working conditions (e.g. regulation of working hours, work load, availability of job descriptions-)
Training capacity
• Initial and post-graduate training opportunities
• Continuous education opportunities (e.g. short and long-term education possibilities)
Health service level
• Team building and interaction e.g. management, supervision, information and communication, skills matched with tasks, codes of conduct, safety, quality standards
• Performance management and productivity
• Physical working environment/Infrastructure and supplies (e.g. drugs and health products)
Health sector level
• Composition of workforce and skill mix
• Geographic imbalances
• HRH policy and planning (recruitment policy, bilateral agreements to manage migration, retirement policy, succession planning)
Socio-political and economic country context
• Multi-sectoral approaches/collaboration
• Governance and overall policy framework
• Political stability

[1] Push and pull factors are those factors which either forcefully push people into migration or attract them. A push factor is forceful, and a factor which relates to the country from which a person migrates. It is most commonly a problem which results in people wanting to migrate. Different types of push factors can be seen further below. A push factor is a flaw or distress that drives a person away from a certain place. A pull factor is something concerning the country to which a person migrates. It is generally a benefit that attracts people to a certain place (http://en.wikipedia.org/wiki/Push_and_pull_factors).

Based on information generated in the interviews and other information sources such as documents or the world wide web, general trends in HRH activities of each Swiss actor contacted as part of the HRH survey were established. For data analyses a mixed-methods approach consisting of quantitative and qualitative methods was applied using excel. The analysis of the closed-ended questions was fairly straight forward by using quantitative analyses methods. The open replies were coded according to categories which facilitated the identification of general response patterns. Coding was used as an interpretive technique that both organized the data and provided the means to introduce the interpretation of it into a quantitative form. As a result, the prevalence of codes and their interrelationships could be summarised to highlight response trends.

2 Opinions on cooperation practices of Switzerland

2.1 Key issues and priorities in HRH development

In response to identifying the most common HRH problems faced by health personnel in sources countries, the majority of interviewed Swiss governmental and non-governmental actors mentioned the following five problems areas the most frequently (see also table 3), starting with the most widely encountered HRH problem and following a descending order:

1. Low salary levels and lack of monetary incentives
2. Poor working conditions
3. Inadequate staffing
4. Brain drain and migration
5. Absence of or weak HRH policies

Despite a detectable tendency of the rating, the responses varied and were heavily dependent on the respective country context and should therefore only be interpreted as indicating a general overview or trend. Multiple ratings were possible.

Table 3. HRH development problems such as identified by respondents

HRH problem areas	Total responses/ratings per HRH problem area
Low salary levels/income and lack of monetary incentives	32
Poor working conditions	27
Inadequate staffing	26
Brain drain and migration	19
Limited career development prospects	17
Absences or weak operational HRH policies	17
Limited staff productivity and performance	16
Limited training capacities	16
Political instability	11
Other	11

All interviewed Swiss actors were, although not as a prime objective, active in some way or another in the HRH field. Most actors highlighted that HRH activities made up an important project component of nearly every project. Within their activities (see section 4 of this report) the majority of Swiss actors pointed out their investments especially in the fields of capacity building (96%) and improvement of the staffing situation (96%) followed by investments to improve working conditions (88%) and staff productivity (75%) (see table 4). An increase or top-ups of salary levels was mentioned by 67% and 67% also indicated investments in career development prospects. About 33% were active in directly trying to counteract brain drain or intervened at the policy level. Hardly any organisations were engaged in the elaboration or operationlisation of the HRH policies of the country they were working in.

Table 4. Areas of activities in HRH development such as identified by respondents

HRH activity/focus areas	Nb	%
Improvement of staffing (e.g. adequate staff numbers, staff qualifications, skill mix, balanced staff geographical distributions)	23	96
Improvement of staff productivity	18	75
Improvement of salary levels	16	67
Improvement of career development prospects	16	67
Improvement of working conditions (e.g. adequate infrastructure, acceptable working hours and work load, strengthening the development and implementation of work regulations and good practice standards, strengthening the provision of non-monetary incentives (e.g. supplies, staff well-fare medical services, housing provision, childcare facilities	21	88
Improvement of training capacity (e.g. undergraduate/graduate training, continuous education and learning opportunities)	23	96
Activities against brain drain	8	33
Strengthening of operational HRH policies (e.g. HRH policy, retention policy, retirement policy)	8	33
Strengthening the political stability	3	13
0ther	2	8

The initiative to invest in HRH strengthening activities is grounded on a perceived or apparent need (e.g. medical need, key objective to promote sustainability), identified and defined either by local partners e.g. local partner organisations (e.g. local hospitals, faculties of medicine, NGOs, local communities) or governments (e.g. MoH, districts) in cooperation with the Swiss actors or by the Swiss actors themselves. Almost all Swiss actors (about 92%) saw a strong need to address HRH strengthening activities in all projects given as examples and in some cases even defined it as an integral part of their organisational vision and hence an essential aspect of project implementation. Most commonly, Swiss actors are approached by local authorities or partners and asked to invest in selected capacity strengthening activities such as for example for a SNSF funded project in Romania focusing on reproductive health. The capacity building measures comprised post-graduate training in reproductive medicine and biology, workshops and training of trainers. About 83% clearly stated the importance to invest in long-term projects, most commonly between 3-10 years, and emphasised a strong collaboration link with local partners (approximately 58%).

Although the majority of Swiss actors do no define their HRH activities in contractual agreements with the local partners, they still make up important project components. Only few of the interviewed Swiss actors (approximately 21%) formulate clear agreements or Memorandums of Understanding (MoU) and conditions with defined performance based outputs. Nevertheless, as repeatedly mentioned before, HRH investments are seen as very important project activities which are essential to contribute to sustainable development beyond project implementation and to achieve

local independency. Where desirable, partnership arrangements with other international actors are entered but the focus is clearly placed on long-term collaboration links with local partners.

Although about 1/3 of respondents claimed to be active against brain drain, they mainly referred to indirect activities meaning that they used a wealth of measures to improve the job satisfaction of health professionals through monetary (e.g. salary top-ups mainly of selected key staff however) and non-monetary incentives (e.g. provision of staff housing) and through training opportunities abroad or in-country. As a result, Swiss actors hoped to convince health professionals to remain in their local job positions.

"We follow long-term sustainable strategies to strengthen HRH by trying to train key health personnel who are able to pass on the training once the project comes to an end."
Survey respondent comment (NGO)

2.2 Limitations of the Swiss contributions to HRH development

About 38% of organisations interviewed did not see themselves in a position to pin point limitations of the Swiss Development Cooperation, mainly due to unawareness about the existence of concrete, clearly identifiable HRH activities of the Swiss Development Cooperation. To a limited extent, knowledge of individual efforts of other organisations to address the HRH situation in source countries could be named. The general picture from the responses, namely the existence of well-targeted but scattered non-harmonised individual attempts to remedy the unfavourable HRH conditions, is further supported by the second most frequently highlighted opinion (about 25% of respondents) that "no harmonised approach" of the Swiss Development Cooperation seems to have been initiated.

Along this argumentation line, the interviewed organisations criticised the "varying priorities", the involvement of "too many actors without a common approach" and the non-availability of "information exchange" among the various Swiss organisations. A platform for information and experience exchange is wished for, which especially also gives the smaller organisations a voice and equally involves and acknowledges their efforts. Individual voices either emphasised that there were no weaknesses at all detectable or criticized the too bureaucratic procedures in source countries, the too strong focus on specific disease as opposed to a preferred more holistic approach such as targeting underfinanced health systems, and the "relief type approach" some organisations apparently display which does not support long-term investments.

There is a general perception among Swiss actors that it is time for the Swiss Development Cooperation as a whole to resume it's already late responsibility with regards to HRH strengthening in source countries and to acknowledge and counteract it's role by directly or indirectly contributing to brain drain of health professionals in these countries. Some survey respondents see a need to further sensitize Swiss politicians about the lack of health resources in Switzerland which are compensated through the recruitment of foreign health professionals. Although these mainly come from European Union countries (e.g. Germany), Switzerland's recruitment practices still have an indirect impact on the health staff composition of other source countries (e.g. Africa, Asia) as these tend to migrate and replace those countries providing for the Swiss job market. Hence, the Swiss should recognise their impact with regards to brain drain and initiate respective counter measurements. Some respondent raised also the issue that NGOs often pro-actively recruit staff in low- and middle income countries so to satisfy their needs for implementing their activities. Especially at policy level, more ethical and sustainable HRH policies need to be developed and implemented.

"No information exchange between actors and no common strategy exist. HRH issues have been neglected too long." *Survey respondent comment (NGO)*

2.3 Strengths of the Swiss contributions to HRH development

According to approximately 1/3 of interview respondents, the key strength of the Swiss Development Cooperation in the field of HRH strengthening is its approach to set up long-term projects and to emphasise the sustainability of the project activities and results. Non-colonial historic links to beneficiary countries exist and have developed into collaboration networks with local partners in which the Swiss actors are perceived as "reliable", "trust-worthy" and without a "hidden agenda". Long-term partnerships have for example been established in Tanzania (see chapter 4.1.2) promoting a well-established dialogue with the local government and partnerships with local institutions. The strong collaboration links with local partners, especially the strengthening of institutional capacity building and the promotion of a strong local ownership are described as additional key strengths of the Swiss Development Cooperation.

Other assets of the Swiss Development Cooperation are seen in its "flexibility" (especially of the small organisations) to provide development assistance, its "innovativeness", the strong focus on "training provision and "knowledge transfer" and it's "internationally recognised expertise in niche areas and selected countries". About 21% did not have enough background information to identify key strengths of the Swiss Development Cooperation.

"The Swiss Development Cooperation characteristics are "flexibility, collaboration creating ownership based on needs, strong monitoring and sustainability as many projects are still running today." *Survey respondent comment (GO)*

2.4 Priorities for Swiss contributions to HRD development

One third of respondents would like the future perspective to include further investments in capacity building and in basic and continued education offered by qualified local and international experts. According to survey respondents, additional HRH strengthening efforts should target the HRH policy level as well as the project level.

At policy level, HRH policies should be developed and put into practice which define a clear vision about the desired HRH outputs, regulate recruitment and retention procedures and bilateral agreements need to be agreed on to manage health professional movements. Especially the intervention of larger organisations at policy level such as the SDC could be of importance whereas the smaller Swiss actors should rather focus on activities at project level.

At project level, support should be provided to further strengthen HRH management capacity e.g. by developing and implementing HR employment standards and guidelines, job descriptions clearly defining responsibilities, working hours, performance targets, development perspectives, work place regulations etc. and overall working conditions in health facilities. Furthermore, the Swiss Development Cooperation actors should not step out of community and primary health care but rather get more involved at this level by supporting projects, community efforts and grass roots activities. Although, individual respondents claim to observe the opposite trend, meaning that the

Swiss Development Cooperation is more and more converting to provide mainly consultative and advisory services, a strong wish voiced by several respondents is to keep Swiss actors involved at project level.

As perceived by survey participants, the key for success for any type of future HRH strengthening efforts, is the maintenance of close collaboration links to the local governments and other local actors in order to facilitate sustainable outcomes. Only long-term approaches which aim at an improvement of general working conditions of HRH personnel (e.g. through adequate salaries, adequate infrastructure and equipment and fair work regulations) will have a chance to turn out successful. At the same time, while investments to change the HRH situation in source countries are important, the Swiss should also find ways to satisfy their own needs for medical personnel without drawing off health professionals from other countries. The Swiss should identify strategies to train enough own doctors and nurses.

In addition, a platform for information, experience and best practice exchange is desired by survey participants which at the same time aids the sensitization of Swiss organisation regarding the HRH topic. Something similar to the Medicus Mundi network or the organisation of symposia, conferences and workshops were mentioned as possible future platforms or events. In order to assure a harmonised approach with regards to HRH strengthening activities, survey respondents would like to see SDC taking the lead and developing a strategic reference document.

Individual respondents made additional suggestions to strengthen the HRH situation in source countries through:

- Supporting the status of clinical officers as they are less prone to migrate because the job title is non existent in Europe or not recognised as a profession.
- Further developing distant communication approaches by introducing eLearning methods.
- Basing all strategies on evidence based medicine and best practice examples.
- Supporting faith based organisations more.

"An even stronger focus should be placed on training e.g. in the field of primary health care, community health and strengthening the role of community nurses and social workers as more and more health staff are leaving." *Survey respondent comment (GO)*

3 Cooperation practices and modalities of Switzerland

With regards to human resource development in low- and middle-income countries, Switzerland has various instruments at its disposal. They can be broadly categorized in governmental and non-governmental actors. The following chapter establishes a short inventory of Swiss cooperation practices and their modalities in the area of human resource for health (HRH) development.

At governmental level, there are five offices involved in one way or another in HRH development in source countries:

1. Swiss Agency for Development and Cooperation (SDC)
2. Federal Office for Public Health (FOPH)
3. The State Secretariat for Economic Affairs (SECO)
4. Federal Office for Migration (FoM)
5. Swiss National Science Foundation (SNSF)

Specific examples on activities and projects funded by these actors are given in the sections below (section 4.1 to 4.5). As the number of activities in the area of HRH development supported by SDC is extremely large and broad, the activities of this agency are being looked at through two specific country studies: Romania and Tanzania.

A relevant number of Non-governmental Organisations (NGOs) operate in the area of international health cooperation and aim to contribute to health systems strengthening in middle and low income countries. Their volume of activities and the importance given to HRH development do strongly vary. Most of them are members of the Medicus Mundi Network Switzerland (MMS), a network that provides a platform for knowledge, experience and expertise exchange among it's members. Of the total of 46 NGOs which currently enjoy the network's membership, the activities of 15 are inventoried in chapter 4.6.

3.1 Role and modalities: Swiss Agency for Development and Cooperation

Swiss Agency for Development and Cooperation (SDC) is Switzerland's international cooperation agency within the Federal Department of Foreign Affairs (FDFA). Key responsibilities lie in the overall coordination of Swiss development and Swiss cooperation activities with developing countries and Eastern Europe respectively with a focus on social development (including health), income generation and setting up democratic structures. A close cooperation with other relevant federal offices is herby assured.

The key objectives of the Swiss development cooperation in the health field are to contribute to improved access to basic health care, especially for disadvantaged population groups**.** Since the 1990s, SDC has also been involved in providing financial and technical assistance to Eastern European Commonwealth of Independent States (CIS) countries. Since 2007, SDC is also administering a part of the Swiss Cohesion Funds to the European Union and one billion CHF will be invested as part of the framework credit to reduce economic and social disparities within the enlarged EU. The specific health care focus targets primary health care, modernization of the health facility infrastructure, reform of health systems and preventive measures and are agreed-on on a bilateral basis between SDC and the beneficiary country. (For further information, please consult: http://www.sdc.admin.ch/ and http://www.sdc-health.ch/)

SDC cooperates bilaterally with a number of selected partner countries. In each country, cooperation is by choice focusing on three major sectors only. Hence, support to health development may not be a focus in some of SDC's priority countries, but health is a priority in a number of the country portfolios. The agency collaborates with a wide range of different public and private partners in countries such as Albania, Bangladesh, Benin, Bosnia-Herzegovina, Chad, Kyrgyzstan, Moldova, Mozambique, Nepal, Rwanda, Tajikistan, Tanzania or Ukraine.

