Human Resources for Health Workforce
A "Promising Practices" Study

Promising Retention Practices of the Christian Health Association of Malawi

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Consultant

Daniel Aukerman

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Abbreviations and Acronyms

BLM	*Banja La Mtsogolo* (family planning NGO)
CHAM	Christian Health Association of Malawi
CHAMSEC	CHAM Secretariat
CO	Clinical Officer
Cordaid	Catholic Organization for Relief and Development Aid
DFID	Department for International Development
DHO	District Health Officer
ECM	Episcopal Conference on Malawi
GTZ	German Technical Cooperation
HIPC	Highly Indebted Poor Countries
HMIS	Health Management Information System
HRH	Human Resources in Health
ICCO	Interchurch Organization for Development Cooperation
IMA	Interchurch Medical Assistance
KCN	Kamuzu College of Nursing
LG	Local Government
MCC	Malawi Council of Churches
MK	Malawi Kwacha[1]
MO	Medical Officer
MOH	Ministry of Health
MOU	Memorandum of Understanding
NCA	Norwegian Church Aid
NT	Nurse Technician
NMT	Nurse Midwife Technician
PAYE	Pay-as-you-earn tax
RN	Registered Nurse
SETP	Six-Year Emergency Pre-Service Training Plan
SWAp	Sector Wide Approach
USAID	United States Agency for International Development
VSO	Volunteers in Service Overseas

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The Capacity Project Team bears full responsibility for the report.

[1] In May 2006, the exchange rate was about 140MK to 1US$.

HRH Retention from a different view:

Literature around health worker retention typically looks at the issue from one of three perspectives. First, is from that of the birds-eye national perspective, which refers to MOH HR plans as well as and ministry statistics. Such studies provide an overview of the HR situation in any given country. In Malawi the "Proposed 6-Year Human Resource Relief Programme For The Malawi Health Sector: Retention, Deployment And Recruitment" has been an often referenced review. Second, are studies which focus on a specific cadre of health providers. A recent Capacity Project study for the USAID Africa Bureau looked at the retention specifically of nursing tutors in Malawi, predominantly at faith-based training facilities. Third, are the studies which focus on elucidating factors which contribute to retention. Martineau and colleagues studied factors affecting retention of rural health workers in Malawi. Indeed all three elements -the macro-view, the cadre, and the retention practice – are presented in most studies, even if one is highlighted above the others.

Yet there remains still another view – a contextual one, specifically the the experiences of CHAM. The following discussion about retention practices at CHAM endeavors to do is to look at how the CHAM's complimentary health network has approached retaining health workers. Within its context, as will be described further, CHAM is beholden to other actors setting and influencing the HRH agenda. Thus by necessity CHAM has no choice but to confront the HRH challenges of its member institutions in light surrounding political and financial realities.

Therefore, in order to explain CHAM's approaches to HRH, this paper will proceed as follows:

- Give an overview of CHAM especially its operational structure
- Review HRH data from affiliated institutions
- Look at elements faced by CHAM with regards to retention
- Analyze what, in this context, CHAM has done to promote retention

The Christian Health Association of Malawi (CHAM):

CHAM is an ecumenical, not-for-profit non-governmental organization of Christian owned health facilities. CHAM was established in 1966 and is jointly owned by the Mother Bodies, the Malawi Council of Churches (MCC) and the Episcopal Conference on Malawi (ECM). CHAM is governed by the General Assembly of Churches with a Board of Trustees and a Board of Directors answerable to the Mother Bodies, i.e. ECM and MCC. Thus CHAM is owned by and accountable to church systems within Malawi.

In comparison to other Christian Health Associations, CHAM is quite integrated with the MOH. CHAM provides an estimated 37% percent of healthcare throughout the country, with 85% percent of that care in rural areas. CHAM has a signed MOU with the government which outlines operating

principles. CHAM is a non-donor signatory to the SWAp and had committed to its implementation. CHAMSEC designates participants on all the technical working groups organized by the MOH and similarly invites MOH officials to its own training workshops to promote cooperation. CHAM is seen as a major stakeholder within the health sector and meets quarterly with the MOH to coordinate activities.

The close connection with the MOH is especially evident in the area of human resources. The MOH pays the salary of all health workers, excluding those on the CHAM payroll. CHAM receives monies from the MOH to administer the payroll to its affiliated institutions. Moreover, recognizing the staffing needs at CHAM facilities, the MOH has seconded staff to fill posts at CHAM facilities, persons who are paid directly by the MOH. Thus remuneration decisions by the MOH or by CHAM affect the whole system. CHAM facilities do charge user fees to augment the government funding they receive, but these fees are fall short of cost recovery.

