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COMMISSION OF THE EUROPEAN COMMUNITIES

Brussels, 16.9.2008  
SEC(2008) 2476

**COMMISSION STAFF WORKING DOCUMENT**

**European programme for action to tackle the critical shortage of health workers in  
developing countries (2007 – 2013)  
Progress report on implementation**

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## List of main abbreviations

<b>CAMES</b>	Conseil Africain et Malgache pour l'Enseignement Supérieur
<b>CESAMES Sanitaires</b>	Cycle d'Etudes Supérieures Africain en Management des Etablissements Sanitaires
<b>EDCTP</b>	European and Developing Countries Clinical Trials Partnership
<b>EQUINET</b>	Regional Network on Equity in Health in East and Southern Africa
<b>GAVI</b>	Global Alliance for Vaccines and Immunization
<b>GBS</b>	General Budget Support
<b>GFATM</b>	Global Fund to fight AIDS, Tuberculosis and Malaria
<b>GHWA</b>	Global Health Workforce Alliance
<b>HRH</b>	Human Resources in Health
<b>HSS</b>	Health Systems Strengthening
<b>IHP</b>	International Health Partnership
<b>MDGs</b>	Millennium Development Goals
<b>MTEF</b>	Medium-Term Expenditure Framework
<b>PfA</b>	European Programme for Action
<b>SBS</b>	Sector Budget Support
<b>TTF</b>	Telemedicine Task Force
<b>WHA</b>	World Health Assembly
<b>WHO</b>	World Health Organization

## 1. EXECUTIVE SUMMARY

In December 2006, the European Commission adopted a European Programme for Action (PfA)<sup>1</sup> to tackle the shortage of health workers in developing countries (2007-2013). The PfA produced a clear set of actions that should be supported in a joint and coordinated manner by the European Commission and Member States. The Conclusions of the Council of the European Union of 15 May 2007 adopted the PfA and the Council has further requested the Commission and Member States to report back on joint implementation.

The present report is based on responses from 18 Member States to a questionnaire designed by the European Commission. As such it cannot provide a full overview of joint implementation of the PfA. Nevertheless, it attempts to draw some preliminary conclusions about the overall trend of EU action in relation to the implementation of the PfA. The report follows the structure of the PfA, looking at EU policy and programming activities at the country, regional and global level against the background of the main commitments agreed in the PfA. This serves as a basis for preliminary conclusions and makes recommendations for further joint implementation of EU efforts in the area of Human Resources in Health (HRH).

Based on the responses, the EU is making an effort to work at country, regional and global levels with the objective of increasing the ability of developing countries to train, manage and retain their health workers. The available information shows that the EU supports health programmes with an HRH component in 51 out of the 57 countries that have been identified by the World Health Organization as facing a HRH crisis; it provides support for regional research, capacity building and knowledge-generating initiatives and begins to explore, at the global level, opportunities for stimulating circular migration and the introduction of other mechanisms helping to deal with the pull factors of HRH migration.

Yet, the responses from the Member States also indicate that actions in health and on HRH are being pursued for the most part in an uncoordinated manner. This runs counter to the idea of the PfA as a guiding tool for EU collective action on health and HRH. The information also points to the existing mismatch between the EU's financial aid and its capacity to have an effective policy dialogue. This undermines the effectiveness and impact of EU action and shows that additional work is required in order to translate the commitments embraced at the central level into action at country level. Perhaps most importantly, it is impossible – on the basis of the available information - to determine the overall volume of EU resources for HRH.

The report reiterates the need to apply existing aid effectiveness policies to the health sector, and points out opportunities for a more effective sharing of EU technical resources. It also suggests focusing further implementation of the PfA first and foremost in a set of countries where the EU is already active in HRH. Similarly, it underlines the importance of linking EU aid for health with joint institutional support at country level in the area of health. In addition, the report calls for reinforced implementation of the PfA at the global level in order to reduce the negative impact of migration on the HRH crisis in developing countries, including further progress on work aimed at stimulating circular migration<sup>2</sup>. Finally it calls for strengthening of the EU's commitment to implementation of the PfA and other relevant existing policies.

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<sup>1</sup> COM(2006) 870

<sup>2</sup> Details outlined in COM(2007) 248 and is component part of the Global Approach to Migration (See COM(2006) 735 and COM(2007) 247). In this context, Mobility Partnerships between Member States and a third country can also play a role. Recently pilot Mobility Partnerships with Moldova (see

## 2. BACKGROUND

In December 2005, the European Commission produced a Communication entitled an EU Strategy for Action on the Crisis in Human Resources for Health in Developing Countries<sup>3</sup>. The Strategy reflects the EU consensus on the need for action, and recognises that Europe has an important role to play at the country, regional and global levels. The Strategy also recognises that Europe, as a major beneficiary of migrant workers, has a responsibility to support those countries facing a crisis that are losing health workers through migration to Europe and other wealthy regions of the world.

In December 2006, the European Commission adopted a European Programme for Action (PfA) to tackle the shortage of health workers in developing countries (2007-2013). The PfA, which was developed in consultation with the Member States, produced a clear set of actions that should be supported by the European Commission and Member States. The Council of the European Union adopted the PfA on 15 May 2007 and requested the Commission and Member States to report back on joint implementation by December 2007.

The Commission requested information from all Member States about their own activities in the area of human resources for health in June (and additionally in August) 2007<sup>4</sup>. By the middle of September 2007, the Commission had received responses from 15 Member States<sup>5</sup> and called for a meeting of Member States to discuss the results. That meeting took place on 26 February 2008. Further responses to the original questionnaire were submitted by three countries<sup>6</sup> in a follow-up to this meeting, which recommended postponing the completion of the report until after the First Global Forum on Human Resources for Health to be organized by the Global Health Workforce Alliance in March 2008 in Kampala, Uganda.

## 3. SCOPE OF THE REPORT

This report is based on responses from 18 Member States. As such, it cannot provide a full overview of EU's joint implementation of the PfA. Nevertheless, it attempts to draw some preliminary conclusions about the overall trend of EU action towards the implementation of the PfA.

The report follows the structure of the PfA, comparing EU policy and programming activities at country, regional and global level against the main original commitments agreed in the PfA. This serves as a basis for preliminary conclusions, as well as providing recommendations for further joint implementation and monitoring of the EU efforts in the area of HRH.

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IP/08/893) and Cape Verde (see IP/08/894) have been established and a pilot project on circular migration with Mauritius is currently under discussion.