SDC investments in HRH development are substantial but typically do not relate to stand alone investments in human resource development or the prevention of migration and are an integral element of broader health systems strengthening efforts. For example in Tajikistan SDCs funds three important health programs, one focusing on the revision of the undergraduate and graduate curriculum of the medical faculty, and the other two on primary care development within the context of on-going health reform. All these programs have important components of HRH development but are integrated in broader health systems strengthening efforts. Similar observations do apply for other country programs of SDC for example the one in Albania, Bosnia-Herzegovina or Kyrgyzstan.

The scope and focus of these health sector development programs vary and an exhaustive inventory of activities of these programs would be beyond the scope of this review. We consequently limit ourselves and will only focus on the review of SDCs investments in HRH development in two countries: Romania and Tanzania.

Besides country specific investments in HRH development further detailed in the next paragraphs, SDC is also making a substantial amount of funding available to multi-lateral organisations such as the World Health Organization, UNFPA, the Global Fund to Fight HIV/AIDS, tuberculosis and malaria, the Special Programme for Research and Training in Tropical Diseases (TDR) or the Special Programme of Research, Development and Research Training in Human Reproduction (HRP). These multi-lateral organizations directly or indirectly give emphasis to HRH development in low and middle income countries.

3.1.1 SDC investments in HRH development in Romania

Romania has gone through a period of rapid and major changes in every sector, including health, since the revolution of 1989. Demographic trends since 1989 show continual population decline caused by emigration, a falling birth rate and a rise in mortality. Health status in Romania is poor compared with the other European countries: average life expectancy is six years shorter than the EU average, and infant and maternal mortality are among the highest in the European Region. Major reforms began in 1989 and by 1998 the previous centralized, tax-based system had been transformed into a decentralized and pluralistic social health insurance system (administrated and regulated by the National Health Insurance Fund) with contractual relationships between purchasers, the health insurance funds and health care providers. With regard to HRH development it is observed that there is no clear workforce strategy in place (Vlădescu et al., 2008). The actual planning is based on a relative constant number of workplaces within the public system. The number of places in residency for doctors is determined by the Ministry of Public Health based on the historical level of doctors for each speciality. Each year, the district health directorates report their estimated needs for each speciality in five-year periods (five years is the average duration of residency training) based on new entrants and exits from each speciality. The migration of young physicians especially to France, Germany and the United Kingdom is an important concern and the Ministry of Public Health has been asked to elaborate a strategy for human resources for the health care system that takes into consideration the high rates of emigration to come, especially among young physicians.

SDC was active up to 2007 (which will be followed by assistance through the Swiss Cohesion Funds from 2010 onwards) in contributing to HRH development in its transition program in Romania at all levels and targeted all identified key problem areas faced by source countries such as improvement of staffing situation, improvement of staff productivity and performance, improvement of salary levels/income and provision of monetary incentives, improvement of career development prospects, improvement of working conditions, improvement of training capacity, strengthening of operational HRH policies. This is however done as in the case of other countries through broader health systems strengthening projects and below we provide the example of three such initiatives.

Funded by the SDC, the Romanian - Swiss Neonatology Project (RoNeonat), covering the period 2001-2007, was realised by the Ministry of Public Health in cooperation with the Swiss TPH and local partners which provided mainly technical assistance in collaboration with a Romanian NGO the CRED Foundation “Centre for Health Sector Development” which was founded specifically to strengthen the local implementation process. The project was initiated in response to the low accessibility to high quality neonatal care, a weak referral system and limited neonatal intensive care units with the overall goal to modernise the neonatology care system in Romania. HRH development made up a very important key activity area and comprised a wealth of project components. Medical equipment was procured and related to user training. User trainings in modern health technology of neonatal intensive care units were conducted (60 participants - nurses and clinical staff and also hospital managers and administrators), 25 bioengineers, technicians and engineers of other specialties were trained. Further training of Trainers (ToT) was held in Switzerland. Medical training of health professionals (MDs, nurses, Obstetricians and gynaecologists, infant surgeons and physiotherapists) was conducted in Romania in the field of neonatology, as well as obstetrics, child surgery, neonatal transport, follow up of premature newborns, quality management and project management. Over 700 staff from neonatology wards including physicians and nurses underwent step down training and 526 community nurses were exposed to neonatology issues through specific training sessions. There was also a series of training workshops in hospital and quality management. Clinical Practice Guidelines (CPG) for neonatology and obstetrics were developed.

The Romania - Regional Emergency Medical Services Systems (ReMMSy) project, aimed at increasing access of the population to high quality emergency medical services in Romania. The project was running over four phases from 1994-2007 with SECO acting as the major funding agency in the first phase, followed by shared funding with the SDC in the second phase and the final two phases only financed through SDC. From 2002 onwards, a Romanian NGO, the Centre for Health Policies and Services (CHPS), was entrusted with the detailed planning, the conduct of activities and with the monitoring of project implementation. Key project components aimed at establishing a sustainable basic and continuous medical education system in emergency medicine and to provide tools and mechanisms for quality assurance and monitoring in 14 REMSSy districts disseminated at national level. Again, a wealth of project activities focused strongly on HRH development. Specific HRH relevant activities of setting up the emergency medicine services comprised the initiation of emergency medicine services reforms and the establishment of emergency medicine as a medical speciality. 15 training centres were created and furbished. Quality management tools and mechanisms were introduced and a plethora of capacity building measures were provided such as training dispatch staff, physicians and ambulance staff at a national level, training of 300 emergency physicians in sonography, certification of 59 physicians and 32 nurses by the MoPH as “trainers for emergency medicine, training of 168 physicians and 32 nurses from prehospital emergency medical services (ambulance services), training of 224 physicians and 613 nurses from the hospital emergency services as well as the provision of distance learning opportunities.

The project Training of health specialists in Health management (1995 - ongoing) is led by Swiss development actors in Switzerland (Canton Ticino and later Swiss TPH) with participates from all over Eastern Europe. The Public Health Management course is today also offered in Romania but managed by the Romania partners. With the aim to build up public health management specialists, the course topics include health economy, health management, social marketing, quality care promotion and communication within health organisations. The participants are most frequently managers from the health institutions at local and departmental level. The course content is delivered jointly by Swiss and Romanian experts. The project start up phase in Ticino had originally focused on the training targeting selected policy makers, Hospital Managers and medical doctors from Romania (and other Eastern European Countries) who were invited to Ascona to receive training in health management. With the aim to train trainers and develop courses for health professionals in Romania a separate project has been introduced from 2001-2007 implemented by the Canton of Ticino in cooperation with Romanian partners. The course has been rolled out and offers in Romania today a full-fletched Master program carried out at the Department of Public Health of the Bucharest Faculty of Medicine.

3.1.2 SDC investments in HRH development in Tanzania

The United Republic of Tanzania despite recent achievements in reducing infant and under five mortality has generally still poor health outcomes and a variety of aspects such as malnutrition or maternal mortality remain a concern. In 2005 the HRH situation was officially declared a crisis and the Ministry of Health and Social Welfare (MOHSW) passed a moratorium that, for the next 3 years, they shall serve as a broker and ensure that positions are filled in the system. A HRH taskforce has been established. It includes representatives of several ministries. There is high political commitment to act on human resource related issues and HRH development is for example mentioned in the Poverty Reduction Strategy Paper, PRSP. The issue was raised in each annual sector and General Budget Review since 2006 as an issue to address urgently. Civil Society Organisations as well as Donor and Government Agencies provided analysis and reports on the human resources crisis in general and the inequity in particular.

Indeed, The Tanzanian government has realised that it is facing a serious HRH crisis and hence has set-up a HRH Task Force which has been operating since 2004. The HRH working group, composed of various development agencies such as the WHO, GTZ, USAID, CIDA etc., meets regularly and is designed to provide advisory support and facilitate better coordination of HRH activities on behalf of the Ministry of Health and Social Welfare (MOHSW). The objectives of the HRH Task Forces include the review of immediate, medium, and long-term HRH priorities, the monitoring of progress with regards to implementation, stock tacking of human resource roles from sector ministries, problems and issues, and provides practical advice for improving and advocating HRH issues with appropriate government offices and line ministries and partners.

Wages in the public sector as a whole were raised as the health sector saw a doubling of allocations for salaries over the last years. Nevertheless, observers note that the salary levels are still not sufficient to assure a minimal living standard. Especially the living conditions in remote areas are a huge concern. Basic needs such as water and electricity are not assured; schools are missing and transport means are non-existent. Supplementary income sources continue to be sought by health workers, for example through complementary assignments in the private sector if they have the chance to do so. Further, health workers in the relatively important faith-based institutions are particularly negatively affected, as their institutions have been unable to match the salary rise.

Tanzania represents a country benefiting from long-term development assistance through Swiss Cooperation, represented by SDC. One of the three programmatic areas targeted by the Swiss Cooperation Programme in Tanzania is the health sector. The Swiss supported health program has three main initiatives: (1) Switzerland is an active partner in the technical and policy dialogue, being a member of the Technical committee of the SWAp (Advisory Role at the highest technical level), active in many technical working groups and politically being in the leading role of the Donor Partners Group Health. (2) Switzerland contributes together with ten other development partners to the health basket fund, a kind of sector budget support that funds the implementation of the health sector strategic plan and (3) provides support to bilateral projects which pilot initiatives related to community involvement, health promotion, traditional medicine, social protection and health prevention as i.e. the distribution system of insecticide treated nets.

SDC presently supports a number of projects including the Health Sector Reform Support Program (HSRSP), Community Based Health Initiatives (CBHI), a health insurance project, Ifakara Health Institute (IHI), Netcell - Insecticide Treated Nets Upscaling Project (ITN), and traditional knowledge for health project. Specific HRH development activities of the SDC in Tanzania across all projects take up a number of aspects. At policy and national level SDC is contributing to the implementation of the health sector strategic plan III, through specific health basket funding. 40-60% of basket funding goes to district level and is used to implement the district health plans. The other part, going to the central ministry is mostly used for drugs and equipment procurement. SDC supports also the Ifakara Health Institute which in turn has a number of activities in the field of capacity building. SDC is engaged in technical and political talks with the government to convince governmental actors that staff should be adequately skilled and receive non-monetary incentives such as staff housing. SDC does further support Civil Society Organizations which are very active in the political arena on HRH, provide analytical material and dialogue with the parliament requesting an equitable improvement of this important concern.

All SDC supported projects in Tanzania address HRH development, but none of them have defined HRH as the only focus area of a project. Within the SWAp, there is a division of labour among the Development Partners, whereby SDC decided to not engage in the Human Resources for health working group. Nevertheless, SDC is – especially through its coordination role in the DPGH, well informed about the activities in the Human Resources for Health Task Force (HRH Task Force). This is a subgroup of the Development Partners Group for Health (DPG Health) working group, which specifically aims at addressing the shortage of HRH in Tanzania (see http://hdptz.esealtd.com/).

3.2 Role and modalities: Federal Office for Public Health

Federal Office for public health (FOPH) principally oversees domestic aspects relating to the Swiss health system and oversees among others the operations of health insurance companies. The FOPH has regulatory and supervisory functions on a number of health topics for example in the fields of narcotics, sera and vaccines, poisons, food quality and radiation protection. Its activities in combating disease are directed towards epidemics, tuberculosis, rheumatism, and AIDS. Over the last two decades, the FOPH has established national health promotion and prevention programmes which are directed against the AIDS epidemic as well as against the misuse of drugs, alcohol and tobacco. However, the political and legal competencies of the FOPH for health promotion and prevention activities are only feebly supported by the parliament and weakly guaranteed by laws and the constitution.

At international level, the FOPH assures that the priorities of the Swiss Health Foreign Policy are implemented in tandem with the Federal Department of Foreign Affairs (FDFA). Activities related for example, to infectious diseases control, the strengthening of relations with the EU, comparing healthcare systems or access to medicines for low and middle-income countries.

An international dialogue on all aspects of migration policy is actively cultivated with countries of origin, transit and other target countries as well as with international organizations. The FOPH also represents Switzerland at the level of the World Health Assembly and has coordinated the Swiss position towards the WHO code of ethical conduct for health workers recruitment and has followed-up in this frame the preparation of the code (for further information, please consult: http://www.bag.admin.ch/org/index.html?lang=en).

Jointly with the Swiss Federal Department of Foreign Affairs, the FOPH has established a foreign policy relating to health matters which especially aims to coordinate national and international health policy and places emphasis on international migration (EDI and EDA, 2006). The FOPH does however not directly fund activities steered at HRH development in low- and middle-income countries. Its mandate is however to oversee, examine and analyse human resource relevant developments for Switzerland as a destination country for health worker migration and its overall workforce planning and policy framework in order to shift towards a position of greater self-sufficiency, and therefore a situation whereby it is not making an undue impact on health systems of low- and middle-income as well as transition countries in Eastern Europe.

Besides direct HRH targeted activities, the benefits of innovative technologies, such as eHealth, telemedicine and remote care etc. to reduce the detrimental impact of the HRH shortage should not be neglected. They have the potential to facilitate the work of HRH and even to reduce manpower requirements. Such technologies are also developed in Switzerland and are partially subsidized by federal institutions and state funds such as e.g. through KTI (for further information consult: http://www.bbt.admin.ch/kti/index.html?lang=en). In 2007, the Swiss Federal Council adopted the “Strategy eHealth Switzerland” which defined the framework conditions and national standards for eHealth projects in Switzerland with the aim to improve health service provision in the fields of administration, diagnostics, therapy, patient transfer and accounting (BAG 2007).

3.3 Role and modalities: State Secretariat for Economic Affairs

The State Secretariat for Economic Affairs (SECO) is part of the Federal Department of Economic Affairs (FDEA) and mainly promotes sustainable market economy structures, competitiveness and infrastructure investments in developing countries, Eastern European States and Central Asia and the new EU member states in the field of energy, environment and climate change. The central focus is herby poverty reduction. Although the health focus is not a predominant one, it has, especially in the past received some attention. Today, SECO is more and more phasing out of health sectors activities, leaving it to the other national arm which targets it as a prime focus area: the SDC. At present, activities of SECO in the health field focus on infrastructural, equipment and capacity building support for health projects financed within the Swiss enlargement contribution.