CHAM functions as the umbrella healthcare organization for 161 health facilities of various sizes, ranging from outpatients only up to a 150 bed hospital. These facilities are commonly broken down into health posts (13), health centers (104), community/rural hospitals (18), and general hospitals (23). Community Hospitals, formerly called rural hospitals, have an operating theatre, a maternity, male wards, female wards, an outpatient department, and usually also an ambulance. CHAM also oversees ten health training colleges. An overview from a few years back, 2002, with slightly different numbers, compares institutions by supervising network:

> "The health infrastructure consists of dispensaries and clinics, health centers, and community, district, and central hospitals which are linked by a referral system. The MOH accounts for about two-thirds of all facilities, CHAM operates 26 percent, BLM about 5 percent, and the Ministry of Local Government (LG) another 5 percent; the rest are operated by the private sector."

Ownership and Type of Facility:

Type	BLM	CHAM	LG	MoH	NGO*	Total
Central hospital				4		4
Clinic	27	8	4	2	1	42
Dispensary		8	4	54		66
District hospital				22		22
Health centre	1	115	12	288		416
Hospital		27		19		46
Maternity		1	12	2		15
Mental hospital		1		1		2
Rehabilitation center		1				1
VCT center**					3	3
Total	28	161	32	392	4	617

Source: MoH and Japan International Cooperation Agency (2002)

*NGO refers to not-for-profit NGOs.

**Number of voluntary counseling and testing centers has increased significantly since this survey was conducted.

The CHAM Workforce:

CHAM Units Current Vacancies for 2006/2007 Recruitment

CHAM Retention Spreadsheets

Title of Post	Established	Actual Filled	Vacancies	% Filled
Medical Officers	80	31	49	39%
Clinical Officers	601	166	435	28%
Medical Assistants	215	94	121	44%
Nursing Officers	158	52	106	33%
Senior Nursing Sister	374	145	229	39%
Nurse/Midwife Technician	813	325	488	40%
Enrolled Nurses/ enrolled midwife / nurse technician	1269	89	1180	7%
Patient Attendants	951	664	287	70%
Hospital Attendants	1376	1002	374	73%
Homecare Workers	709	262	447	37%
Pharmacist/Senior Pharmacy Technicians	58	0	58	0%
Pharmacy Technician/ Assistant/ Attendant	340	67	273	20%
TOTAL POSITIONS	**13,401**	**5,516**	**7,885**	**41%**

Percentage of Posts Filled by Cadre:

Title of Post	Established	Actual Filled	Vacancies	% Filled
Medical Officers	80	31	49	39%
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HRH Cadres in Rural vs Urban Areas, Comparing the MOH with CHAM:

2005	MOH Urban vs Rural				CHAM Urban vs Rural			
	Total	Area			Total	Area		
		Urban	Rural	% Rural		Urban	Rural	% Rural
1.Physicians								
Generalists	88	61	27	31%	37	8	29	78%
Specialists	36	36	0	0%	0	0	0	0%
2. Nurses								
Registered Nurses	384	212	172	45%	89	20	69	78%
Enrolled Nurses	1834	276	1558	85%	1019	148	871	85%
Auxiliary Nurses	374	65	309	83%	0	0	0	0%
8. Clinical Officers	450	46	404	90%	115	26	89	77%
Totals	**4283**	**868**	**3415**	**80%**	**1535**	**240**	**1295**	**84%**

As the charts above indicate, CHAM clearly has a huge number of vacancies, filling only 41% of its established positions. Remarkably low occupancy rates are noted for enrolled nursing positions at 7%; and at 28% COs is another cadre which CHAM facilities have struggled to staff. Hospital and patient attendants comprise one-third of the whole workforce, which includes administrative and support staff not delineated in the table. This suggests that the backbone of getting work done remains in the hands of unskilled workers. Indeed in Martineau's study indicated that these very unskilled rural health workers, the patient attendants, are much less likely to receive training only an average of one in three attendants in the last year, as compared to the overall average of one person health worker.

Determinations of staffing requirements are based on facility assessments by the MOH and CHAM which designate facilities to warrant a certain number of health personnel. For example, a recent decision increased the allotted medical officers per hospital from two up to four, which would make the reported shortage numbers dire. Note that target staff numbers are not determined by patient volume nor by catchments area, which would be better than facility based staffing.