<sup>3</sup> COM(2005)642

<sup>4</sup> See Annex 1 – EC Questionnaire for development of a joint implementation and development plan in the area of human resources for health

<sup>5</sup> Bulgaria, Czech Republic, Denmark, Estonia, Finland, France, Germany, Hungary, Italy, Latvia, Lithuania, Netherlands, Poland, Slovenia and Spain

<sup>6</sup> Portugal, Sweden, and UK.

## 4. MAIN FINDINGS

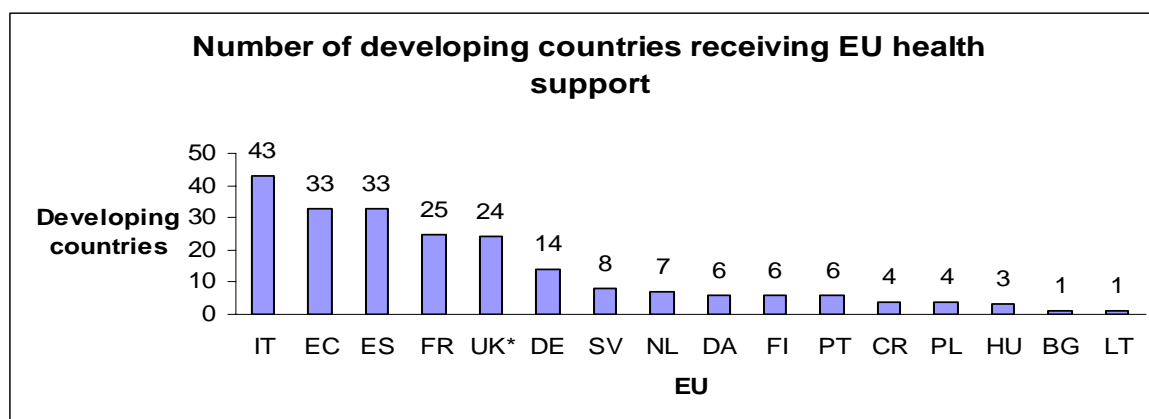
### 4.1. EU actions at country level

#### 4.1.1. Aid effectiveness and financing

"The EU, working with other funding and technical agencies, will make a concerted effort to align support at the country level with nationally defined strategies and priorities, supporting the active engagement of all key stakeholders. The EU will provide increased support to country-level efforts to strengthen national health systems."

Aid effectiveness is at the forefront of the EU's policy agenda. In 2006 and 2007, the EU adopted a range of policy initiatives aiming to maximize the impact of its aid by increasing the level of aid and delivering it more effectively<sup>7</sup>. The principles of these initiatives – increased support, country alignment, division of labour and others - are applicable to the EU's assistance across all sectors. As such, the challenge is to ensure that they are implemented in the health sector, where significant needs for expenditure, driven by high recurrent costs and infrastructure investment, cannot be sufficiently covered from domestic resources and where the external aid has been particularly fragmented and unpredictable. Unless this is done, developing countries committed to tackling the crisis in human resources for health, as part of strengthening their health systems, will not be able to ensure a reasonable quantity and quality of health workers, which is one of the preconditions for making progress towards better health outcomes and the achievement of health MDGs.

**Figure 1: Geographical coverage of EU health development programmes**



\* UK provided list of 24 priority countries (out of the total of 63 where it provides bilateral health support)

The information collected through the questionnaire prepared for this report indicates that, of the 18 countries that responded, 15 are active in the area of health<sup>8</sup> and, together with the

<sup>7</sup> These policy initiatives include: Communication on financing for development and aid effectiveness (COM (2006) 85 final); Communication EU Aid: delivering more, better and faster (COM (2006) 87 final); Communication Increasing the impact of EU aid: a common framework for drafting country strategy papers and joint multi-annual programming (COM (2006) 88 final); and Communication on an EU code of conduct on division of labour in development policy (COM (2007) 72 final)

<sup>8</sup> Estonia, Latvia and Slovenia do not have programmes in the area of health and human resources for health.

European Commission, are supporting health programmes in a total of 90 countries,<sup>9</sup> with 32 countries benefiting from pooled financing or budget support under nationally developed health sector programmes. The remaining EU assistance is delivered above all through project support. One Member State – Italy – also provides support in the health sector through soft loans. The information supplied by Member States about the volume of financial assistance in individual countries was not complete and therefore makes it impossible to determine the overall scale of EU funds targeted at the HRH support.

**Table 1: The use of sector budget support (SBS) in EU health development programmes 2007/2008 (in order of the overall number of country programmes)**

	Developing countries	SBS Programmes
Italy	43	8
European Commission	33	13
Spain	33	3
France	25	6
Great Britain	24	5
Germany	14	7
Sweden	8	6
Netherlands	7	3
Denmark	6	5
Finland	6	2
Portugal	6	0
Czech Republic	4	0
Poland	4	0
Hungary	3	0
Bulgaria	1	0
Lithuania	1	0
<i>Total (dev. countries)</i>	90	32

Sector Budget Support (SBS) in the health sector is fully aligned with national priorities and complements the domestic resources that accrue to the national budget through taxation or other ways of generating revenue to finance the delivery of health care. As such, and especially if it is provided in a predictable, robust and long-term manner, this support creates a good enabling environment for strengthening health systems, including the production, management and retention of health workers. At the same time, SBS requires a reasonable

<sup>9</sup> For the overall breakdown, see Annex 2 – EU support to health by country and type of aid support mechanism.

level of institutional capacity and a clear political commitment to health on the part of the receiving government; as such, SBS cannot necessarily be used in all countries where the EU provides assistance to health.

Based on the responses from Member States, SBS in health is proportionately most favoured by Denmark, Sweden, Germany, the European Commission, the Netherlands. The UK provides funding for the health sectors in almost half of its priority countries through the use of general budget support (GBS) or SBS, or combination of the two. Italy and Spain, who are active in the largest number of recipient countries, are mostly in favour of project support. Further clarification would be needed in order to determine the extent to which such support is, or can be, aligned with country-defined priorities and delivered through a sector-wide approach. France is between these two groups. None of the EU-10+2 Member States are currently using sector budget support as a means for allocating assistance in the area of health.