In other words, health is not a key focus area for SECO, since it is seen principally as a core mandate of SDC. Within a number of projects and programs funded by SECO, HRH strengthening activities have so far focused on the improvement of staffing situations, staff productivity and performance, salary levels/income and provision of monetary incentives, improvement of career development prospects, working conditions, training capacity, strengthening operational HRH policies and contributions to strengthen the political stability.

Indeed, since the 1990s, SECO has been involved in providing financial support in the form of transition assistance to Eastern European countries. Since 2007, SECO, in cooperation with SDC, manages the Swiss contributions to the EU enlargement process by supporting projects in the fields of security and reform, the environment and infrastructure, private sector promotion as well as human and social development including health-care and education. The aim of the Swiss contributions to EU enlargement is to reduce social and economic disparities within the EU. In 2007, the first framework credit of 1 billion CHF was approved for the EU, followed by an extension of investments by 270 million CHF for Bulgaria and Romania. SECO has been involved in funding health care related projects in new EU countries by mainly investing in infrastructural improvements and equipment provision. Often, these investments are also combined with training of medical professionals.

In the following sections we briefly present health related projects which include a number of relevant investments relating to HRH development such as technical and vocational training; research and development (scientific exchange programs, scholarships and grants, cooperation in applied research) and healthcare (modernisation of hospitals, reform of health insurance systems, etc.).

In Estonia, SECO funds the project “Reorganisation of children’s homes” focusing on the construction of new children's homes, which have a more home like appearance, in three municipalities and four sites, catering for social care of 80 children. In addition, two projects are envisaged to be supported in the near future, both focusing on strengthening information and communication technology systems of the national emergency care system in Estonia. From 2009 onwards, software and hardware for faster emergency location trapping as well as new communication devices for ambulances shall be provided. In Lithuania within the project “Improvement of Mother and Child Health” medical equipment shall be provided for 30 hospitals such as specialised vehicles for the transportation of neonates, software development services and further specialist services. Complementary, training of medical staff in perinatal and neonatal health care services shall also be assured. In Slovenia international standards in oncological radiotherapy shall be reached under SECO funding through construction and equipment investments in a new centre for radiotherapy services as well as capacity building of 44 medical professionals. In Poland, in November 2009, the Polish-Swiss Research Programme (PSRP) was approved which aims at fostering research collaboration between Switzerland and Poland and especially Polish research capacity through infrastructural and equipment investments and training. About 30 projects will be funded through the 18 million CHF grant, with the health sector making up one of the priority areas.

For EU member countries, the Scientific Exchange Programme between Switzerland and the New Member States of the EU (sciexNMSch) under SECO funding provides investments in human capital, the promotion of research and innovation, and the support and development of scientific networks. Research training placements funded through the Sciex Fellows program target promising doctoral candidates and post-doctoral researchers, especially young researchers from the new EU member states by providing scholarships to engage in research at Swiss research host institutions. Cross-country research partnerships and knowledge transfer as well as scientific capacity building represent key expected benefits. Costs covered include salary coverage, social taxes, allowances (conference attendances, travel) and reimbursable costs which can reach up to a total of 90’000 CHF per scholarship. 30 million CHF are available for this programme in eight EU member states - Czech Republic, Estonia, Hungry, Latvia, Lithuania, Slovakia, Slovenia and Poland (http://www.sciex.ch).

In other priority countries of SECO, albeit phasing out its investments in health, SECO funds a number of activities. Health projects for incineration of medical hazardous waste are presently con-

ducted by the Infrastructure Division of SECO in three countries: Jordan, Slovakia and Bulgaria. Egypt is currently one of the focus countries for SECO where it supports two projects in the health sector, one aiming at the rehabilitation of radiology services (implemented by the Swiss TPH), and the second one on the rehabilitation of blood transfusion services (implemented by the Swiss Red Cross). The key HRH development activities for both projects focus on assistance in technical expertise to use medical equipment, improving guidelines and policies, improving working procedures and conditions as well as setting up and implementing quality management procedures.

3.4 Role and modalities: Federal Office for Migration

Federal Office for Migration (FoM) regulates the conditions under which people can enter Switzerland in order to live and work here. Moreover, the Office for Migration co-ordinates Federal governmental, cantonal and communal efforts on behalf of integration and is the organ responsible for naturalization matters. Thus activities are primarily of domestic nature. Further, the FoM represents Switzerland at international forums on migration issues. It supports the formulation of a widely-shared political UN agenda on migration issues, and promotes the Global Forum on Migration and Development as a catalysing force for cooperation on migration issues.

In the area of international affairs, the FoM has the mandate to promote “migration partnerships” (set out in Federal Law on Foreigners). This mandate comprises the promotion of bilateral and multilateral migration partnerships designed to be long-term and to continue as well as to set-up and implement projects and programmes that relate to immigration and emigration. Such projects and programs promote among others the voluntary return and reintegration of persons who have migrated to Switzerland, the strengthening of governmental structures in the country of origin (e.g. support to immigration authorities), support in the fight against human trafficking as well as increase the efficiency of remittances from migrants in the country of origin and encourage the dispersion to make a contribution to the development of its country of origin. In concrete terms the conclusion of a migration partnership is intended to ensure a coherent Swiss migration policy (“whole of government approach”) and thus the FoM collaborates with a number of other departments of the Swiss administration for example as part of the concrete implementation process with SDC and SECO)

In 2009 migration partnerships in the West Balkans (Bosnia and Herzegovina, Serbia and Kosovo) and in Nigeria have been initiated and concluded through Memorandum of Understandings with Bosnia and Herzegovina and Serbia.

Around a third of the budget of the FoM is used for development assistance. This assistance include also the above mentioned “migration partnerships” (OECD, 2009). The aspects they address vary depending on the partnership, and can include the strengthening of migration management capacities, return assistance, prevention of irregular migration, fight against trafficking in human beings, remittances, development cooperation or humanitarian aid. In some instances funds are used for investments in health system development.

3.5 Role and modalities: Swiss National Science Foundation

Swiss National Science Foundation (SNSF) acts as the central instrument for state funded research. As the Swiss federal arm it funds scientific research in all possible research disciplines. Especially young scientists from Switzerland are invited to submit research projects which aim at further developing the Swiss research capacity. At the same time there are some programs of the

SNSF which promote scientific collaboration with low- and middle-income countries and researchers, including in the bio-medical area. The most relevant programs – albeit not expressly health sector specific - are the Scientific cooperations between Eastern Europe and Switzerland (SCOPES) and Research Partnerships with Developing Countries programs (for further information see: http://www.snf.ch/E/international/Pages/International.aspx).

Besides the "Research partnerships with Developing Countries Program" and the SCOPES program which are further described below, SNSF funds also the "International short visits" with the aim to enhance mutual knowledge transfer and capacity strengthening. Those benefiting from this program are either foreign researchers invited to Switzerland or Swiss researchers joining a foreign research institution abroad. Researchers are only eligible if they hold a doctoral or an equivalent degree, enjoy employment as a researcher and if long-term research collaboration partnerships are envisaged between the applying institutions. A lump sum payment to cover travel and accommodation is provided for a minimum of 1 week to a maximum of 3 months. Researchers from throughout the world can, from 2010 onwards also benefit from a new SNSF funding instrument. Funds can bee applied for the implementation of "International Exploratory Workshops in Switzerland". International scientists are invited to meet in Switzerland in order to jointly advance a particular research topic. The perceived benefits are again a direct knowledge transfer and the chance for future collaboration modes.

Other multilateral funding opportunities promoting Swiss and European research collaboration include the following non-exhaustive funding schemes: (1) Bi- or Multilateral-agreements (see http://www.snf.ch/E/international/europe/Pages/default.aspx) on collaboration between Switzerland and European countries promoting the mobility of joint and trans-national research partnerships within Europe: "Money follows researcher" and "Lead Agency Line" etc.; (2) EUROCORES programme: The SNSF is part of the programme funding collaborative research, networking and dissemination of research activities between Europe and Switzerland; (3) Research networking programme (RNP) supporting high quality research at European level through international research partnerships; (4) EU Framework programmes (FP): Swiss researchers are actively participating in this programme. ; (5) ERA-NET: The objective of the ERA-NET scheme is to develop and strengthen the coordination of national and regional research programmes through two specific actions: European Research Council (ERC) supports cross border basic research with active participation of Swiss researchers as well as the European Cooperation in Science and Technology (COST) invites European and also Swiss researchers to engage in research partnerships in nine priority areas ranging from health to environmental topics.

In a joint effort with the SDC, SNSF has initiated in the 1990s the "Research partnerships with Developing Countries Program" aiming at strengthening research capacity and the quality of research of developing countries. The program is administered by SNSF. Research partnerships between Swiss and developing countries research institutions targeting research areas important for countries of the South can apply for funding through a call system. For the current 2008-2011 call, 12 million CHF are available for projects of all scientific disciplines for a maximum of 36 months. One example of a project funded under the "Research partnerships with Developing Countries Program" scheme is the project "Improving quality of health care for Tanzanian children: Assessing the use of electronic decision support to promote evidence-based medicine and rational use of drugs" running from 2009-2012. The project aims was to revise standardized diagnostic and treatment procedures for the integrated management of childhood illnesses (IMCI) incorporating more sophisticated clinical algorithms based on current evidence about disease patterns and drug resistance leading to a reduction in the inappropriate use of antibiotics and anti-malarials for children with fever, and therefore improving the quality of care that is being provided to children in Tanzania. Specific HRH development aspects of this project are the provision of career development opportunities and train-

ing of few selected medical doctors to get involved and strengthen their research skills. A PhD and master position were financed within the project whereby both medical doctors were allowed to keep their full time positions at the Ifakara Health Institute as leading doctors. Their participation in a 4 months training course in Switzerland was funded. By ensuring their positions upon return, they were given an incentive to return back to Tanzania after course completion which was seen as a measure to counteract brain drain. The project is also providing salary top ups mainly for the two students in the range of ½ to 1/3 of their total salary.

The "SCOPES Program" (Scientific cooperation between Eastern Europe and Switzerland) financed by SNSF in collaboration with SDC aims at promoting joint scientific partnerships between Swiss and Eastern European research facilities. Within the current 2009-2012 SCOPES Program, 16 million CHF are available to finance Joint research partnerships, conference attendances, project proposal developments in all research disciplines and the modernisation of Eastern European research institutions. The main driving force behind the funding opportunities within this programme is to accelerate the development of Eastern European research institutions through knowledge transfer and involvement in the development of innovative scientific methods which are sustainable.

An example of a project funded within the SCOPES scheme in Romania is the project "Transforming Pius Branzeu Centre of Laporoscopic Surgery and Microsurgery (PBCLSM) Timisoara into an Eastern European Zonal Centre of Development and Research in Laparascopic Surgery. Implemented between 2006 and 2008 it focused on HRH components, transformation of PCLSM from a regional centre in Romania into a zoned centre of training for different categorise of medical staff. Each course was held in English and coordinated by a European expert in the field. Three international laparoscopic courses were organised each year for Eastern European surgeons, in English, with participation of Western European trainers. Another project example funded under the SCOPES scheme in Romania is the project "Institutional Partnership in research and practical training in reproductive health" which was running from 2000-2004. As the title already suggests, the main HRH activity within the project targeted the provision of capacity building opportunities for Romanian medical personnel in the field of reproductive health. Various capacity building approaches were used consisting of post graduate training courses offered in reproductive medicine and biology over a period of 3 weeks (about 8 times in total) for Medical Doctors (MDs) reaching about 160 participants throughout the project. Approximately 35 technical and practical workshops focusing e.g. on the establishment of a referral system of prenatal care, including the upgrading of skills in obstetric and gynaecologic ultrasonography were organised. Courses for training of trainers (TOTs) in Switzerland, together with the Swiss partners in Geneva, who then returned to Romania to develop and implement corresponding training packages were held and a general upgrading of the management capacity of the Romanian partners consisting of the MoH Romania and key university clinics in Romania in the field of reproductive health was assured. The program is seen as a success story by many as it is still running today. In fact, many of those trained take up key positions in leading health institutions in Romania today and in some instances act as trainers within the national reproductive health programme. The established partnerships also ensured continuous monitoring of scientific standards, effective utilisation of trained staff, good clinical practice and the development of research proposals. The project partnership consisted of: the European Institute, Geneva Foundation for research, Faculty of Medicine of Geneva University Hospital, Geneva Medical Association, Geneva Canton, IAMANEH, WHO, MoH Romania and several key Romanian University clinics. Furthermore, the MoH centre for programme training has accredited the training course as part of the continuous medical education program in the field of family medicine and the manual on reproductive health is still valid at national level and has even been copied by Moldova. The project was started based on the need to counteract high Maternal Mortality Rates and abortion rates. It was the first project in Romania to target reproductive health issues.

3.6 Role and modalities: Non-Governmental actors

In the frame of the telephone interviewed, 15 NGOs provided information on their activities in the area of HRH development in sources countries. Of the 15 NGOs reached, all declared to be active in HRH strengthening activities as it represents an integral part of project implementation. The scope of HRH strengthening activities did however vary from NGO to NGO and only in very few cases made up the main focus area of a project and more commonly only represented one of several project components. In the following sections we present specific examples of activities in the area of HRH development of those 15 NGOs which were interviewed. However, the list of project examples per NGO should not be seen as exhaustive but rather only as a representation of a selection of individual project examples highlighted by the interviewed NGOs.

1. **CO-OPERAID** (http://www.cooperaid.ch) has long-term working relationships in Uganda. The most important HRH focus area of the organisation is capacity building of health workers. Project staff are trained in HIV/AIDS prevention, psychological counselling, memory work etc. In other countries, CO-OPERAID supplies health and hygiene relevant educational materials.

2. **FAIRMED** (http://www.fairmed.ch) allocates about 20% of it's project investments in Cameroon for HRH strengthening activities such as for supervision, provision of occupational or educational training opportunities or on the job training, infrastructural support, equipment (e.g. motorcycles for a mobile health services) and medicines provision and performances based incentives with the aim to enhance the independence of local health professionals and to achieve sustainable project results. Organisational specific capacity building initiatives mainly consist of short-term health facility and basic community trainings of one to several weeks duration. Local as well as international experts conduct the trainings. Community focused capacity building (e.g. for community volunteers or community midwives) is based on the needs of the community such as in hygiene, antenatal care and birth support, leprosy, buruli ulcer and TB early detection and management. One week health facility trainings and two to three weeks secondary hospital trainings for e.g. physiotherapists are also offered. Based on the number of vaccinations given per health centre, performance based incentives in the form of cash are paid into the health centre account. Supervisory visits are conducted by FAIRMED in cooperation with the District Health Departments (DHD) on a regular basis. In Ivory Coast, FAIRMED supports similar HRH activities as in Cameroon, however, a stronger emphasis is placed on operational research in collaboration with the Centre Suisse de Recherches Scientifiques Abidjan (CSRS).