Comparative staffing by geographical location for the MOH and CHAM shows both some similarities and some differences. Both networks have a dominantly rural health workforce, at 80% and 84% respectively. CHAM has no specialist physicians listed, consistent with its focus on basic and general health services. CHAM also has no auxiliary nurses, having decided to designate as nurses only those with a higher level of training. Within the ministry ranks, there is a clear tendency of its higher skilled staff to be located in urban areas, which is not the case for CHAM. Within the MOH 31% of generalist physicians and 45% of registered nurses worked in rural locations, as compared to 78% and 78% for CHAM respectively. This suggests that CHAM may be more successful at retaining its upper skilled workforce in the rural areas. MOH does not routinely second staff to CHAM facilities, with the exception of some nursing tutors placed within CHAM institutions who remain on the government payroll.

The Context of Top Ups Within CHAM Institutions:

CHAM institutions face the ongoing challenge of retaining staff in a country with a huge health worker shortage. Top Ups by the individual member institutions is a longstanding practice. Sometimes these expenses are recovered by user fees, although they are not enough to support institutional self-sufficiency. Individual institutions also have their own unique relationship with church sponsorship which aids them in meeting their expenses.

CHAM recently conducted a survey to determine how member facilities were running their various salary schemes, for distribution and type of funds beyond what the salary support given through CHAM. It was found that there is high variability in facility behavior around top ups. Among the eighteen

institutions surveyed there were a total of 23 different types/names for their allowances. Additionally even allowances with similar names can be interpreted uniquely by each institutions criterion and can be given to different health worker cadres. Top ups ranged from 200 KW to 30,000 KW per month. Again all the funding for these institutional salary supplements are generated independently of CHAM.

Five Most Common Type of Institution Supported Allowances:

Type of Allowance	Number of Hospitals with Allowance
Call allowance	10
Hardship allowance	7
Salary Top Up Allowance	7
Responsibility allowance	5
Duty allowance	5

The principle point to highlight here is the great challenge CHAM faces in designing a top up or allowance policy in light of this variability. CHAM does not deal with uniform salaries within its affiliated institutions. Thus when CHAM introduces salary top ups for doctors, those funds are supplemental to whatever is offered by the individual institution. Indeed then certain cadres may get double allowances and certain cadres will not be included within the schemes. One group that particularly complained about the doctor top ups were the clinical officers who argue that they do the bulk of the work but yet are not rewarded for their long hours.

Salary Top Ups Explained as an Example:

Affect of DFID Top Ups on Salaries (KW/month), Mlambe:

2005	**Salary**	**Special Medical Allowance**	**Professional Allowance**	**DFID Top Up Allowance**	**Pension**	**Gross**	**PAYE**	**Net**	**DFID % Top Up**
Medical Officer	23297	1500	2300	14090	2330	43517	9866	33650	41%
Clinical Officer	13848	1500	1800	8917	1385	27450	5479	21970	40%
Nurse/ midwife tech	13848	1500	1800	8917	1385	27450	5479	21970	40%
Ward Attendant	5149	545	0	0	515	6209	280	5929	0%

Additional Top Ups By Cadre (KW/month), Mlambe:

	2004 Net	2005 Net	Hospital Fund Top Ups	Hardship Allowance	CHAM/Cordaid 300 €	New Net Pay
Medical Officer	23,788	33650	1000	11649	53455	99754
Clinical Officer	15,728	21970	600	6924	0	29494
Nurse/ midwife tech	15,728	21970	600	6924	0	29494
Ward Attendant	5,929	5929	200	2575	0	8704

The combination of different top up schemes is illustrated at Mlambe for 2005. Notice that the DFID funding resulted in a 40% increase in take home pay for employees, compared to prior net pay in November 2005. This increase is partially mitigated by the government's decision to begin taxing allowances, which they had not done previously.

The second chart demonstrates the added Cordaid and Mlambe proprietary top ups. As shown the added funding quadruples the take home pay for medical officers over the salary supported by CHAM in November 2004. Midlevel providers also see a substantial increase in pay to nearly double. But as with any type of allowance, the question arises what is the appropriate size and can those funds be sustained over time.