Apart from the nature of the assistance, the responses from Member States also indicate the extent to which the EU is trying to ensure a division of labour in the actual provision of assistance in the area of health. While the EU does support health programmes in virtually all countries facing a shortage of human resources for health<sup>10</sup>, the available information shows that some countries benefit from EU support more significantly than others. This is probably mostly due to the fact that opportunities to engage governments in developing countries on the reform of health systems and the improvement of health outcomes are better in some countries than in others. However, EU support to strengthen health systems, tackle the critical shortage of health workers and deliver better care is needed just as much in countries where governments have not shown sufficient commitment or when their ability to act is limited. There is need to coordinate EU assistance in health, both to minimise overlapping or disconnected actions within individual countries and also to avoid having a strong focus on some countries, while neglecting others with similar needs.

The EU Code of Conduct on Division of Labour in Development Policy suggests that the Member States and the Commission agree on taking a lead in specific sectors in individual countries, focussing on two main sectors only and agreeing not to have more than three EU donors present in the same country and within the same sector. Implementation of these voluntary principles is at an early stage, although there are already examples of some attempts to coordinate EU assistance in health more effectively at country level. One of them is the International Health Partnership (IHP), signed in 2007 by six Member States – Germany, France, Italy, Portugal, Netherlands and the UK – and the European Commission, and in 2008 by a further three Member States, namely Finland, Spain and Sweden. The IHP+<sup>11</sup> now covers 14 "first wave countries"<sup>12</sup> in which a more effective coordination and delivery of aid will be pursued to stimulate faster progress towards the achievement of health MDGs. It is important to ensure that similar efforts are pursued also in other countries affected by the HRH crisis.

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<sup>10</sup> WHO estimated in its 2006 World Health Report that there are 57 countries with a critical shortage of human resources for health (36 of them in Sub-Saharan Africa). Based on the collected information, out of these 57 countries, the EU does not provide health assistance in Bhutan, Benin, Gambia, and Papua New Guinea. In Iraq and Myanmar the EU provides humanitarian assistance only.

<sup>11</sup> IHP+ comprises the International Health Partnership and related initiatives, including the Global Campaign for Health MDGs, the Catalytic Initiative, Providing for Health, etc.

<sup>12</sup> The 14 countries are: Benin, Burkina Faso, Burundi, Cambodia, Ethiopia, Ghana, Kenya, Madagascar, Mali, Mozambique, Nepal, Niger, Nigeria and Zambia.

In Sub-Saharan Africa alone there are 10 countries where health programmes are supported by four or more EU donors<sup>13</sup>. For example, Mozambique benefits from seven SBS programmes of the EU, Malawi from three SBS programmes and one project programme; Kenya has two SBS programmes and four project programmes. On the other hand, there are 15 countries where only one EU donor in health is present<sup>14</sup> and the assistance is mostly delivered through project support. More information would be needed in order to determine whether the size of the countries, the health indicators, the state of health systems, including the shortage of human resources, the opportunity for EU intervention and the role of non-EU donors explain why there is such an imbalance between these two groups in the allocation of EU aid.

In 10 cases, several Member States are supporting projects in the same geographical location of Sub-Saharan Africa<sup>15</sup>. Further information would be necessary in order to determine the extent to which these projects complement each other or at least do not overlap. Similarly, more data would be needed to see whether they are implemented as part of a national health strategy (if one exists) or at least whether the national or sub-national government is aware of them, so as to determine their sustainability, replicability and impact going forward.

#### 4.1.2. Country level political and policy dialogue

"The EU will raise the issue of HRH as a barrier to progress towards MDGs 4, 5 and 6 in national policy dialogue on poverty reduction and in discussions on strengthening social governance."

"The EU will take forward the work initiated on developing MDG contracting mechanism to link longer-term budget support more closely to MDG progress."

Having a sufficient focus on human resources in EU supported programmes calls for an active policy dialogue with developing countries over a wide range of issues, including production, assignment, management and retention of health workers. This has to be part of the overall multi-sectoral dialogue about the wider policy objectives, financing and reform of the health sector, and an ongoing discussion with Ministries of Finance and senior government officials about the place of health financing in the medium term expenditure framework (MTEF) for implementing national development strategies. Such a dialogue requires the relevant capacity, expertise and experience, and may be conducted bilaterally or through a lead EU donor.

The information collected from Member States indicates that sufficient technical expertise on the ground is often scarce, and it is more likely to be attached to a sector-specific type of programme than to project support. There are 31 developing countries where one of the 15 Member States operates as a lead donor, leads on policy dialogue in health, and leads - or has the capacity and potential to lead - on the issue of human resources. Germany seems to be best at concentrating resources and matching them with a capacity to conduct policy dialogue with a recipient country. Italy appears to have capacity in place in a number of countries, but shows more of a potential to take a lead, rather than already having an actual lead. UK has health advisers based in 13 of its 24 priority countries.

<sup>13</sup> Angola, CDR, Ethiopia, Kenya, Malawi, Mozambique, Tanzania, Uganda, Zambia and Zimbabwe.

<sup>14</sup> Burundi, Central Africa, Comoros, Eq. Guinea, Eritrea, Gabon, Ghana, Guinea-Bissau, Ivory Coast, Liberia, Madagascar, Sao Tome, Senegal, Somalia, and Togo.

<sup>15</sup> Angola, Chad, Congo, CDR, Guinea, Nigeria, South Africa, Sudan, Swaziland, and Zimbabwe.

**Table 2: EU coordination in health and HRH policy dialogue**

<b>Developing Country</b>	<b>Lead EU donor/focal point of coordination in health</b>	<b>Lead or capacity to lead on policy dialogue in HRH</b>
Afghanistan	Italy (potentially)	Italy (potentially)
Albania	Italy (potentially)	
Bangladesh		Netherlands, UK
Burkina Faso		Italy
Cambodia	Germany	Germany, UK
Cameroon	Germany, France	Germany, France
Chad		France
Djibouti	Italy	
Guinea	Germany	
Ethiopia	Italy (potentially)	Italy, UK
India		UK
Indonesia		Germany
Kenya		UK
Madagascar	France	
Malawi		UK
Mali	Netherlands (largest donor but rotation over lead)	
Mozambique	Italy (in 1 region and potentially at nat. level)	UK
Nepal	Germany	UK
Nicaragua	Sweden	Finland (potentially)
Niger	France	
Nigeria		UK
Pakistan		Germany, UK
Palestinian	Italy	Italy
Sierra Leone		UK
Somalia	Italy (potentially)	
Sudan	Italy (potentially)	
Swaziland	Italy (potentially)	
Tanzania	Germany	Netherlands (partly)
Vietnam		Netherlands
Uganda	Italy	Sweden, UK
Zambia	Sweden	UK