3. **Fondation PH Suisse** (http://www.partnershipsinhealth.ch/) has running projects until 2010 with a stronger HRH component in the Western Balkans, Tajikistan and other countries. In the two focus regions, capacity building concentrates on the provision of certified as well as basic training courses and training of trainers. In Tajikistan adolescents, parents, teachers and community leaders are trained in reproductive health and life handling skills. Training methods consist of focus group discussions, orientation sessions and training youth as peer educators. In the Western Balkans (Albania, Bosnia & Herzegovina (BiH) and Croatia, Kosovo, Republic of Macedonia, Montenegro and Serbia) a program is running to fight HIV/AIDS. The programme consists of 3 major components to: 1) Build social capital through participatory social networks at the community level, 2) Scale-up capacity and to achieve sustainability and 3) Strengthen regional collaboration and partnerships.

The HRH capacity building component is rather strong and has generated a number of training opportunities. Among else 3'900 Primary Health Care providers were trained in HIV knowledge and skills in Albania, BiH and Kosovo.

4. **Globalmed** (http://www.globalmed.ch/) is involved in HRH strengthening activities in particular in Zambia and Serbia. In Zambia HRH components mainly focus on training of specialized doctors either locally or through short-term regional courses in neighbouring African countries. Further monetary incentives in the form of monthly salary top-ups (about 250 USD) are paid for key hospital staff such as medical doctors, clinical officers and administrative staff, and non-monetary incentives are offered to nurses by financing their trainings in exchange for their commitment to stay at their work place. Non monetary incentives through investments in staff housing and equipment support (e.g. x-ray machines, beds) are provided. In Serbia health personnel (e.g. MDs and nurses) benefit from training courses in Switzerland for 3 months to improve their medical skills e.g. in gynaecology, lab technologies etc. Strong collaborative links exist with Swiss hospitals which provide the training. A maximum of about four medical professionals are invited per year. They are however only allowed to observe medical treatment in Switzerland and do not have the right to practice. Medical seminars are organised for local health professionals (100-150) once per year for one week on medical topics identified by local partners according to their perceived needs e.g. spine issues, neurological, physiotherapeutic issues etc.

5. **Cooperation Cameroon Jura Suisse** (http://www.jura.ch) is active in strengthening primary health care in 8 districts in Cameroon. HRH promotion is realized through salary top ups for the two local program managers. They primarily work as District Medical Officers (DMOs) and receive monthly salary top-ups for their additional project work in the range of 250 CHF to 500 CHF. Further training courses for nurses are provided. Approximately 200 nurses per year benefit from these capacity building measures. The project topics are identified by the two DMOs and target the treatment of diseases of local importance such as e.g. diabetes, hypertension. The course duration varies from two days to one week. In addition continuous medical education measures for doctors are offered. Their participation in a Master program abroad is funded. However, only selected individuals can benefit from this opportunity e.g. 1-2 per year. These investments in HRH development are complemented by a number of activities such as for example infrastructural support and equipment provision through the installation of water pumps for health centres and construction of 40 health centres.

6. **Mission 21** (http://www.mission-21.org), a faith based NGO, is active in health promotion, especially in Cameroon and Tanzania. HRH strengthening activities in Cameroon include the provision of scholarships in the amount of CHF 50'000 per year for Cameroonian medical doctors to participate in training activities in Africa. The money is managed by the local partner – the church. The positions of two medical doctors from Europe who are based in the supported hospital. The aim is to increase motivation of local staff by initiating expertise exchange through on the job training and knowledge transfer. Annually 50'000-100'000 CHF are invested in infrastructural and equipment support e.g. to improve the water supply and electricity provision of the hospital. Technical maintenance staff is also sent to Cameroon to improve the working conditions.

7. **Médecins du Monde-Switzerland** (http://www.medecinsdumonde.ch/) runs projects with a HRH component in Benin, Haiti and Palestine. In Benin, Médecins du Monde has opened a department within a hospital to treat sickle cell anaemia and has been involved in the recruitment of staff. Technical assistance is mainly provided through capacity building measures (e.g. short-term training of 2-3 months on specialised medical topics such as sickle

cell anaemia) and on the job training. Local and international professionals act as trainers. In addition, research opportunities are also offered. In Haiti, the organisation is working with 10 rural health centres within a nutritional and family medicine project which has been running for 10 years. The main HRH component is the provision of training for medical staff as well as community training. Other activities comprise medical equipment and food supply. In Palestine the NGOs HRH activities cover the provision of short-term training in mental health care through international experts and supervision. The training course takes place over a time span of 6 months (not full-time).

8. **Novartis Foundation for Sustainable Development** (http://www.novartisfoundation.org) has been involved in HRH strengthening activities in two projects in Tanzania in collaboration with the Swiss Tropical and Public Health Institute, SDC and the local government and organisations. In Tanzania support has been focusing on the re-establishment of the Training Centre for International Health (TTCIH) in Ifakara. The aim of the project was to develop a distinctive profile in health training which should also secure the centres financial self-reliance and improve the quality and range of courses and trainers and overall managerial capacity. The infrastructure and facilities and equipment have been substantially upgraded. Whilst the basic renovation of the existing buildings complex was financed by SDC, the Novartis Foundation covered the necessary upgrading and new constructions as well as the equipment of the training rooms, offices, accommodation and laboratories. Training courses are directed at all kinds of medical professionals and include courses for assistant Medical Officer (AMO) training (about 80 AMOs are trained annually), refresher courses for Clinical Officers and computerized IMCI (Integrated Management of Childhood Illnesses), short courses for sponsors etc. in specific topic areas (e.g. maternal and neonatal health) as well as facility provision for external agencies to conduct training. The Swiss Tropical and Public Health Institute provides courses in District Health Management, Rational Management of Medicine and Clinical Priorities in Tropical Countries. Another project funded by Novartis Foundation is the ACCESS project which comprises various activities such as the continued improvement of the quality of care assessments through the training of healthcare personnel, e.g. in infection control and IMCI. In Mali, the a**ccess to primary health care services project in Mali focuses on** establishing a health insurance scheme linked with an improvement of the quality of curative and preventive health services. Since 2007, the Foundation, in cooperation with the regional authorities for health and social development supports HRH development through the training of community health associations and the managers of existing health insurance schemes in financial and administrative management, marketing strategies and communication approaches.

9. **SolidarMed** (http://www.solidarmed.ch/) activities focus on five South-Eastern African countries (Mozambique, Zambia, Simbabwe, Lesotho, Tansania). HRH is a key strategic topic area and forms and integral part of every project and most commonly consists of: **t**raining opportunities abroad in other African countries (short-courses on specific topics areas e.g. HIV/AIDS for medical professionals) and in retaining health workers at their place of work. In the field of infrastructure support nursing schools as well as staff and student houses have been constructed. SolidarMed is also engaged in incentive provision through salary top ups for selected personnel e.g. by financing salary top ups for two doctors in health facilities in Zimbabwe or by providing non-monetary incentives such as capacity building opportunities. Or, as for a Tanzanian example, the salary of a Hospital doctor is financed for 2-3 years. The financed doctor works in a tandem with a Swiss doctor who ensures capacity building and knowledge transfer before phasing out. After the phasing out period, the hospital will cover pay the salary of the hospital doctors according to local salary levels. In Mozambique rotation funds are implemented: Governmental agencies

receive funds for salaries of health personnel for a certain time period with the aim to finance these positions through local authorities in the long-term. Two HRH focused projects are located in Tanzania and Zambia: In Tanzania, a nursing school is supported and in Zambia a training college for assistant medical officers is financed and medical specialists (e.g. gynaecologist, obstetrician) from Switzerland are sent there to provide training. In addition, student and staff houses are constructed, budget support for quality improvements (e.g. teaching and training material) is assured and capacity building in planning, monitoring and reporting also represents an important line of action.

10. **Swiss and German Aid Caritas** (http://www.kinderhilfe-bethlehem.ch/en). The given project examples refers to the Palestinian country context. The predominant HRH strengthening activities refer to: planning support and the development and provision of job descriptions, job analyses, and performance appraisals. Specific capacity building measures include training courses for nurses conducted by local experts. One-two training courses are offered per year targeting a total of 80-90 nurses. Internally recognised certificates are provided and the topic areas vary. The organisation also offers general courses and supports individually selected MDs to obtain specialisations abroad, e.g. Master degree.

11. **Swiss Dental-Aid International** (http://www.secoursdentaire.ch/) is active in the field of dentistry. HRH support focuses on infrastructural and dental equipment support to build up a dental clinic in Kinshasa which is now independently run and managed by four local dentists. In the area of capacity building European and Swiss experts offer short-term trainings (2 month duration) on basic topic areas such as sterilization and hygiene practices, extractions techniques and prophylactic tooth cleaning. Funding is provided for training courses for selected medical staff e.g. 1 dentist in Gabon. Non-monetary incentives through local partners (the church) e.g. free or reduced accommodation are also given.

12. **Swiss Red Cross (SRC)** (http://www.redcross.ch/) has a broad range of activities and a long project experience of 20 years in Cambodia, Kyrgyzstan and Tibet. One of the projects with a stronger HRH focus in Cambodia, commencing in 2004, focused on "Health system strengthening" activities in two operational districts with the aim to increase affordability of health services and improve overall service delivery at hospital and health centre level. "The strategy was to foster a win-win situation in which the users benefit from affordable services of good quality provided through a rational health system in which the health personnel have a satisfactory income and professional development. The aim was to reach a stage of sustainability and in fact of virtuous self-development." In the first 5 years, HRH aims focused on adequate staffing of health facilities according to MoH standards following correct and transparent recruitment procedures. Village health support groups (VHSG) received training on patient rights and channels to give feedback. Infrastructure and equipment support was provided through the provision of monitoring machines, sterilisation equipment (table), staff housing, and the construction of a post-delivery room. In the current follow-up phase, the Swiss Red Cross is only engaged in capacity building activities with a strong aim to make them sustainable (e.g. on the job training, peer education, study visits to well run health facilities, HR management and planning, financial management, human resource management, community participation, quality management, health financing in the form of workshops (one to several days), on-the-job training/coaching, peer-education by competent personnel within the health system and best-practices. For example, the managers of the provincial referral hospital and of the remaining three operational districts receive training in HR management by learning how to develop HR strategies, appropriate job descriptions, labour contracts and staff appraisals. Midwives working in the health centres are trained in reproductive health and life saving

skills. The reward for staff to participate in capacity building activities is that, once they get a good grading by the MoH for their staff performance, their institution gets access to additional funds meant to improve the HR situation (80% go towards staff support and 20% towards operational costs). Hence bonuses are paid for good performance. In Kyrgyzstan, the Swiss Red Cross is implementing the Kyrgyz-Swiss Swedish Health Reform Project" (2000-2011) which targets HRH capacity building of government staff of the health care sector to plan, implement and monitor the health actions in the communities and to train the hospital management in financial planning and budgetary savings for maintenance and repair. Renovation support was also initiated. Lastly another example is a project run in Tibet on "Health Care Improvements in Rural Areas" offering a wide range of capacity building activities such as training and support for medical staff in managerial aspects, capacity development of different government staff (health workers, fire brigade employees, school teachers as well as local youth as peer educators on HIV and AIDS prevention, community capacity building and support of local health initiatives through women's federations at village level (health promotion, hygiene education and improvement of water and sanitation), training of eye doctors and assistants.

13. **Verein Partnerschaft Kinderspitäler Biel-Haiti** (http://www.biel-haiti.ch/) is supporting a primary health care project in rural Haiti and within it, implements the following HRH components: Assurance of appropriate staff composition and skills with highly qualified paediatricians and other medical professions. Salary coverage of selected medical staff is provided e.g. one staff member, the chief of the paediatric department of the Hôpital Albert Schweitzer (HAS). An agreement with the hospital exists, that the money the hospital saves by not financing this position will instead be used for other staff salaries. On the job training and peer education of medical professionals through international experts is provided. Experience has shown that this training method increases the motivation of local staff. Participation in one year training opportunities (learn and observe) in Switzerland is offered. Since 1989, approximately 10 surgeons and nurses have benefited from this possibility.

14. **Bündner Partnerschaft Hôpital Albert Schweizer** based in Haiti (http://www.hopitalalbertschweitzer.org/Home.34.0.html?&L=4). Within the project, the HRH focus is placed on capacity building in the form of short-term trainings in the field of e.g. lab technology, paediatrics, surgery, anaesthesiology; on the job training through Swiss medical experts who work in the hospital in Haiti and share their experience with local medical staff; opportunities to participate in training courses (2 month duration) in Switzerland for selected health personnel e.g. 1 MD, 2 nurses on special medical topics (e.g. ultrasound, paediatrics). Working conditions through infrastructural support and provision of medical equipment e.g. ultrasound devices, lab equipment, nursing equipment are improved. Salaries are paid for positions not covered by the hospital e.g. of the head nurse, lab positions, paediatricians according to local salary levels.

15. **University Hospital Geneva** (http://www.hug-ge.ch) (www.fondacigafamy.org) supported a primary health care reform process and contributed to the development of Family Medicine in Bosnia and Herzegovina. The SDC funded project initiated reform processes of health services in Bosnia. Until the end of 2007, it was managed by the NGO 'Foundation PH – Partnerships in Health' and Geneva's University Hospital. Since 1998, it has retrained hundreds of doctors and nurses to work in general medicine in family practice teams, and many medical centres have been renovated and refitted. At the beginning of 2008, the responsibility for the project was transferred to the local organization "fami", thus securing local participation in the project. The model project is having a considerable impact. Its ob-

jectives have been adopted by the Bosnian authorities and broadly implemented as part of health-service reform. A strong focus was placed on professional capacity development in family medicine matters such as training of family medicine teams according to nationally recognised training curricula or the provision of training and re-training for general practitioners, nurses and health centre mangers in the field of professional Family Medicine and health care management skills in educational centres in Zenica, Sarajevo and Doboj (120 health care professionals per year). Assistance was also given to developing national Family Medicine training and re-training curricula and the training of trainers (TOT) as well as to refurbishing and equipping health centres and ambulances in selected regions, according to international Family Medicine standards. Non-monetary incentives as well as salary top-ups are provided through the "Contract per capita". MDs receive salary top-ups according to the number of patients handled. Non-monetary incentives include: a) provision of resources (e.g. material provision e.g. stethoscopes) or the allowance to hold a new medical title as "Family Medicine Doctor or nurse" once training has successfully been completed.