Salary Top-Ups as a CHAM Retention Strategy :

Regional Comparison of Health Workers per 100,000 Population:

CADRE	BOTSWANA	S AFRICA	GHANA	TANZANIA	MALAWI
Physicians	28.7	25.1	9.0	4.1	1.6
Nurses	241.0	140.0	64.0	85.2	28.6

As the above chart demonstrates, comparing Malawi to some of its neighbors, the HRH concerns in Malawi exceed those of its neighbors. Within

this context CHAM, its' donors, and CHAM facilities are trying to do whatever possible to retain their health workers. CHAM reports that in 2005, 88 nurses and 16 of 20 newly graduated doctors have left the country, and this even after the government increased health workers salaries by 52%. Whether it is due to external or internal NGO competition, CHAM staff expressed concern that Malawian doctors are not staying in the country.

CHAM did not set out to bolster physician salaries, but arrived at this approach sequentially. Prior to its merger with Cordaid in 1999, Memisa contributed to the HRH shortages in Malawi by sending Dutch expatriate doctors to remote mission hospitals and by providing topping-ups (extra salary on top of local salary, often combined with scholarships) to stimulate local doctors to take a post at a mission hospital. At that time the value of the total salary package in these mission hospitals was less than that obtained from governmental or private hospitals. At times almost 20 Memisa doctors were working in the country.

At of the time of the Cordaid merger a health policy review the Cordaid approach towards the sending of expatriate doctors changed. The idea was that they work together with local MO's. But due to HRH crisis expatriates often found themselves alone with too much work to do. To make these placements of Dutch MO's more effective and sustainable, felt it necessary to have more local MO's next to them. Thus Cordaid entered into discussions with CHAM which encouraged salary equity between Protestant facilities and Catholic facilities, both of whom CHAM administered salaries for. After discussions with CHAM (Christian Health Association of Malawi) and comparison with the governmental package it was decided that, in Malawi, a reasonable topping up of Euro 300,- for a Medical Officer (MO) and Euro 400,- for a Medical Officer in charge (MOic or medical superintendent) would be applied for all hospitals with whom Cordaid has already a partner or programme relationship. This Cordaid decision was based on the following argumentation:

> "The topping-ups are a temporary solution to a complex problem. Therefore the Southern Africa team and especially the Malawi team will make sure that the issue of topping-up and the human resource crises in mission hospitals will be discussed during the 'health policy development trajectory' with ETC/PHC and that solutions are proposed. CHAM as a central Christian organ for health issues in Malawi will be integrated in the process of resolvement of the deficit of local medical officers in mission hospitals."

An underlying assumption was that the CHAM top ups could stimulate discussion at national level on the competitiveness of Malawian health salaries. In 2004 the Cordaid top-ups were extended to all CHAM institutions. The idea was to provide a bridging top-up to the government increases which were projected to be coming. Again the salary supplements were designated only to physicians.

How the planning of these top ups was incorporated with national plans or with MOH efforts is unclear. MOH officials expressed that they would have desired greater interaction around the plan. CHAM efforts, consistent with their mandate, is to advocate for the best interest of member institutions. Given that many institutions are struggling to survive combined with the tendency of health worker flight to outside the country, CHAM's focus was on retaining doctors as best they could. Reports have been that the higher

salaries have helped attract and retain providers at affiliated institutions. (Although some turnover data by cadre is available through CHAM, its reliability is uncertain and therefore not presented here.)

Given that HRH decisions in one sector affect those in another, the MOH has clearly recognized implications. The MOH have complained that government physicians have been leaving due to the better compensation packages at CHAM institutions, although again there are no hard numbers to substantiate these perceptions. On the other hand, the MOH also recognizes that the key issue in the Malawi HRH crisis is the overriding lack of resources, and that it does not want to get wrapped up into squabbling over limited funds, when the fundamental issue remains that funding is inadequate.

To what extent CHAM top ups recruit away from government (an outcome with little overall net benefit to the country as a whole) and to what extent their fundamental influence is the curb out migration of health personnel (a result which could be embraced by the MOH and CHAM both) is impossible to gauge from available data.

As CHAM weighs the future of doctor top ups, the scales have tipped clearly towards their discontinuation, in spite of their apparent effectiveness at attracting and retaining the medical doctors. The negative ramifications in other areas are too large. The biggest concern is that top ups threaten the arrangement CHAM has with government for paying the salaries of personnel at affiliated institutions. Maintaining good working relations with the MOH, which are better than what CHAs in numerous other African countries enjoy, must remain a priority. Moreover CHAM also recognizes the salary subsidies are not sustainable over the long term, as the funding from Cordaid will not be available indefinitely. Therefore at the CHAM general assembly spring 2006, 2006, voted to discontinue the top ups. Cordaid agrees with the decision of CHAM General Assembly to discontinue the top ups and is looking forward to new CHAM initiatives and proposals to fight the difficult HRH situation in the country.In the 2005-2007 contract between CHAM and Cordaid the following was included: "From the year 2006 onwards, Cordaid will no longer accept the earmarking of its contribution for the Doctors Incentive Package and the MPH trainings."