Most of the Member States that responded to the questionnaire highlighted the necessity to rely on other EU donors for policy dialogue in the area of health and human resources for health. At the same time, the responses also show that, in some countries, EU programmes are guided by the expertise of more than one Member State. The lack of capacity on the one hand and the overlap on the other seem to indicate that better coordination and a more formal division of labour at country level would be desirable in order to ensure that policy dialogue is an integral part of EU financial assistance and that the existing or potential capacity of individual Member States is used to the benefit of the overall EU assistance. There are already some examples of such delegation of responsibility – for example, Sweden provides its budget support to Mali through a partnership with Netherlands, which is then in charge of the policy dialogue. However, other mechanisms, such as coordinated recruitment for HRH and other health expertise in countries where EU operates, could probably be developed further.

Policy dialogue around health and the issue of human resources for health can only make sense if financing is available to take the step from policy formulation and development to policy implementation. Human resources represent a long-term recurrent cost, and effective implementation of any policy that is attempting to increase the existing numbers of health workers can only take place if there is a reasonable guarantee of long-term and sustainable financing. Achieving such a guarantee requires further changes in the way in which domestic resources are collected and allocated to health, as well as in the way donors provide their assistance.

The European Commission and the Member States have been working together in order to better respond to the need for stable resources. In view of the expected increases in the EU ODA flows, the European Commission and the Member States have taken a range of steps to develop new, more predictable and less volatile aid mechanisms. In particular, the European Commission has been developing the "MDG Contract" that is intended to provide recipient countries with longer-term, more predictable budget support. The MDG Contract will target well performing countries that have successfully implemented budget support and demonstrated a commitment to achieving and monitoring the MDGs. This form of budget support will be over a period of six years and provide a minimum, guaranteed level of support each year within a strong framework for monitoring performance and results. At this point the drafting of the concept is at an advanced stage, but has not been fully completed.

#### *4.1.3. Research and technical assistance*

"The EU will increase coordination of its technical assistance in support of country programming and support greater coordination of access to EU TA by recipient countries."

"The EU will support relevant research for better-informed policy making at country level."

Reforming public services is a highly complex exercise which, apart from political commitment and financing, requires a sufficient level of technical expertise within the public administration of the country embarking on such reform. This is particularly the case for health services and the human resources for health, where steps need to be taken in the areas of public finance, public administration, education, research, training and others, with key issues related to the production of health workers, their financing, assignment, management and retention. In order to ensure that EU financing and policy dialogue are indeed translated into successful implementation of strategies designed to increase the numbers of health workers in developing countries, the EU has undertaken to support action-oriented policy research and to ensure that quality technical advice is available to developing countries.

On the research side, the response from Member States indicates that, if any resources at all are spent on research<sup>16</sup>, they are used for internal studies and evaluations related to the implementation of country programmes or are invested in global initiatives and international organizations with the objective of generating information for policy advice (e.g. World Health Organization, Global Health Workforce Alliance, university-based research initiatives in OECD countries, etc.). Except for one Member State, none of the countries has indicated any kind of country-focused programme, where local research – say, through a network of think tanks, universities or policy centres – has been encouraged, perhaps even as part of a wider effort to strengthen local capacity to provide policy advice and monitor policy implementation in the area of health. The notable exception is Sweden, which has been providing core support to the Regional Network on Equity in Health in East and Southern Africa (EQUINET), which works through grants with African academic and policy institutions on action-oriented policy research, advocacy, monitoring and knowledge building in the area of health systems strengthening and health equity, along with a strong focus on HRH and health financing. This type of support makes an important contribution to the better understanding of HRH challenges and the development of country - tailored solutions, and as such should probably be extended further.

The response from Member States on the issue of technical assistance (TA) in health systems strengthening (HSS) and HRH has been incomplete, with only Germany, Italy, Portugal, Sweden and the UK providing detailed replies. Yet, even this incomplete sample shows that, while the EU has existing technical expertise in areas such as HR development, HR management, quality assurance and standards, incentives, sector financing, service delivery/decentralization and health information system, there seems to be little scope for sharing these resources in a way that would underpin overall EU action in this area. Technical assistance is in principle linked only to the countries of operation of each Member State. Only Italy, Portugal and Sweden indicated that their TA may be also available upon demand in other countries.

Moreover, the technical assistance provided by each Member State appears to be linked directly to the implementation of its own programmes and no others. This may raise questions about continuity of technical advice in cases where the lead in health or in a particular health area is rotated among several EU donors. Success or failure to deliver TA is determined not only by its quality, but also by the level of trust between the TA provider and the TA recipient. Frequent changes among the TA providers may undermine the ability to establish a desired level of trust and, as such, may lead to worse results. In addition, more information would also be needed so as to establish to what extent recipient countries themselves have the opportunity to choose and access the technical assistance that they themselves regard as being most useful, and to what extent the delivery of TA includes a component for strengthening of local capacity to eventually take on the role of TA provider. This has to be linked with joint and coordinated institutional support of governments in the area of health through traditional and innovative mechanisms, such as twinning, circular training and involvement of diaspora.

#### 4.1.4. *Capacity building*

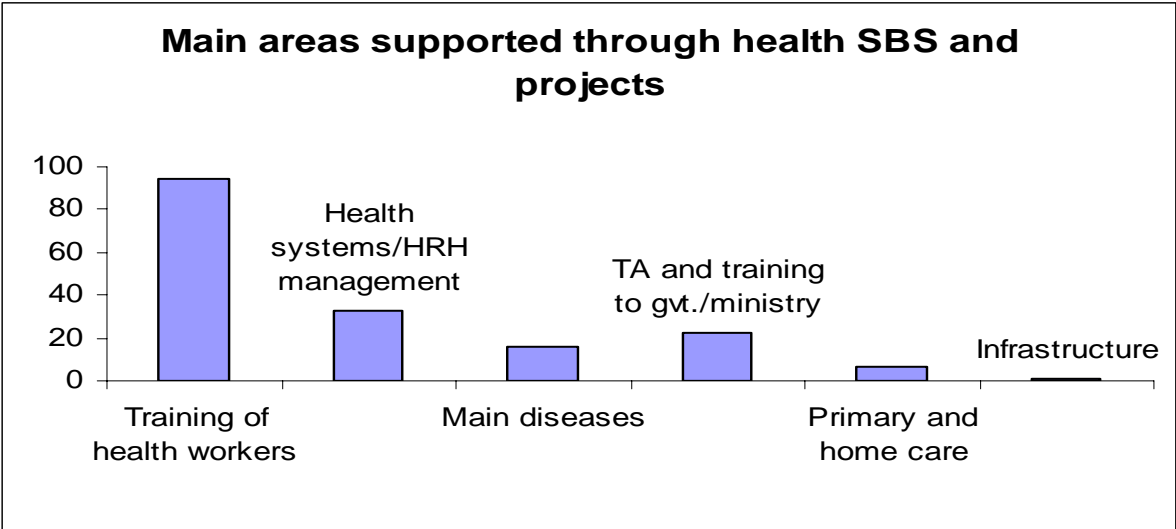
"The EU will support expansion of country-level training capacity, including for human resource management training capacity."