The various NGOs were able to come up with the following success and failure stories with regards to their HRH strengthening activities which can be used as lessons learnt and have been experienced by many of the Swiss actors:

3.7 Intermediate summary on cooperation practices and modalities

In the previous sections an inventory of cooperation practices of Switzerland with middle- and low-income countries in the area of human resource development has been established. This inventory is all other than exhaustive as it relied on a limited number of contacts and telephone interviews with Non-Governmental Organizations and a number of Swiss hospital partnerships were not included in the inventory. Thus, there is a range of small-scale initiatives often around one or several individuals active in the area of HRH development which is not included. The inventory shows that Switzerland supports through its development assistance a substantial number of initiatives and projects which focus on changing the conditions for health care workers in source countries, including increasing wages and opportunities for training and improving working conditions. At the same time, Switzerland does not pursue a specific policy to minimize the reliance on foreign health professionals nor regulates the recruitment of health workers from EU countries facing a shortage of health care workers.

It is also being observed that Swiss investments in human resource development are substantial but typically do not relate to stand alone investments in HRH development or the prevention of migration and are in most instances an integral element of broader health systems strengthening efforts. Investments in human resource development are channelled through different mechanisms (SDC, SNSF, Swiss Cohesion Funds, SECO, NGOs, etc.).

The developmental approach concerning HRH development chosen by the different actors of the Swiss Development Cooperation including governmental key actors such as the SDC, SECO, FoM, SNSF and non-governmental organisations (e.g. SolidarMed, Swiss Red Cross etc) rather focuses on individual priorities and projects. At present a strong will to consolidate the work in the area of HRH development exists in practice and in the field. However, there is still room for improvement for programme harmonisation. When comparing the activities across the different actors, a common picture emerges: HRH development is not specifically targeted as a project goal but is rather seen as a tool which constitutes an integral part of most projects and programmes.

Table 5. Summary on cooperation practices and modalities of the Swiss Development Cooperation with regard to HRH development

	Relevant Mandates	Geographical focus	Modalities of collaboration	Practices relating circulatory migration
Swiss Agency for Development and Cooperation	▪ Policy dialogue, strategic planning for HRH development as a part of a health system's approach ▪ Technical assistance in the area of HRH development and capacity building to the public as well as the private sector, including ensuring support to SWAp ▪ Capacity Building of health training institutions in the South	Low- and middle-income countries (including transition countries in Eastern Europe)	Bi-lateral and multi-lateral project funding	No explicit but implicit practices
Federal Office for Public Health	▪ Dialogue on migration policy with countries of origin, transit and other target countries as well as with international organizations ▪ Pushing for political visibility of the HRH development and political coherence with the global code of conduct on the ethical recruitment of health workers	Domestic	-	-
State Secretariat for Economic Affairs	▪ Financial Cooperation including infrastructural support	Low- and middle-income countries (including transition countries in Eastern Europe)	Bi-lateral and multi-lateral project funding	No explicit but implicit practices
Federal Office for Migration	▪ Return and Reintegration Programme to assist experts who study/work in Switzerland to return home	Domestic and international	Bilateral "migration partnerships"	-
Swiss National Science Foundation	▪ Facilitate academic and research possibilities in Switzerland through scientific partnerships with developing countries ▪ Facilitate partnerships between Swiss and International Universities and the provision of scholarships	Domestic and international	Project funding	No explicit but implicit practices
Non-Governmental actors	▪ Depending on NGO but in a general way capacity strengthening in low- and middle-income countries	Low- and middle-income countries (including transition countries in Eastern Europe)	Project funding	No explicit but implicit practices

From table 5 two aspects can be observed:

- No single agency among the different instruments of the Swiss Development Cooperation has the mandate for assuring the leadership, coherence and definition of priorities (including funding. In other words, activities in the area of HRH development in low- and middle-income countries are not well inserted into a broader and comprehensive Swiss health policy for cooperating or into an overall strategy for combating health worker migration and retention in the source country.
- A number of actors do have experiences with circulatory migration: SDC, SECO, SNSF and NGOs. However none of them uses circulatory migration as an explicit strategy to retain health workers of source countries thereby promoting temporary working and training opportunities in Switzerland.

4 Norwegian and German HR collaboration modalities

4.1 Norway

4.1.1 Background

As Switzerland, Norway has been recruiting health workers from other countries in an important way so to meet the domestic needs. At the same time Norway has, over the last years, started with the identification of solutions to counteract the current human resources in health crisis and has attracted international attention for its engagement.

In 2006, the Government of Norway committed itself to stem the flow of qualified health workers from poor countries in a proposition to the Norwegian Parliament. The Ministry of Health and Care Services assigned the Directorate for Health and Social Affairs to outline the central features and components of such a policy and it actions along three dimensions were suggested for a health workforce policy which is based on solidarity with developing countries Norwegian Directorate for Health and Social Affairs. 2007: 5-6):

- Norway's future needs for health personnel must be solved using national resources.
- Norwegian development assistance must be directed towards capacity building and the reduction of migration-driving factors in poor countries and
- Norway must take the lead in the effort to ensure responsible recruitment of health workers from poor countries. By creating an internationally agreed framework of obligations and/or 'codes of practice' that address the interests of poor countries, it is possible to help ensure that health worker recruitment takes place in a manner that is based on solidarity with poor countries.

This report and the recommendations given, highlight the scope for Norway as a destination country to examine its overall workforce planning and policy framework in order to shift towards a position of greater self-sufficiency, and therefore a situation whereby it is not making an undue impact on health systems of developing countries. The key to such an approach is to achieve effective inter-ministerial agreement and collaboration so that finance, regulatory, overseas development aid, health and immigration authorities, among others, work together in an agreed overall policy direction. Such a multi-ministerial collaboration between the Ministry of Foreign Affairs (MFA), the Ministry of Education and Research, the Ministry of Health and Care Services and the Ministry of Labour and Social Inclusion has been initiated in 2007. It lead among others to Norway's public health sector limiting the recruitment from most developing countries. However, it has signed bilateral agreements allowing nationals from Poland and the Philippines to work there.

The discussions between the four Ministries resulted in the decision to develop a coherent and comprehensive Norwegian health workforce policy. In March 2008, the Government commissioned two work groups, one to propose measures for Norway's own workforce planning up to 2030 and the other one to make recommendations for HRH strengthening in Norway's foreign policy and development cooperation (Norad 2009). The two reports have recently been submitted to the relevant Ministers and are currently examined. Next steps are to decide on the policy components and to secure follow-up.

The Norwegian Agency for Development Cooperation (Norad) is a Directorate under the Norwegian Ministry of Foreign Affairs (MFA). Norad is not directly responsible for implementing development cooperation as it provides advice and support and assures the quality of development assis-

tance through other actors involved in development cooperation: the MFA, Norwegian foreign service missions and other Norwegian and international actors (NGOs, voluntary organisations, the private sector, ministries, directorates and research institutions). In total, Norad consists of 13 departments. The focal point for HRH issues in Norad is located in the department of Global Health and AIDS. Health has long been a priority area of Norwegian development policy and cooperation. Supporting the health-related MDGs (goals 4, 5 & 6) is one of the main priorities of the Norwegian development cooperation. Norway's support to tackling HRH issues in source countries is very much embedded into this priority area.

Today, Norway allocates funds to HRH measures through bilateral development assistance and through funds for health systems strengthening that are channelled through multilateral agencies and global funds such as GAVI and the Global Fund. Additionally, smaller-scale civil society project strengthening HRH in various countries receive Norwegian funds. There are seven areas of HRH strengthening where Norway is most active:

- improvement of the staffing situation
- improvement of staff productivity and performance
- improvement of training capacity
- activities to counteract brain drain and migration
- strengthening of operational HRH policies
- strengthening the political stability
- financing of health systems support (GAVI, Global Fund)

Special importance is given to education and capacity building of health workers in tackling the human resources crisis (see also section 4.1.4 Education and Institutional Twinning). However, these seven areas are considered to be only the main focus areas. Norway does contribute – on a smaller scale and indirectly – to other areas of HRH strengthening such as the improvement of career development prospects or the amelioration of working conditions.

Annex 4 is providing a short outline of the selected Norwegian-funded initiatives to strengthen HRH globally and in specific countries.

4.1.2 Research, Higher Education and Institutional Twinning

In their report the Working Group, commissioned by the Government in March 2008 to provide recommendations to HRH issues in Norway's foreign policy and development cooperation, grants high importance to education of health professionals through reciprocal commitments and agreements to education, training and research exchange. The Working Group proposes to give an earmarked health education stream and to possibly expand it to include the bachelor level as well to Norad's program for master studies (NOMA). Today, a number of measures targeting education of health professionals and research are already being funded and implemented. Below, some of Norway's cooperation modalities in the field of research, higher education and institutional twinning are described shortly.

- Norad's Programme for Master Studies (NOMA) 2006-2010 is a programme for providing financial support to develop and run Master Degree Programmes in the South through collaboration between local and Norwegian Higher Education Institutions. One of the long-term objectives of NOMA is to achieve sustainable capacity of institutions in the South to provide the national workforce with adequate qualifications within selected academic fields of study – among them health, HIV & Aids and education. Eligible for NOMA support, however not exclusively, are Bangladesh, Bolivia Malawi, Mozambique, Nepal, Nicaragua, Tanzania, Uganda and Zambia.

- The counterpart programme on the research side is the Norwegian Programme for Development, Research and Education (NUFU). This programme, financed by Norad and the Norwegian Centre for International Cooperation in Higher Education (SIU) with a total budget of CHF 53 million (NOK 300 million) for the period 2007-2011, supports independent academic cooperation based on initiatives from researchers and institutions in the South and between South and North (18 different countries). Examples of research projects funded for the period 2007-2012 with relevance to HRH are for example: "Capacity building in the field of mental health in South-Sudan" or "A comprehensive school- and health system-based approach to adolescent health promotion in South Africa and Tanzania". Both programmes, NOMA and NUFU, are administered by the Norwegian Centre for International Cooperation in Higher Education.
- In 2008, Norway became a partner in the ESTHER programme (Ensemble pour une Solidarité Thérapeutique Hospitalière en Réseau) initiated by France. ESTHER is a hospital-to-hospital collaboration that encourages hospitals and health institutions in Europe and in developing countries to establish twinning arrangements to help improve the quality of health care services. The initial focus was on HIV and AIDS. The Norwegian ESTHER programme, administered by Fredkorpset on behalf of the MFA, focuses on health systems issues, including HIV and AIDS, however, particularly linked to health workforce strengthening and the MDGs 4, 5 and 6. The 2008 and 2009 budget is USD 1.5 million annually. Already before joining ESTHER, Norway supported twinning programmes. In Malawi for example an agreement was signed in 2007 with three Norwegian university hospitals Ullevål, Haukeland and Tromsø regarding support for an institutional cooperation project with Lilongwe Central Hospital with a view to improving childbirth services (Norad 2008a: 12-13).
- Linked to ESTHER, Fredkorpset together with Norad and the Directorate of Health have established the Norwegian Health Development Network in 2009, which serves as an exchange platform of knowledge and experience in Norway. The platform brings together Norwegian institutions engaged in health development activities such as NGOs, universities, hospitals and state actors in order to utilise rich experience of Norwegian health institutions in partnerships and institutional cooperation with developing counties (Norad 2008c and Report by the Workgroup 2009:8).
- Norway also supports the World Bank's Human Resources for Health Trust Fund established in 2006, which is part of the Christian Michelsen Institute's (CMI: http://www.cmi.no/about/) Health and Development Programme. The CMI is an independent centre for research on international development and policy and works in close cooperation with researchers in the South. The objective of the Trust Fund is to participate in the World Bank's efforts to build evidence relevant for solving the human resource crisis in the health sector in Sub-Saharan countries.

4.1.3 Beyond Aid – International Advocacy

The MFA was quick to become active in HRH at the international level and Norway has shown readiness in supporting leadership and advocacy to promote HRH agendas in international forums and global arenas – politically and strategically.

Norway took up the challenge of assisting WHO in implementing the Global Health Workforces Alliance (GHWA) Strategic Plan. Norway also played a key role in the process of establishing the GHWA, convened two of the meetings in 2005 and 2006 respectively and Sigrun Møgedal from the MFA eventually became one of the founding board members (Norad 2008d). Today she chairs the Board. Together with other six foreign ministers, Norway launched the Foreign Policy and Global Health Initiative in 2006. The initiative puts health security on the foreign policy agenda. HRH is one of the 10 focus areas of the initiative (Ministers of Foreign Affairs 2007:1367).

As described above, Norway supports HRH strengthening through strategic HRH components that are integrated in the Norwegian government's MDG 4 & 5 initiative, aiming at reducing maternal and child mortality. The HRH shortages, misdistribution and skills needs represent severe bottlenecks in achieving the health related MDGs. In addition to its efforts in selected countries such as India, Tanzania, Nigeria and Pakistan described above, Norway is also very active at the advocacy level.

We are half way to 2015 and very limited progress has been made by countries in brining down maternal and child mortality rates. The launch of the Global Campaign for the Health Millennium Development Goals is a renewal of the global efforts and commitments with a focus on political action at highest level. This umbrella Global Campaign for the Health MDGs, launched in September 2007 brings together a number of initiatives involving a range of bilateral and multilateral partners and global health funds. It includes:

- Deliver now for Women and Children: A global business plan for maternal and newborn health;
- the Catalytic Initiative to Save a Million Lives focused on reducing under-five mortality
- the International Health Partnership (IHP);
- the Network of Global Leaders initiated by Norway and the UK to provide political backing and advocacy at the highest possible level for the Global Campaign for the Health MDGs;
- the Results-Based Financing Initiative launched by Norway and the World Band and the
- Providing for Health Initiative for sustainable and equitable financing structures for health systems (WHO and GHWA 2008: 67).

In September 2007, Gordon Brown together with Norway's Prime Minister, Jens Stoltenberg, launched the International Health Partnership (IHP). Norway takes an active role in the IHP's Task Force for innovative international financing of health systems through the participation of Jens Stoltenberg. Special Advisor Tore Godal supports this work and Sr. Advisor Helga Fogstad in Norad's Global Health and AIDS Department has been requested to be on the Working Group analysing constraints for scaling up and costs (Norad 2008e). Norway participates in the steering group of IHP and contributes financially to the IHP+ work plan with funding through WHO. Results-Based Financing (RBF) is a strong feature in the Norwegian initiative for Millennium Development Goals 4 & 5 and the bilateral programmes of cooperation with India, Pakistan, Tanzania and Nigeria, where RBF elements are integrated. Norway and the World Bank established a US$ 105 million trust fund in December 2007, which will run over six years until December 2013. The multi-donor trust fund is linked to IDA credits, and will provide financing to national authorities to pilot RBF programmes. Selected interested countries have been asked to develop brief proposals outlining how they would use grants to strengthen the health system to deliver results. Proposals address issues such as the critical bottlenecks to delivering health services – among them HRH – and an RBF mechanism to address them. Five out of 16 interested countries were selected in the first selection round, including Afghanistan, Eritrea, Rwanda, Zambia and some limited funds for the Democratic Republic of Congo (The Global Campaign for the Health Millennium Development Goals 2008:39)

In essence, Norway does play a role in all the above listed initiatives – in some of them as the leading agency. The government closely follows these initiatives, with particular HRH attention.