But as much as the top ups helped to retain medical officers, the big concern among CHAM institutions is what will happen when the top ups are withdrawn. CHAM's generally strategy is to switch from to non monetary incentives. Yet whether these will be enough to keep medical officer on is unclear. CHAM itself recommends against top ups to other CHAs for many of the reasons already mentioned. This is in spite of the perception that the top ups actually do work. Isolated top ups, unlike the country wide top ups form DFID, can easily lead to strained relations with government. The second big reason is sustainability of salary increases. Salary supplements are subject to donor funding, which is only available for chunks of time.

CHAM's Retention Context:

CHAM's Retention Levers	Relevance to HR Retention
Controls	
Payroll agreement c Govt	*Gives CHAM influence with individual institutions*
Project funds channeled by donors to CHAM	*Supplementing facility funding for retention makes facilities accountable to CHAM*
Approval of staff positions	*Facilities cannot recruit unless there is a vacancy, review senior md and administrator*
Sends a budget each year to MOH & ultimately treasury	*Allows for setting HR priorities within the budget*
Influences	
Participates in MOH HR working group	*Can give input and advise MOH of how HR decisions are likely to impact CHAM*
Decisions of individual institutions regarding retention packages	*Advises and compares what other institutions have successfully done, as well as advise affiliates of MOH initiatives.*
CHAM delivers around a third of Malawi's healthcare, and thus shares the healthcare load with MOH	*CHAM patients and the MOH recognize that the delivery of quality health service by is needed to compliment government capacity, and thus advocate for good staffing at CHAM facilities*
Donors interested in including CHAM in funding	*Includes CHAM in staff support funding, ie DFID required 52% to be extended to CHAM*
Appreciates	
That MOH makes the ultimate decisions, ie regarding salaries	*CHAM respects those decisions, and adjusts. CHAM needs to be sensitive to MOH feeling that CHAM has an unfair competitive advantage for retaining physicians with donor funding*
Salary and benefit offers by the private sector, NGOs, neighbors, and industrialized countries are higher than in Malawi	*CHAM hospitals are not the wealthiest employers, and must tailor retention to these realities. They can point to low comparative salaries and argue for additional donor support for HR retention.*
Decisions around infrastructure development are made by MOH	*Locating facilities in promity to CHAM institutions instead of supporting them causes competition and thus affects retention*
High turnover of senior MOH staff with whom HR coordination takes place	*Requires extra effort the reestablish relationships and bring understanding to CHAMs HR perspectives*

Comparative Recruitment/Retention Strengths of Government, CHAM, and International NGOs:

Government	CHAM	INGOs
Increased opportunity for training	No bureaucracy, decisions made autonomously at the institution. Thus more responsive to the staff person's need.	Competitive package and salary
Government has a transferable system between units, eventually can move closer to family	Find CHAM facilities provide a sense of community, staff have social network.	Pay higher allowances, attractive to employees as well as communities
Ultimate controller of salary funds	Top Ups for Higher Pay	To whom are they accountable?
Revisions to salaries and benefits go first to government employees	Doctors are in charge of institution, can make independent decisions	Least job security, project related and subject to discontinuation
Better medical insurance system	Accountable to community, government, church, and donors	
Higher pension scheme (25% v 15%)	Workforce which works under trying circumstances, yet are dedicated and committed.	
Higher job security	CHAM security is there in salary	
More Hierarchical		

Contacts

Name	Position	Affiliation
1. Mrs. Ruth Mwandira	Executive Director	CHAM
2. Mr. Francis C Gondwe	Deputy Executive Director	CHAM
3. Ms.Desiree Mhango	Health Coordinator	CHAM
4. Mr. Christopher Gandidzanwa	Health Information Officer	CHAM
5. Mr. Crispin Kamanga	Administrative Officer	CHAM
6. Frank Dimmock	Health Coordinator- Malawi	Church of Central Africa Presbyterian (CCAP)
7. Michael O'Carroll	Senior Technical Adviser	MOH
8. Marjan Kruijzen	Program Officer, Malawi	Cordaid

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