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<sup>16</sup> Only Germany, Portugal, Sweden and the UK indicated spending in this area.

The ability of the EU to support the production of larger numbers of suitably qualified health workers in developing countries is an important part of finding an overall solution to the crisis of human resources in health<sup>17</sup>. Based on the available responses, training of health workers appears to be the area that is most frequently supported through EU health programmes and projects, with a main focus on in-country training, supplemented by the granting of scholarships and twinning opportunities. There appears to have been significantly less focus directed at the management and retention of health workers at country level.

**Figure 2: Support for training activities at the country level**



The responses from Member States indicate that most training activities are focused on in-service training, but for the most part they do not provide a detailed enough picture to determine whether such activities strengthen a country's long-term capacity to provide training or whether they rather represent ad-hoc training programmes that are fully dependent on delivery by the donor. Denmark is a notable exception in this regard and Sweden too, to some extent. These countries have indicated that they support activities leading to transfer of expertise to local actors, such as development of curricula and text books, training of teachers, construction or improvement of teaching facilities, support for national training institutions, and others. Another exception is Portugal, which has been supporting the development of a Portuguese Speaking Countries' Network of National Public Health Institutes, as well as a Network of Nurses and Paediatricians for the exchange of best practices and practical collaboration on training of health workers. It would be useful to evaluate the impact of these programmes, as they might be taken as models to be embraced more widely by the EU, so as to improve the chances of better sustainability and replicability of EU-supported training activities.

In-country training activities supported by Member States are supplemented by several existing scholarships and twinning programmes between EU and developing countries (supported by Finland, Germany, Italy, Netherlands and Portugal). France also supports delivery of an e-based Master in Public Health for candidates from French-speaking countries

<sup>17</sup> World Health Assembly (WHA) specifically called on Member States in 2006 to help rapidly increase the production of health workers. "Rapid scaling up of health workforce production" WHA resolution 59.23.

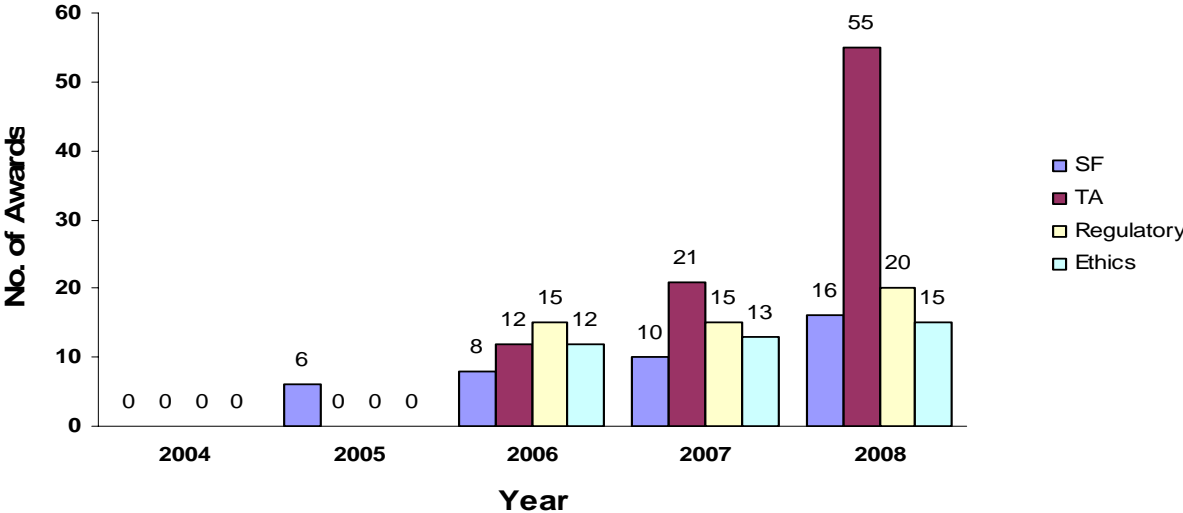
in Africa, plus a number of regional training activities for specific types of health workers<sup>18</sup>. Apart from the potential use of the EU's Nyerere programme for educational exchange among African, Caribbean and Pacific countries in the academic year 2009/2010, no Member State reported support for south-south educational and training programmes in health that could make use of regional facilities to train health workers.

**4.2. EU actions at regional level**

"The EU will support regional mapping, analysis and the technical and political dialogue on human resources necessary for effective advocacy and action. This will include support for development of a regional observatory for Africa, support for mapping and potential sharing of regional training capacity, support for research capacity building through the European and Developing Countries' Clinical Trials Partnership (EDCTP) and support to explore the potential for use of information technology for training, capacity building and service delivery in health."

EU responses at regional level indicate that the EU chiefly provides support in two main areas – a) through the UN system (in particular through the WHO) and b) through the Global Health Workforce Alliance (GHWA) – a global partnership hosted by the WHO which brings together a variety of public, private and other stakeholders – dedicated to identifying and implementing solutions to the crisis of human resources in health. Based on the available responses, the European Commission, France, Germany, the Netherlands and the UK currently support or intend to support GHWA. Italy and Spain provide support primarily through the WHO, while Spain has been financing regional activities in South America through the Pan American Health Organization (PAHO).