4.1.4 Selected elements of relevance for Switzerland

As an intermediate summary on the strengths of the Norwegian approach towards HRH development in low- and middle-income countries and key characteristics of relevance to Switzerland, it is being observed that:

- Norway has defined HRH development as a priority and accordingly gives importance to this topic in Norway's development policy underlining that Norway's future needs for health personnel must be solved using national resources and that Norwegian development assistance must be directed towards capacity building and the reduction of migration-driving factors in poor countries;
- Norway conceives HRH development as a multi-ministerial approach and at an intersection between parallel, complex reforms. This requires coherence between domestic and foreign development policies and action plans. More generally, achieving these synergies is acknowledged to determine in an important way the effectiveness of the contributions of the Norway development support to HRH development;
- Norway favours a strong presence in international forums and initiatives advocating and addressing human resource development. Norway for example has been initiating and/or supporting strongly initiatives such as the Global Health Workforce Alliance or the Global Campaign for the Health Millennium Development Goals. This assures a high visibility of Norway at international level.

4.2 Germany

4.2.1 Background

Compared to Norway, Germany has, over the past years, not put HRH development in low and middle income countries in the spotlight as explicitly. For example, Germany has not explicitly established new policies for German development assistance in order to direct them towards capacity building and the reduction of migration-driving factors in poor countries. Germany has also not committed itself through bilateral agreements to a reduction of the flow of qualified health workers from poor countries. However, HRH development has been a longstanding concern of the German Development Cooperation and the country has various instruments at its disposal. One instrument, InWent, has the prime mandate for capacity building of persons and institutions in low- and middle-income countries and the other five instruments of the German Development Cooperation (Gesellschaft für technische Zusammenarbeit (GTZ), Kreditanstalt für Wiederaufbau (KfW), Centrum für Internationale Migration und Entwicklung (CIM), Deutscher Akademischer Austauch Dienst (DAAD) and Deutscher Entwicklungsdienst (DAD)) put a strong emphasis on HRH development. The six main actors and their relevant mandates with regard to HRH development are briefly presented in table 6.

Table 6. Summary of the most relevant mandates of the instruments of the German Development Cooperation with regard to HRH development

Instrument	Relevant Mandates	Main level of intervention
BMZ	▪ Assuring the coherence and supporting priorities (including funding) of the different instruments of the German Development Cooperation ▪ Pushing for political visibility of the topic and political coherence between policies of EU countries ▪ Relating HRH development to global priorities such as universal access, e.g. at G8 and EU level	Global and European Union level Policy development with partner countries
GTZ	▪ Policy dialogue, strategic planning for HRH development as a part of a health system's approach ▪ Technical assistance in the area of HRH development and capacity building to the public as well as the private sector ▪ Coordination of the introduction of different instruments of German Development Cooperation with partner ministries to avoid confusion and assure "EZ aus einem Guss"	National, regional and district level
KfW	▪ Financial Cooperation including infrastructural support and contributions to SWAp	National (and regional) level
InWEnt	▪ Creating opportunities for political exchange and dialogue ▪ Support for continuous professional development for individuals ▪ Capacity Building of health training institutions in the South	International (and national)
CIM	▪ Capacity strengthening in low- and middle-income countries through the recruitment of technical experts from the EU ▪ Return and Reintegration Programme to assist experts from the South who study/work in Germany to return home	Germany/EU/ National and regional (and local) level in the South
DAAD	▪ Facilitate academic and research possibilities in Germany for scholars from around the world ▪ Facilitate partnerships between German and International Universities	International and national
DED	▪ Capacity strengthening in low- and middle-income countries through the recruitment of technical advisors	(National, regional and) Local level

4.2.2 Instruments of the German Development Cooperation and HRH development

Six agencies (instruments) under the leadership of the German Federal Ministry for Economic Cooperation and Development (BMZ) constitute the pillar of the German Development Cooperation. Their characteristics and some of their activities are briefly presented in the following sections.

Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) is a technical assistance agency active in international cooperation. The GTZ mainly works for the German Federal Ministry for Economic Cooperation and Development, but also operates on behalf of other German ministries, partner-country governments and international clients, such as the European Commission or the World Bank. GTZ supports in a number of countries such as Indonesia, Malawi, Tanzania, Cameroon or Rwanda, either through specific projects or broader health sector strengthening programs, HRH development and management. Activities cover a broad range of activities and include assistance to planning and administration processes across different departments (health, education, finance – civil service reform) at national and provincial level, the systematic staff planning system, the development of guidelines and quality standards, admission requirements, incentive systems and training and upgrading programmes for HRH training and management. In addition to a number of specific HRH development projects, GTZ is also funding since 2020 the “GTZ BACKUP initiative” so to help partner countries taking advantage of the opportunities provided by global initiatives in the field of HIV/AIDS, tuberculosis and malaria. The initiative seeks among others to

strengthen national and international partnerships to make global finance work and to assist in developing relevant skills and know-how of stakeholder implementing organisations. Thus, an important focus are capacity strengthening measures for example at the level of Country Coordination Mechanisms, especially of civil society members. Additionally, GTZ also assists other specific capacity building initiatives such as the Centre International de Formation en Recherche Action located in Burkina Faso and covering West Africa geared at adult training and network-building. The focus upon capacity building is structured into training courses, with a field work element, at local national and regional level, the coaching of participants and the training of trainers. Examples include courses addressing the issues of gender violence and female genital cutting through strengthening health and social services to approach the issue from "within".

Kreditanstalt für Wiederaufbau (KfW) is involved in a wide number of financial activities. Financial cooperation with developing countries forms one work area. In 2005, the German Development Bank (KfW) committed € 1.9 billion for projects in developing and transition countries. Two thirds of the money was provided from the German state budget and one third from KfW own funds. Albeit the prime focus of KfW lying on large infrastructural investments, in the health sector on primary care and hospital infrastructure and equipment, KfW promotes at country level synergies and close collaboration with the other actors of the German Development Cooperation ("Entwicklungszusammenarbeit aus einem Guss").

Internationale Weiterbildung und Entwicklung (InWEnt - Capacity Building International, Germany) has the mandate to contribute to capacity building of persons and institutions in low- and middle-income countries. InWEnt offers a large variety of possibilities for exchange and professional development for staff from partner countries in their home countries, in other countries in the South or in Germany. InWent focuses its activities on providing support to individuals as well as institutions through offering continuous education programmes, study tours/exposures, training using "training of trainers (TOT)" model" and multipliers, network building- including Alumni networks – which keep in touch via community of practices, online portholes and face to face meetings at regional and supra regional level. Particular emphasis is placed upon supporting South to South dialogue through E-learning, building of local teaching capacities in new subject areas and in methodologies for adult-centred learning, developing curricula/accompanying processes of accrediting curricula. InWEnt orientates its training offers to the wishes of employers and seeks for training to be practice orientated and highly relevant for the health worker in his/her workplace. An example is the one year training in hospital management in Germany which is open to young professionals from 5 African Countries – Malawi, Tanzania, Cameroon, Rwanda and Kenya. Students receive theoretical input and undertake a placement in Germany and are then supported to return to their original workplace and to implement their new knowledge via a so-called "transfer project". InWEnt also supports studies for students from the South within other institutions based in the South. By doing so, an important contribution is made to ensure that sustainable training institutions are in place. An example is the Tanzania Training Centre for Orthopaedic Technology. It is important to acknowledge InWEnt's contribution to non-monetary incentive packages. Training is known to have a motivating effect; taking part in InWEnt's wide selection of courses - e-learning, blended or classroom-based - can be seen as a chance for personal development and whilst the courses generally don't lead to an academic title, feedback from participants and employers alike are extremely positive. InWEnt regularly monitors and evaluates the impact of trainings through tracer studies with trainees and their employers.

Deutscher Entwicklungsdienst (DED, German Development Service) places professional advisors in developing countries. They provide technical assistance and work to develop capacity at the level of both individuals and institutions. In a number of countries DED makes available well qualified and experienced staff from Germany/the EU to work in Asia, Africa, Latin America and Eastern

Europe, in various instances within health sector programs. These staff are often placed within broader health sector programs of the German Development Cooperation and are run by agencies such as KfW or as in the case of Malawi by GTZ ("Entwicklungszusammenarbeit aus einem Guss").

CIM is a joint operation of the GTZ and the German Federal Employment Agency (BA) and works to reverse the brain drain of highly qualified staff, including health staff, from low and middle income countries to Europe. Nearly 600 European professionals (around 60 of them working in the health sector) are currently working and transferring skills and know-how through the CIM Integrated Experts Programme in 70 countries throughout the world. CIM cooperates with senior public services and private employers in partner countries and undertakes recruitment in the EU on their behalf. A pre-selection is made with the final decision lying with the local employer. The recruited expert is subordinated to the local employer and structures, hence the term "integrated expert" is used. The contract of employment is provided by the local employer. The intention of CIM is to strengthen institutions as well as their workers. The interest is always greatest where the impact has a potentially broader reach than simply within the placement institution. It is of great benefit when CIM operates within Programmes of the German Development Cooperation so that the experience of CIM workers can be fed into policy dialogue at national level. In addition, CIM actively recruits specialists who have undergone training in Germany and who are interested to return to their home countries. This is the so-called "Return and Reintegrate Programme". Amongst academic diasporas who have come to work, study, teach and research in Germany for a variety of reasons CIM is a well known instrument. CIM provides those looking to repatriate with transport subsidies and topping up of wages for up to two years– benefits which greatly ease the financial implications of a relocation and reintegration into local public services. In total, between 600 and 700 qualified people (all qualifications confounded) return home with CIM support every year. Some of the key countries are Ethiopia, Ghana, Cameroon, India, Indonesia, Israel/Palestine and Syria. Overall between 50-60 health specialists leave Germany for the public sector in their home countries as part of this programme every year.

Deutscher Akademischer Austausch Dienst (DAAD, German Academic Ex-change Service) facilitates academic and research possibilities in Germany for scholars from around the world. Continuous education options and alumni networks help to ensure contact with professionals from low and middle in-come countries beyond the mere length of their stay in Germany. Deutscher Akademischer Austausch Dienst (DAAD, German Academic Exchange Ser-vice) facilitates tertiary level education and research possibilities for academics and students worldwide to come to Germany and for Germans to study and teach abroad. DAAD offers some 200 different programmes for those interested to pursue studies in a wide variety of disciplines including medicine. It also promotes German Universities and their international attractiveness, for example, through the introduction of Master courses taught in the English language and by international marketing activities. Overall 42% of DAAD's total annual expenditure, some Euro 39 million, is channelled to developing countries. The number of academics involved in DAAD activities in 2005 totalled 51,478 with 38,583 at graduate or post graduate level (23,813 coming from overseas and the rest from Germany). The remaining 12,895 were post-doctorate level, research assistants or professors.

Measures financed by DAAD include facilitating partnerships between universities in the "South" and in Germany with the overall aim of strengthening training capacity within institutions in resource constrained contexts. For example, the University of Heidelberg and Clinical Medical Faculty in Mannheim support the specialist surgical training of medics at the Mbarara University in Uganda. The DAAD medical programme supports German universities to realize a university partnership with one or more developing countries and offers summer schools or other short courses for students from developing countries at German medical schools or alumni who have already

returned to their home countries. Today more than 35 Postgraduate Courses with relevance to developing countries and professions are offered at German universities in the English language. Since the programme began in 1987 more than 4000 international professionals have benefited with well over 90% successfully obtaining a Masters degree. These programmes place a special emphasis on ensuring that the students keep in touch with working in their home countries through internships and tailored trainings throughout their time in Germany. Upon returning to their home countries after the period of study, continuous education options and alumni networks help to ensure contact with the returnees. Examples include further training in DNA technology at the University of Hamburg which aims at researchers from the University of Damascus in Syria, accident surgery and nephrology training at the University of Ulm tailored to the needs of medics from the Komfo Anokze Teaching Hospital, Kumasi in Ghana. Graduates and post-graduates are largely supported for further studies in Germany as part of second degrees or for further studies, in particular Doctorate level. These options cover periods of 12 months to several years. At doctorate level, PhD students can combine spending study and research phases in Germany and in their home country ("Sandwich-grants"). Their work is jointly tutored by academics in both locations with the final degree being awarded by the home university. Examples include research being done in the area of HIV and how the response thereto has been taken up in country policies in Kenya at the University of Bielefeld. A best practice example is the DAAD's medical programme which actively counters the brain-drain. Medical training institutions in Germany with high numbers of foreign students are supported to implement packages of measures to help medical graduates return to their home country. During the course of their training this includes additional input upon tropical medicine, appropriate technology and the facilitation of internships in the developing world. Once back home, the Universities stay in touch with the graduates to ensure that they continue to receive additional training, visiting placements and teaching assignments in Germany on a regular basis in the sense of life-long learning and a continuing connection to Germany. They are also brought in touch with German instruments of development cooperation insofar as they are active in the graduates' home countries. A particularly successful example is the programme at the University of Heidelberg for medical students from Cameroon, Vietnam, Ethiopia and the Yemen.

4.2.3 Selected elements of relevance for Switzerland

As intermediate summary on the strengths of the German approach towards HRH development in low- and middle-income countries and key characteristics of relevance to Switzerland, it can be observed that:

- The German Development Cooperation promotes its development assistance around six instruments (agencies) under the umbrella of the German Federal Ministry for Economic Cooperation and Development (BMZ) and promotes synergies and close collaboration across these actors ("Entwicklungszusammenarbeit aus einem Guss") at country level.
- Germany has at its disposal one instrument, InWent, with the prime mandate for capacity building of persons and institutions in low- and middle-income countries and another one, CIM, which runs a specific program the so-called "Return and Reintegrate Programme" for helping highly qualified migrants living in Germany to return to their country of origin. The other four instruments of the German Development Cooperation (GTZ, KfW, DAAD and DED) give strong emphasis to HRH development.
- The potential of German development cooperation appears to be linked to its different institutions respectively instruments and their ability to support training and teaching facilities, placing external staff at local rates, as well as facilitating reintegration. Moreover, a frequently perceived advantage of this bilateral agency is its representation at national and district level (Windisch et al., 2009).

- Experiences and contributions of the German Development cooperation concerning the HRH problematic at priority country level vary. In some countries such as Malawi or Tanzania, HRH development is a priority concern for health sector support. In other countries such as Cameroon, HRH development is promoted in a more horizontal way in line with the “traditional” German support and includes programmes to assist health sector reforms, quality improvement activities or strengthening of district health services, including collaboration with the private health providers. Doing so, Germany acknowledges that HRH development lies at an intersection between parallel, complex reforms, requiring also investments in good governance, decentralisation, civil service and health sector reform and interlinkage to other agencies/actors, including to Global Health Initiatives.

5 Conclusions

Well trained and motivated health workers are the single most important input to health service provision and improved health. Without them, advances in health care cannot reach those most in need. Despite this, health systems in high- middle and low-income countries are finding it increasingly difficult to train, support and retain their health workforce.

The present study established an inventory of cooperation practices of Switzerland with middle and low-income countries in the area of human resource development HRH including two country case studies of Swiss cooperation practices (Romania and Tanzania) and reviewed cooperation practices in the area of HRH development of two European countries (Germany and Norway) in the light of their validity for Switzerland. In the subsequent paragraphs, the document establishes selected recommendations on cooperation approaches aiming at the retention of health workers in their country of origin and "next steps" of Swiss cooperation practices in the area of HRH development.

The present study has two major limitations:

- The inventory of cooperation practices was not exhaustive but relied on a restricted number of contacts and telephone interviews with Non-Governmental Organizations and Institutions which were arbitrarily selected through the Medicus Mundi Network. Furthermore, not all cooperation offices of the Swiss Agency for Development and Cooperation with health sector activities responded to the E-mail questions. It can be frequently observed that a large range of small-scale initiatives often target one or several individuals active in the area of HRH development in middle and low-income countries. Such initiatives include health staff (generalists, specialist doctors, nursing staff) working at the level of Swiss hospitals or health providers facilitating capacity building measures in countries of origin and visits of health staff from low and middle income countries over shorter and longer periods in Switzerland. In various instances they materialise into formalised hospital partnerships. The implementation of vocational training opportunities in receiving countries regulated by agreements which specify recruitment contingents for both, source and receiving countries, with the aim to achieve a win-win situation, represent additional measures. The study did also not include other currently discussed intiatives, such as the once of Careum Foundation which considers investments in training schools in low-income countries (e.g. Philippines) with the aim that a part of the newly trained health workforce can become availble for Switzerland. These initiatives were however not included in the present study but contribute to HRH development.
- The study is not in a position to quantify absolute and relative financial investments of Swiss actors and institutions into HRH development in source countries. There are several reasons for this. Firstly, budgets of development projects are typically spread over different calendar years and are often not tied into fiscal years. Secondly, budgets do not necessarily correspond to expenditures. Thirdly and most importantly, investments in HRH development are typically part of broader health systems strengthening projects and programs which do not specifically disclose budget lines related to human resources. For example the budget tool used by SDC does not present HRH budget lines in a structured way and furthermore does not synthesise investments in HRH through a summary budget. This makes it impossible to quantify Swiss contributions to HRH development in source countries in monetary terms, both in absolute and relative terms of development assistance.

The inventory of Swiss cooperation practices shows that Switzerland supports, through its development assistance, a substantial number of initiatives and projects which focus on changing the conditions for health care workers in source countries, including increasing wages and opportunities for training and improving working conditions. This is also underlined by Swiss foreign policy relating to health matters which emphasises that attention should be given to problems relating to international migration of health workers (EDI and EDA, 2006). At the same time, Switzerland does not pursue a specific policy to minimize the reliance on foreign health professionals and does not regulate the recruitment of health workers from EU countries who themselves are facing a shortage of health care workers. With the adaptation of the Code of Practice on international recruitment of health personnel during the World Health Assembly 2010, this situation is likely to persist.

Rather than restricting the movement of health professionals, such schemes emphasize the minimization of the factors that foster migration. In light of the disparities between sending and receiving countries and the critical need for health workers in poor countries, the WHO and other global actors are giving high-level consideration to such actions. Complementary, Switzerland is promoting the application of innovative technologies as defined in the national “eHealth strategy” with BAG and BBT taking on leading roles.

Key findings/messages emerging from this study are:

1. The importance of investing in human resource development in low- and middle income countries as an integral part of efforts to strengthen health systems and to prevent health worker migration is acknowledged by a broad range of Swiss governmental and non-governmental actors.
2. Swiss investments in human resource development are substantial but typically do not relate to stand alone investments in human resource development or the prevention of migration and are an integral element of broader health systems strengthening efforts.
3. Swiss investments in human resource development are channelled through different mechanisms (SDC, SNSF, Swiss Cohesion Funds, SECO, NGOs, etc.). They are not well inserted into a broader and comprehensive Swiss health policy for cooperating with low- and middle income countries or into an overall strategy for combating health worker migration.
4. The Norwegian and German experience indicate to Switzerland
    a. the importance of promoting synergies and close collaboration of the different agencies and their aid modalities of a given country
    b. the importance of multi-ministerial approaches for policy coherence between domestic and foreign/development policies and development of plans of action
    c. the need for a strong presence in international forums (e.g. Global Health Workforce Alliance, World Health Organization)
    d. the relevance for defining HRH problems as a global health priority in countries development policy

    If more emphasis is given to these factors, the effectiveness, efficiency and sustainability of Swiss investments can be enhanced.
5. While long term investments in health sector development are a key strength of Switzerland, it runs the risk of being less visible than the actions of other donors and agencies. In an increasingly competitive environment it is therefore utmost important to create a clear Swiss development cooperation profile that makes the varying strengths of the different governmental and non-governmental organizations more widely known.
6. As there is little evidence available on which of the used "Swiss" strategies really work for human resource development in the health sector, there is potential to focus on a systematic capitalisation and dissemination of country based and regional experiences and to

monitor and measure better measure of the impacts of its domestic and foreign investments.

Some of the above observations are in line with the peer review of the Development Assistance Committee (DAC) of OECD. This analysis concluded among others, that Switzerland should promote a better understanding of the concept of policy coherence for development - including within the Swiss administration and should translate its vision of policy coherence for development into a framework common to all federal offices (OECD, 2009). The report also emphasised that Switzerland should explore ways to ensure that development concerns are heard in government decision-making and in the drafting process of law, and that best use is made of inter-departmental agreements to promote development through domestic and foreign policies. Along the limitations presented above with regard to the impossibility to financially quantify Swiss contributions to HRH development in source countries the OECD review observes that Switzerland should make efforts to better measure, monitor, and report on the impacts of its domestic and foreign policies on its development efforts and results.

The implementation of HRH strengthening measures, suggestions, decisions and activities realised by multilateral organisations (OECD Policy Brief 2010, International Migration of Health Workers, recommendations of International Council of Nurses or the WHO etc.) or foreign countries should be closely observed and translated into action, where applicable, by relevant Swiss actors. An attempt should be made to e.g.: (i) learn and benefit from best practice examples and country experiences, (ii) improve and use standardised statistical country data, (iii) improve statistical data generation by systematically tracing the migration of health professionals, their country of origin and educational status (EDV 2010), (iv) implement the WHO code of practice regarding the international recruitment of health personnel (WHO 2010), (v) consider to become a member of the International Health Partnership (IPH), (vi) support research efforts and consider the foundation of relevant research programs, (vii) assess the need to invest in innovative technologies (eHealth, remote care), and to (viii) consider the responsibility of receiving countries to reduce their recruitment of health care professional from source countries.

Governments and donors who aspire to achieve the ambitious United Nations Millennium Development Goals, such as reversing the child and maternal mortality rates or the spread of priority diseases (HIV/AIDS, malaria, tuberculosis), must commit themselves for mid and long-term investments in health systems and health systems strengthening. Concurrently, source and destination countries of health workers must adopt migration regimes that seek to secure within source countries an adequate number of health workers who are further adequately trained and are well performing. Albeit there is general agreement on the end goals, approaches that different actors and countries may support are contested. In the next paragraphs we briefly provide an outline of selected approaches which might be of relevance for Switzerland.

Switzerland may promote **bilateral treaties** so to steer health worker flows that are more beneficial to source countries. Such treaties may as in the case of Norway limit recruitments by the public sector from most low-income countries. As Switzerland is however recruiting its health staff principally from EU countries the impact of such measures are likely to be limited. Alternatively, Switzerland may establish and engage in agreements with middle and low income countries which provide the frame for sending medical professionals to Switzerland for training purposes. In other words, the implementation of vocational training opportunities in receiving countries regulated by agreements which specify recruitment contingents for both, source and receiving countries, with the aim to achieve a win-win situation, represents one possible measure as an element of bilateral treaties.

The Swiss development cooperation may also **promote Circulatory Migration**. In-line with the concept of circulatory migration it might also be considered to change the visa policies of Switzerland to promote skills development through short-term visas. The hope is that such training could improve health care treatment and retention in the health care profession within source countries. We talk of circulatory migration when staff remain based in their home country and work in the system for the majority of the year - with all the benefits this holds for their colleagues and students gaining from their expertise and supervision. For the remaining, shorter part of the year they are based in another country, at a partner institution, where they provide input through teaching, supervising student, taking part in joint research projects, or spend part of the time accessing continuous training. They then start to move their way around the circle again. There is no notion of permanency attached to the migration and no intention to settle – neither from the perspective of the individual nor the receiving country. Clearly, the costs of running such schemes are high in terms of economic expenditure. Circulatory migration is also likely to be an approach to target specific categories of health professionals, typically the well educated who can easily adapt to training and research settings in Switzerland. Albeit Germany is using circulatory migration as an element in its strategy for HRH development, to date there is little hard evidence as to whether participation in such schemes really facilitates that highly qualified health professionals decide not to emigrate. Research into the benefits for receiving countries is also limited. The little data that is available indicates a “win-win” situation. In particular, universities in Germany engaged in such partnerships report a high level of cultural interaction, the generation of new ideas, and a rich exchange in both the subject matter and working approach.

The Swiss development cooperation may also engage in **facilitating the Migration of Health Care Professionals to Countries with Health Worker Shortages**: A large number of health professionals are living outside of their country of origin. Many of them are willing to contribute their skills to their home countries and may be interested in initiating and sustaining initiatives for HRH development. There are a range of tools available to countries to promote such transfers, including allowing dual citizenship to foster more circular migration. Countries such as Switzerland may also more systematically allow health staff to return to their country of origin under special arrangements that will not penalize them upon their return to Switzerland. Many health professionals abroad are unaware of opportunities at home, a weakness that organizations such as the International Organization of Migration are working on to strengthen.

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Annex 1. List of NGOs contacted

1. CO-OPERAID
2. Enfants du Monde – *no response and not included in the survey*
3. FAIRMED – Health for the poorest
4. Fondation PH Suisse
5. globalmed
6. IAMANEH – *no response and not included in the survey*
7. Jura Afrique
8. medico international Switzerland – *interview cancelled and not included in the survey*
9. medicuba-Suisse – *interviewed cancelled and not included in the survey*
10. mission 21
11. Missionary Department of the Protestant Churches – *interview cancelled and not included in the survey*
12. Médecins du Monde-Switzerland
13. Novartis Foundation for Sustainable Development
14. Pharmaciens sans Frontières Suisse – *no response and not included in the survey*
15. SolidarMed
16. Swiss and German Aid Caritas
17. Swiss Dental-Aid International
18. Swiss Red Cross
19. Terre des hommes Foundation – *no relevant information and not included in the survey*
20. Verein Partnerschaft Kinderspitäler Biel-Haiti
21. World Health Foundation of Switzerland – *no response and not included in the survey*
22. Bündner Partnerschaft Hôpital Albert Schweizer, Haiti
23. Graduate Institute of Development Studies IUED – *no response and not included in the survey*
24. Geneva University Hospital

Annex 2. Questionnaire used by study

HR Survey – Telephone interview

by the Swiss Centre for International Health (SCIH) of the Swiss Tropical Institute (STI), Basel, Switzerland

The Swiss Centre for International Health (SCIH), a department of the Swiss Tropical Institute (STI) (http://www.sti.ch) has been mandated by the Swiss Federal Office for Public Health (FOPH) and the Swiss Agency for Development and Cooperation (SDC) to conduct a survey to identify *"best practices"* and evaluate the Swiss Cooperation Strategies aiming at *strengthening human resources*[1] in health. In this context a telephone interview will be held with selected representatives of the main Swiss stakeholders engaged in the international health context. The actor's views on the level of involvement, types of activities, best practice examples and collaboration modalities of their organisation to support the development and stabilisation of HRH situation in source countries shall be assessed.

General Information

Name/Type of organisation: _____

Name: _____

Position: _____

Country Focus (if relevant): _____

[1] The term *strengthening HRH* refers to actively getting involved in measures directed to maintain human resources in source countries by improving the so called push factors at individual, health service, health sector and socio-economic level. These comprise e.g. investments in capacity building efforts, working conditions, infrastructure, salary regulations, incentive schemes, HR policy improvements and activities targeting the strengthening of the health system and related labour market.

1

Human Resource information – Organisational level

1. What in your opinion are the **five** most pronounced human resource in health problems faced by source countries? *Please identify the **five** most important HRH problems by choosing from the **10** answer options listed in the table below and rating them (1 – most urgent HRH problem, 2 – 2nd most urgent HRH problem etc.).*

HRH problems	Most urgent HRH problems
1) Inadequate staffing (e.g. inadequate staff numbers, staff qualifications, skill mix and imbalanced staff geographical distribution)	
2) Limited staff productivity and performance	
3) Low salary levels/income and lack of monetary incentives	
4) Limited career development prospects	
5) Poor working conditions (e.g. lacking infrastructure, long working hours, high work load, lacking work regulations and best practice standards, lacking non-monetary incentives (e.g. supplies, staff well-fare medical services, housing provision, childcare facilities))	
6) Limited training capacities (e.g. low output of undergraduate and post graduate training, lack of continuous education and learning opportunities)	
7) Brain drain and migration	
8) Absence of or weak operational HRH policies (e.g. HRH policy, retention policy, retirement policy)	
9) Political instability	
10) Other	

2

2. In which HRH areas is your organisation most active in source countries? *Please choose between the "active" or "not active" answer options for each defined HR focus area in the table below.*

HRH focus area	Active	Not active
1) Improvement of the staffing situation (e.g. adequate staff numbers, staff qualifications, skill mix, balanced staff geographical distributions)		
2) Improvement of staff productivity and performance		
3) Improvement of salary levels/income and provision of monetary incentives		
4) Improvement of career development prospects		
5) Improvement of working conditions (e.g. adequate infrastructure, acceptable working hours and work load, strengthening the development and implementation of work regulations and good practice standards, strengthening the provision of non-monetary incentives (e.g. supplies, staff well-fare medical services, housing provision, childcare facilities)))		
6) Improvement of training capacity (e.g. undergraduate/graduate training, continuous education and learning opportunities)		
7) Activities to counteract brain drain and migration		
8) Strengthening of operational HRH policies (e.g. HRH policy, retention policy, retirement policy)		
9) Strengthening the political stability		
10) Other		

3. Is your organisation active or involved in *strengthening Human Resources in Healt*[1] in source country (-ies)? If yes in which countries and which focus areas? *Please elaborate.*

4. What are your organisation's cooperation modalities/strategies with project partners with regards to HRH strengthening activities (e.g. agreements on training, contractual arrangements)? *Please elaborate.*

5. What is your organisation's motivation to support HRH activities? That is, do you base your support on the country's policy documents, are there contractual arrangements etc.? *Please elaborate.*

3

6. What does your organisation do to counteract push factors (e.g. low pay, lack of incentives, poor working conditions) and to prevent brain drain from source countries? *Please elaborate.*

7. If so, how does your organisation support circular migration[2] back to the source countries?

Human Resource information – Swiss level

8. Are you aware of other Swiss actors involved in Human Resource in Health strengthening activities in source countries (e.g. developing countries, Eastern Europe)? *Please elaborate.*

9. What do you consider as the most important failure and missed opportunities of the Swiss Development Cooperation with regard to HRH during the last years? *Please elaborate.*

10. What are comparative strengths of the Swiss Development Cooperation with regard to other country HRH initiatives? *Please elaborate.*

11. Where do you see the priorities for the future and how should future HRH strategies be designed? *Please elaborate.*

12. Do you have any additional final comments to make? *Please elaborate.*

Thank you for your time input and efforts!