**Figure 3: EDCTP capacity building activities**



Support for research capacity building through the European and Developing Countries Clinical Trials Partnership (EDCTP) has been increasing exponentially, despite a very difficult initial period, with some 106 awards being granted in 2008. These include senior fellowships projects (SF), Training Awards projects (TA) such as Masters and PhD

<sup>18</sup> E.g. CESAMES (Cycle d'Etudes Supérieures Africain en Management des Etablissements Sanitaires), CAMES (Conseil Africain et Malgache pour l'Enseignement Supérieur) and others.

scholarships or Career Development Fellowships, capacity building activities for regulatory authorities (regulatory) and programmes for strengthening ethics framework activities. In the period 2003 to 2007, the EDCTP Programme launched 33 calls and committed 52.6 million EUR to fund 74 projects based in 21 different countries in sub-Saharan Africa, involving some 98 African institutions in practically all participating Member States.

Information and communication technology (ICT) offers opportunities and potential for training, capacity building and service delivery in health. As part of the implementation of the programme of action, the EU has started to work jointly with the WHO and the European Space Agency to see to what extent ICT can play a positive role in strengthening health systems in Africa. The programme being driven forward by the telemedicine task force (TTF)<sup>19</sup> has defined two areas where initial efforts will be made to pilot the use of ICT for strengthening health systems in Africa. These areas are a) continuing professional education to support health workforce production and training, and b) satellite based clinical services for remote areas.

#### **4.3. EU actions at global level**

"A concerted European strategy covering issues such as monitoring, training, recruitment and working conditions of a sufficient number of health professionals will be developed, to help ensure that the Union as a whole will be able to meet its objective of providing high quality health care, without exacerbating the human resource crisis in developing countries."

"The EU will develop a set of principles to guide recruitment of health workers within the Union and recruitment from third countries, which will seek to minimise negative impact on health workforce capacity in third countries, including the development of mechanisms and guidelines for support of circular migration of health workers."

"The European Commission and EU will continue to be active on the boards of global funding instruments working to ensure increasing alignment behind country priorities to expand fiscal space for necessary investment in capacity building."

EU actions at global level have generally been less complete and mostly focussed on participation in global financing instruments, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) or the Global Alliance for Vaccines and Immunization (GAVI). This is probably due to the fact that the activities in other areas – such as the work on circular migration or on policy initiatives that may reduce EU's own dependence on health workers from non-EU countries – fall within the remit of several governmental departments, which presents a significant challenge in terms of ensuring coherence between EU internal and external policies.

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<sup>19</sup> The TTF is composed of representatives from: the African Union Commission (AUC), the New Partnership for Africa's Development (NEPAD), the African Development Bank (AfDB), the Communauté Economique et Monétaire de l'Afrique Centrale (CEMAC), the Organisation de Coordination pour la lutte contre les Endemies en Afrique Centrale (OCEAC), the East African Community (EAC), the Economic Community of West African States (ECOWAS), the Secretariat of the African, Caribbean and Pacific group of States (ACP Sec), the World Health Organization (WHO), the European Commission and the European Space Agency.

The EU is developing measures for a common immigration policy,<sup>20</sup> since it too is facing shortages of human resources<sup>21</sup>; these measures include not undermining development prospects of non-EU countries by, for example, exacerbating the "brain drain". As well as the previously mentioned initiatives to promote circular migration and Mobility Partnerships within the Global Approach to Migration (see Footnote 2), in 2007 the European Commission produced a proposal for a Directive to facilitate the admission of highly-qualified migrants into the EU<sup>22</sup>, which includes a clause specifically requiring ethical recruitment in sectors (such as the health sector) suffering from a lack of personnel in developing countries.

The Commission Communication on an "EU Strategy for Action on the Crisis in Human Resources for Health in developing Countries"<sup>23</sup> considered the development of a European Code of Conduct for Ethical Recruitment of Health Workers from outside the EU. The development of such a code, which would seek to minimize negative impact of external recruitment on health worker capacity in developing countries, has already existing examples to build on, such as the "Code of conduct on cross-border recruitment in European hospitals"<sup>24</sup> signed in April 2008 by the European Healthcare Employers and Workers, or the UK Code of Practice published at the end of 2004.

However, as the experience of the UK shows, the adoption of the code has to be complemented by other measures to reduce the outflow of health professionals from developing countries<sup>25</sup> and to make migration work for development. The PfA argues that the EU should take appropriate steps to meet its own objective of providing high quality health care without having a negative impact on the situation in countries already facing shortages of health workers. This includes sufficient production and retention of its own health workers as well as support and promotion of circular migration for health professionals from countries facing HRH crisis, as part of their professional development. The link between challenges facing EU health systems and EU health workers are analyzed in the European Commission's Green Paper on European Workforce for Health, which is currently at an advanced stage of preparation.

The responses from Member States show that some of them - notably France, Germany and the Netherlands – have begun to work on developing programmes which would encourage migrant health workers to return to and resettle in their countries of origin. Similarly, the UK has indicated that it is committed to exploring options for health workers to return to their countries of origin for extended periods without affecting their residency status in the UK,

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<sup>20</sup> See COM(2008) 359 on "A Common immigration policy for Europe: principles, actions and tools"

<sup>21</sup> See, for example, COM(2006)571. According to the latest population projections produced by Eurostat, the working age population of the EU is projected to fall by almost 50 million by 2060, even with continued net immigration similar to historical levels. By 2060, without such immigration, the working age population would be around 110 million lower than today, which would mean that in the EU, overall, the ratio between the number of people over 65 and those at working-age would more than double.

<sup>22</sup> COM(2007) 637 final. At the same time, a proposal (COM(2007) 638) for another directive on a single application procedure and common rights for all legally-resident third-country national workers was adopted.

<sup>23</sup> COM (2005) 642

<sup>24</sup> Available from <http://www.eurofound.europa.eu/eiro/2008/05/articles/eu0805039i.htm>.

<sup>25</sup> The evaluation of the code of conduct prepared in 2007 shows that currently there are fewer international health workers working in the UK than in 2000 – 2005. The impact of the code is, however, not easy to determine, as other factors such as new immigration rules and UK training policies are thought to have primarily influenced the change. Further review of the impact is being conducted.

while at the same time providing support to the International Organization for Migration (IOM) in piloting schemes to allow skilled members of the diaspora to return to their country of origin for short periods to work in specific sectors, including the health sector. Further efforts will need to be made to increase the scale of such initiatives, to institutionalise them and to make "dual posting" or other options that stimulate circular migration sufficiently attractive and still workable for health workers, their families and their employers. The use of similar practices should be also advocated towards other non-EU countries of destination.