[2] The term *circular migration* refers to a triple win discourse promising gains for host countries, home countries and migrants themselves, promising accelerated economic growth, remittances, relative high wages and brain gain, by means of full circles of migration: immigrants should be able to come, go and come back again to their home countries, with few restrictions and making use of contemporary transnational networks.

Annex 3.
Grid used to analyse support of Swiss agencies to HRH development

Potential push factors for migration	Do Swiss governmental and non-governmental agencies support the ….
	Individual level
Career development prospects	• Establishment and transparency of career paths for all health staff in place?
Salary level/Income and monetary and non-monetary incentives	• Compliance with minimum/ acceptable/standard country salary levels? • Implementation of monetary (e.g. salary top-ups) and non-monetary incentives (e.g. transport allowances, free uniform, housing loans, cars, drugs) schemes to promote an improvement of working conditions of health staff? • Improvement of intrinsic motivation of health personnel by e.g. supporting the allocation of responsibilities and reward systems e.g. opportunity to benefit from trainings, monetary or non-monetary incentives?
Gender/Cultural/Social class and ethnic Determinants	• Efforts to counteract gender and cultural negative issues e.g. maternity leave support, linguistic, social, ethnic barriers? Is the right ethnic, gender and social mix of health personnel available to offer health services promoted?
Working conditions (e.g. regulation of working hours, work load, availability of job descriptions-)	• Improvement of working condition e.g. max. working hours defined, work load clearly defined and adhered to, job responsibilities defined and is job security assured?
	Training capacity
Initial and post-graduate training	• Strengthening of education/training institutions (both initial and post-graduate) for the main HRH cadres - in rural and urban areas?
Continuous education opportunities (e.g. short and long-term education possibilities)	• Establishment and support of adequate continuous education and training programs and institutions in line with country priorities?
	Health service level
Team building and interaction e.g. management, supervision, information and communication, skills matched with tasks, codes of conduct, safety, quality standards	• Improvement of the work environment by enhancing e.g. good teamwork, teambuilding exercises and good communication, prevention of abseentisms.
Performance management and productivity	• Establishment of systems to set standards for supervision, leadership and performance assessment (e.g. Monitoring of staff, management meetings etc.) and quality?
Physical working environment/Infrastructure and supplies (e.g. drugs and health products)	• Health infrastructure development is in line with national standards e.g. availability of medical supplies is guaranteed, functioning equipment etc.?
	Health sector level
Composition of workforce and skill mix	• Balanced availability of health skills - are shortages or overcapacity of certain professional medical groups (e.g. nurses, doctors)?
Geographic imbalances	• Prevention of geographic imbalances and an adequate distribution of health personnel in urban and rural areas?
HRH policy and planning (recruitment policy, bilateral agreements to manage migration, retirement policy, succession planning)	• HRH issues in broader development policies and strategic national policy documents (e.g. Poverty Reduction Strategy Paper)? • Establishment of local and national HRH policies? • Establishment of rules and procedures for hiring and firing staff where needed (including of flexibility of regional and district authorities)? • Measure to foster circular migration in terms of: actively contacting and reintegrating health staff trained in developed countries back in to developing countries e.g. harmonization of qualifications, salary top-ups, transport subsidies?
	Sociopolitical and economic country context

Multi-sectoral approaches/ collaboration	• Cooperation across key national actors (health, education, finance – civil service reform) to act on HRH issues? • Cooperation among external funding agencies e.g. by following country's policy documents integrating with national HR strategies?
Governance and overall policy framework	• Coherence of policy measure with regards to HRH e.g. recruitment policies, immigration laws and regulations in place which prevent emigration of medical professionals?
Political stability	• Strengthening the political environment (good governance, absences of war, rebellion)? • Strengthening of the socio-economic context (e.g. GDP, life expectancy, literacy and levels of employment) favourable to maintain health staff in the country of origin?

Annex 4. Selected Norwegian-funded initiatives for HRH development

This annex provides a short outline of the selected Norwegian-funded initiatives to strengthen HRH globally and in specific countries:

1. Malawi has been a main partner country since 1997. The priority areas for Norway's cooperation with Malawi are governance and human rights, economic reforms/budget support, health, HIV and AIDS, and agriculture. The support is based on the country's national growth and development strategy. Norway contributes to HRH strengthening through the health Sector Wide Approach (SWAp) and partially finances the National AIDS Commission of Malawi. The mid-term review of the Malawi health SWAp reports on the progress in general (Norad 2008b) and on the achievements in terms of HRH issues in specific (Martineau 2008). Additionally, through a strategic partnership with Norwegian Church Aid, substantial funding was provided to the Malawi College of Medicine for doctors and nurses training (Norad 2008a: 12-13). For a mid-term review on the nurse training programme see Martinez et al. 2008.

2. In Botswana HIV & AIDS represents the greatest development challenge. The government has responded to this with a number of initiatives, including the roll-out of ART treatment, which requires significant human resources. Based on a request of Botswana's President, Norway has signed an agreement for HRH assistance to the Botswana Ministry of Health for a time period of 4 years (2004-2008). The project objectives are i) to recruit fifteen health professionals to support additional ARV Therapy related to workload, and to complement staff of the Institutes of Sciences for a period of 3 years, ii) to build capacity for the training of health personnel with a view to meeting some of the human resource requirements for the health sector and iii) to improve the ARV Therapy programme uptake through enhanced capacity. Although the project has made a positive contribution to the delivery of health services and has improved the human resource situation the mid-term review identified a number of failures linked to the design and sustainability of the project (see Maphorisa and Lauglo 2007: 16-19).

3. Norway supports HRH issues in Tanzania and India as a component of the MDG 4 and 5 bilateral programmes. The Norway India Partnership Initiative (NIPI) is designed to achieve MDGs 4 and 5. Norway supports a five-year programme in five states where child mortality is particularly high with NOK 500 million in the period 2006-2011. The assistance primarily focuses on strengthening the Indian Government's health programme for rural areas with a focus on vaccinating children and improving access to health services. Teaching material has been prepared for voluntary health workers for promoting breast-feeding, better hygiene and better nutrition (Norad 2008a: 36 and 2007: 28). Similarly in Tanzania, Norway entered into an agreement to support Tanzania's efforts to reduce child and maternal mortality (MDGs 4 and 5). Apart from supporting HIV prevention interventions funding is channelled to various NGOs, such as the Mkapa Foundation, which works to increase the capacity of health personnel to provide treatment and care in remote districts (Norad 2008a: 22-23 and 2007: 18-19). Similarly bilateral cooperation programmes to tackle maternal and child mortality exist with Nigeria and Pakistan.

4. Global Health Initiatives such as the Global Alliance for Vaccines and Immunization (GAVI) or the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) have started to invest in health systems – including human resources – to improve the delivery of health services (GAVI 2008). Today, Norway has a central role in both. Norway made a pledge in

2005 to provide US$ 750 million over 10 years to the GAVI Alliance which would bring the total support from Norway to US$ 1.00 billion to the end of 2015. Several Norwegian partnership countries have been approved for multi-year programs for health systems strengthening for immunization, such as Mozambique, Malawi, Tanzania, Nigeria and Pakistan (Norad 2008f).

Annex 5. Terms of reference of the study

Proposition de mandat d'enquête en vue de procéder à un état des lieux des pratiques de coopération dans le domaine des ressources humaines de la santé et identification des « best practices »

Objectif :

Le projet de code de pratique de l'OMS pour le recrutement international des personnels de santé prévoit à son article 5.1 que « *In accordance with the princip of mutuality of benefits, both source and destination countries should derive from international recruitment of health personal* ». Actuellement, même si la Suisse agit afin de diminuer son degré de dépendance envers les professionnels formés à l'étranger, il paraît inévitable qu'elle continuera à recourir à moyen terme à l'immigration pour compléter ses effectifs, notamment en raison de la durée de la formation des professionnels de la santé. Afin de faire en sorte que les bénéfices de la migration soient répartis équitablement avec les pays d'origine (« win-win ») il apparaît nécessaire de procéder à un état des lieux des pratiques de coopération, tant privées que publiques, qui ont été mises sur pied en Suisse, ainsi que dans les pays voisins. L'objectif est d'identifier les meilleures pratiques (« best practices »), qui permettent un recours raisonnable aux professionnels de la santé tout en contribuant au renforcement des systèmes de santé des pays d'origine.

Proposition :

Il est proposé de confier la réalisation de ce travail d'enquête, sous forme de mandat à Kaspar Wyss (Institut Tropical Suisse). La participation des différents offices membres du groupe interdépartemental au financement de ce mandat est aussi à déterminer. Le coût approximatif du mandat est évalué à 50'000 CHF.

Contenu du mandat :

La Suisse est active depuis longtemps dans le domaine de la coopération et du développement en faveur du renforcement des ressources en professionnels de la santé des pays en développement et en transition. Cette coopération se manifeste notamment à travers des investissements de la Direction du Développement et de la Coopération (DDC), du Secrétariat d'état à l'économie (SECO), de l'Office fédéral des migrations (ODM) et du Fonds National de la Recherche Scientifique (FNRS) dans des pays du Sud et de l'Est. Cependant, il n'existe pas de vue d'ensemble des initiatives mises sur pied tant au niveau privé, institutionnel que gouvernemental. Il existe ainsi plusieurs types de partenariats hospitaliers et scientifiques, dont la forme et la portée varient. La DDC, qui a collaboré à la réalisation de certains de ces partenariats, vise depuis un certain temps à agir de manière préventive contre l'émigration des personnels de santé des pays en développement et en transition par un soutien au renforcement des systèmes de santé. Plus récemment, la Confédération a mandaté la DDC et le SECO pour administrer les fonds de cohésion de la Suisse en faveur des nouveaux pays membres de l'Union Européenne avec notamment pour objectif de renforcer les systèmes de santé des pays comme la Lituanie, la Pologne ou encore la Slovénie. Actuellement un crédit complémentaire mettant à disposition des fonds de cohésion pour la Roumanie et la Bulgarie est en cours d'examen au niveau des deux chambres du parlement. Le FNS, de son côté vise, notamment par ses programmes SCOPES ou de partenariat scientifique pour le développement, à renforcer les compétences des professionnels de santé et notamment des universitaires.

Un état des lieux des pratiques de coopération dans le domaine des ressources humaines pour la santé permettrait non seulement d'identifier, par le biais d'exemples concrets, les meilleures pratiques en cours, mais aussi de mettre en évidence une interface/articulation possible entre les initiatives privées, institutionnelles et gouvernementales, ceci dans la perspective globale du renforcement des systèmes de santé des pays d'origine. Une clarification de la situation nationale permettrait par ailleurs de participer activement aux débats sur le code de l'OMS. La réflexion pourrait aussi être entamée sur la façon de diffuser ces « meilleures pratiques » en Suisse.

Objectifs :

L'enquête approfondirait donc les points suivants :

- Inventaire et état des lieux des pratiques de coopération de la Suisse dans le domaine des ressources humaines pour la santé avec un accent sur :
    - Le rôle des différents acteurs impliqués (gouvernementaux – non gouvernementaux)
    - Les modalités de collaboration avec les individus et pays partenaires
    - Les conséquences de ces pratiques pour le personnel de santé des pays d'origine en termes de motivation de migration
    - La façon dont ces pratiques promeuvent une migration circulaire des professionnels étrangers
- Deux études de cas sur les pratiques de coopération de la Suisse avec la Roumanie et la Tanzanie
- Recherche d'une interface possible entre les initiatives privées et gouvernementales dans le but de renforcer les systèmes de santé des pays d'origine (cohérence entre les pratiques de recrutement de médecins étrangers et les pratiques de développement et d'aide à la coopération)
- Analyse des expériences de coopération étrangères (BMZ pour l'Allemagne, Norad pour la Norvège, etc.) notamment en matière d'accords bilatéraux portant sur l'embauche de professionnels de la santé et vérification de leur applicabilité à la Suisse
- Sur base de l'identification des meilleures pratiques (« best practices ») et l'analyse des facteurs favorables et défavorables à la réussite des initiatives lancées, formulation de
    - Recommandations pour des approches de coopération visant à retenir le personnel de santé dans son pays d'origine (par ex. migration circulaire)
    - Recommendations sur le futur (« next steps ») des pratiques de coopération de la Suisse dans le domaine du renforcement des ressources humaines

Approche et méthodologie:

Les méthodes suivantes seront utilisées pour répondre aux objectifs :

- Revue et analyse de la littérature et des documents des pratiques de coopération de la Suisse. Cette analyse incluera aussi deux études de cas une focalisant sur les pratiques de coopération de la Suisse avec la Roumanie et une sur la Tanzanie
- Revue et analyse de la littérature et des documents sur les pratiques de coopération de la Norvège et de l'Allemagne
- Entretiens face-à-face à l'aide d'un questionnaire semi-ouvert avec
    - Acteurs gouvernementaux (DDC, SECO, FNRS)

- Acteurs non-gouvernementaux du Sud et du Nord par exemple à travers le Réseau des ONG médicales Medicus Mundi
- Personnes- clé (en Suisse ?) ayant des expériences de collaboration dans le domaine de la santé
- Personnes –clé ayant des expériences de collaboration dans le domaine de la santé en Norvège et en Allemagne.

Il est proposé que le rapport soit rédigé en anglais.

Un group d'accompagnement composé d'où moins d'un représentant de la DDC et de l'Office Fédéral de Santé Publique sera constitué. Ce groupe aura essentiellement comme tâche de guider et d'orienter les travaux. Elle aura au moins deux fois des échanges avec le mandataire et ces interactions permettront de se positionner vis-à-vis des résultats préliminaires et l'orientation générale de l'étude.