## 5. CONCLUSIONS AND RECOMMENDATIONS FOR FURTHER ACTION

The information collected for the purpose of this interim report clearly indicates that **the joint implementation of the European Programme for Action to tackle the shortage of health workers in developing countries so far has not been satisfactory**. This is mostly due to the fact that the key principles of the PfA – increased support, joint action and better coordination – have not genuinely been put at the heart of the EU's action on HRH.

The report shows that the EU is making a significant effort to work at country, regional and global levels to strengthen health systems in developing countries and to increase the ability of developing countries to train, manage and retain their health workers. However, it is important to underline that the information provided by Member States about the volume of financial assistance targeting specifically HRH was not complete, and **does not make it possible to determine whether or not EU funding in this area has increased**.

The **existing efforts** to address the shortages of health workers in developing countries **are being pursued, for the most part, in an uncoordinated manner**. This creates inefficiencies in EU action on HRH, runs counter to the idea of the PfA as a guiding tool for EU collective action on health, and on HRH in particular, and it ignores the Code of Conduct on the Division of Labour. The available data show that a greater effort needs to be made to translate the existing EU aid effectiveness policies into concrete actions at the country level in the area of health and HRH.

The available data also point to the **mismatch between provision of EU financial aid on the one hand and the EU's capacity to hold an effective policy dialogue and provide the required institutional support on the other**. The information that has been collected highlights a lack of capacity in some countries, and an overlap in others, once again indicating that better coordination and a more formal division of labour at country level in conducting policy dialogue is an integral part of EU financial assistance. The existing or potential capacity of individual Member States and the European Commission needs to be used to the benefit of overall EU assistance.

The European Commission recalls the principles of the PfA with respect to four main areas where stronger action should be taken to stimulate further progress in joint implementation of the PfA, so as to bring existing European policies closer to the country level in the area of health and to improve the overall effectiveness of EU action on the lack of HRH in developing countries.

1. Improve effectiveness of EU aid in health
  - 1.1. There is a need to *apply the existing Code of Conduct on Division of Labour* and other agreed aid effectiveness policies to the health sector in order to improve

coordination of the EU's input into the health policy dialogue, including HRH issues. This requires an agreement about relocation of responsibilities and better in-country coordination and sharing of available EU resources in terms of financing, policy dialogue capacity and technical assistance, based on the needs of recipient countries and the strengths and weaknesses of individual Member States and the European Commission. Full application of the agreed Code of Conduct will also address the equity of an EU Official Development Assistance (ODA) for health and increase attention to donor orphans.

1.2. The implementation of the PfA should be first and foremost focused on a set of countries where the EU is currently already active on HRH. The experience of these focus countries could be scaled up by sharing best practices and identifying methods and EU technical expertise in this area.

## 2. Strengthen capacity at country level

Successful implementation of the cross-sectoral reforms that are needed in order to address the HRH crisis requires a sufficient capacity to analyse problems, design relevant action and financially viable policy proposals, translate these into costed execution plans and capacity building programmes, and monitor the overall implementation. The PfA outlines the commitment of the EU to provide *increased support to country-led planning for health and country-level efforts to strengthen national health systems*. In order to deliver on these commitments, the EU's coordination of action for strengthening of local capacity for policy formulation, policy implementation and policy monitoring should be significantly improved with the objective of providing joint institutional support, with a particular focus on public administration and health service reform. This may require support for relevant training (including twinning, circular training, involvement of diaspora, etc.), strengthening of local policy organizations (NGOs, policy centres, semi-detached governmental institutions or universities, and specific departments within the government), and other measures, some of which may be regional in character. Such support should be an integral part of EU assistance in health.

## 3. Reduce the negative impact of migration on HRH in developing countries

The Programme for Action includes a set of commitments for intra-EU actions that should be taken to meet EU's own objective of providing high quality health care, without exacerbating the human resources crisis in developing countries. The implementation of these commitments should be accelerated, as little work in this area has been done so far. This is particularly the case of the development and adoption of the *European Code of Conduct for recruitment of health workers from non-EU countries*, which the EU has committed to in the PfA along with the introduction of mechanisms, guidelines and other tools to facilitate *circular migration* and other measures to minimise the negative and maximize the positive impacts on developing countries resulting from the immigration of health workers to the EU. This should include the possibility of introducing a specific *protective clause* preventing the recruitment of health workers by EU health providers from countries confronted by the HRH crisis that wish to introduce such a regulatory mechanism.

## 4. Reinforce EU action on HRH in developing countries

The findings of this report show that the existing policy instruments have not been as successful as expected in stimulating satisfactory translation of EU commitments into action.

*A reflection could be launched on the possibility of Council recommendations to Member States under Article 180 (2) EC Treaty* aimed at generating a new momentum for the implementation of the Programme for Action and other relevant EU policies related to tackling the critical shortage of health workers in developing countries.

**Annexes**

Annex 1: European Commission Questionnaire for development of a joint implementation and development plan in the area of human resources for health

Annex 2: EU support to health by country and type of aid support mechanism

## ANNEX 1

### European Commission Questionnaire for development of a joint implementation and development plan in the area of human resources for health

ANNEX 1: EC questionnaire for development of a joint implementation and monitoring plan in the area of human resources in health

Member state: \_\_\_\_\_

#### I. Assistance at country level

a) Geographical focus and scope of financing - current					b) Policy dialogue and areas supported				
COUNTRIES WHERE YOU PROVIDE SUPPORT IN HEALTH	Type of funding (GBS, SBS, Project, Other?)	Anticipated period of support	Estimated annual spending 2008-2013 (according to your planning cycle)	Comments (e.g. anticipated change in type of funding, anticipated withdrawal from the country, etc.?)	Policy dialogue			Areas supported	Donor coordination
					Is HRH part of your policy dialogue? If so, is it conducted bi-laterally or as a part of a wider consortium of donors?	Do you take a lead or have the capacity to take a lead on HRH policy dialogue in the country?	Do you address HRH and/or allocate financing specifically to HRH also under other areas than health?	Can you identify specific HRH areas supported through the GBS, health SBS or projects?	Are you a lead donor or in health? If so, do you serve as a point of coordination for EU assistance?

a) Geographical focus and scope of financing - future					b) Policy dialogue and coordination			
COUNTRIES WHERE YOU PLAN TO PROVIDE SUPPORT IN HEALTH	Type of funding (GBS, SBS, Project, Other?)	Anticipated period of support	Estimated annual spending 2008-2013 (according to your planning cycle)	Comments (e.g. Anticipated changes)	Policy dialogue			Can you identify specific HRH areas supported through the GBS, health SBS or projects?
					Will HRH be part of your policy dialogue? If so, will it be conducted bi-laterally or as a part of a wider consortium of donors?	Are you able to take a lead or have the capacity to take a lead on HRH policy dialogue in the country?	Will you address HRH and/or allocate financing specifically to HRH also under other areas than health?	

c) MS capacity for technical support				d) Other areas of support			
Three main areas of technical expertise in health systems strengthening (HSS) and human resources?	Readiness to provide TA in others countries on demand? (With external funding? At own cost?)	Availability of relevant case studies /lessons learnt /best practices for sharing? (Please specify.)	Comments (Anticipated changes of focal priorities?)	Any support of scholarship programmes, professional development initiatives for medical personnel or twinning arrangements (hospitals, medical associations, etc.)	Any programmes for topping up salaries of health professionals (specify where)?	Any support of research on HRH? (Please specify.)	Comments

#### II. Assistance at regional and global level

a) Regional and global support						
Any financial support provided to regional programmes? (Please specify type and magnitude or share of your support to the overall budget.)	Any other type of regional or global support?	Estimated spending on regional activities 2008-2013 (according to your planning cycle)	Planned regional activities (Please specify region, period and scope.)	Any policy dialogue provided to stimulate development of a regional HRH programme? (Please specify with what countries.)	Any programmes in place or in development to involve existing diasporas in addressing HRH problem in their home countries? (Please specify scope and implementation stage)	

b) Internal MS action taken			
To prevent (public and private) active recruitment of medical professionals from developing countries (Please specify.)	To facilitate circular and temporary migration of HRH? (Please specify.)	Any other measures on HRH migration from developing countries? (Please specify.)	To reduce own dependence on migrant workers? (e.g. strengthening of training and retention policies and capacity - please specify).

## ANNEX 2

### EU support to health by country and type of aid support mechanism

Annex 2: EU support to health by country and aid modality (2007/2008)

GBS - general budget support, SBS - sector budget support, PS - project support, PF - pooled financing, SL - soft loan

	BG	CS	EC	DA	FI	DE	HU	FR	IT	LT	NL	PL	PT	ES	SV	UK
ASIA																
Afganistan			PS				PS	PS	PS	PS		PS				
Azerbaijan												PS				
Bangladesh						SBS					PF				SBS	PF/ PS
Cambodia						SBS										PF
China									PS/ SL							PF
East Timor			PS										PS			
Georgia			SBS/ PS													
India			SBS/ PS												PS	SBS
Indonesia						PS			PS							PS
Laos								PS								
Maynmar			PS						PS							
Mongolia									PS/ SL							
Nepal						SBS										SBS
Pakistan						PS										GBS/ SBS
Phillipines			SBS			PS										
Sri Lanka					PS											
Tajikistan						PS										
Vietnam			SBS		PS	SBS	PS		PS		SBS			PS		PS

	BG	CS	EC	DA	FI	DE	HU	FR	IT	LT	NL	PL	PT	ES	SV	UK
<b>AFRICA</b>																
Algeria			PS											PS		
Angola			PS						PS			PS	PS	PS		
Burkina Faso								SBS/ PS	SBS / PS						GBS	
Burundi			SBS													
Cameroon						PS		SBS	PS/ SL							
Central Africa								PS								
Cape Verde													PS	SBS /PS		
Chad			PS					PS	PS							
Comoros								PS								
Congo			PS					PS								
CDR			PS	PS										PS		PS
Djibouti								PS	SBS /PS							
Egypt			SBS		PS				PS					PS		
Eq.Guinea														PS		
Eritrea									PS							
Ethiopia		PS							SBS /PS		PS			PS		PS
Gabon								PS								
Ghana				SBS												GBS
Guinea						PS		PS								
Guinea-Bissau													PS			
Ivory Coast			PS													
Kenya				SBS		SBS		PS	PS					PS		PS
Lesotho			GBS													PS
Liberia			PS													
Libya			PS													
Madagascar								PS								
Malawi			SBS			SBS			PS							SBS
Mali								PS			SBS			PS	GBS	
Mauritania								PS						SBS /PS		
Morocco			SBS					SBS	PS					PS		
Mozambique			SBS	SBS	SBS			SBS/ PS	SBS /PS				PS	SBS /PS		GBS/ SBS
Namibia			SBS											PS		
Niger								SBS	SBS					PS		
Nigeria									PS							PS
Rwanda						PS										GBS/ PS
Sao Tome and Principe													PS			
Senegal														PS		
Sierra Leone									PS							GBS
Somalia									PS							
South Africa									PS							PS
Sudan									PS					PS		PS
Swaziland			PS						PS							
Tanzania				SBS		SBS			PS		SBS/PS			PS		GBS
Togo								PS								
Tunisia									SBS					PS		
Uganda				SBS				SBS	SBS /PS						SBS	GBS
Zambia		PS	SBS						PS		PF				SBS	GBS
Zimbabwe			PS					PS	PS							PS

	BG	CS	EC	DA	FI	DE	HU	FR	IT	LT	NL	PL	PT	ES	SV	UK
CARIB.																
Domin. Rep.								PS						PS		
Haiti								PS						PS		
EUROPE																
Albania		PS							PS					PS	SBS	
B-Herz.									PS							
Kosovo					PS											
Moldova	PS		SBS/ PS													
Serb/Mont.		PS					PS									
Ukraine			SBS/ PS									PS				
M.EAST																
Jordan									PS/ SL					PS		
Lebanon									PS					PS		
Palest. ter.								PS	SBS /PS					PS		
Syria			PS						SL							
Yemen			PS						PS		PS					
PACIFIC																
Vanuatu								PS								
S.AMERICA																
Argentina			PS						PS/ SL							
Bolivia			PS						PS					PS		
Ecuador			PS						PS					PS		
Guatemala														PS		
Honduras									PS					PS		
Nicaragua					SBS/ PS				PS					PS	SBS	
Paraguay														PS		
Peru			PS											PS		
Salvador														PS		
Uruguay									SL							
MULTI-COUNTRY																
Unspecified								PS								
SE Asia								PS								
Indian Ocean								PS								
Asia			PS													
Central Asia			PS													