

HUMAN
RESOURCES
FOR HEALTH

COUNTRY COORDINATION AND FACILITATION (CCF)

PRINCIPLES AND PROCESS



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FOREWORD

The serious shortage of human resources for health (HRH) is one of the most critical constraints to the achievement of health and development goals. Moving forward from Kampala and having made significant achievements in raising global awareness on the HRH crisis, the focus is now at the country level. Addressing the challenges of the health crisis requires collaboration from multiple sectors and stakeholders with complementary roles. In the light of having a single platform for coordination of policy and programmes relating to the health workforce, the Global Health Workforce Alliance (the Alliance), through a consultative process, has developed Country Coordination and Facilitation (CCF) - Principles and Process on human resources for health (HRH) for an integrated health workforce response. The CCF was conceptualized in 2009. With a sensitization phase in early 2010, its roll-out commenced in the latter part of 2010 with a first wave of 18 countries across all regions.

The CCF approach requires establishing and supporting the necessary governance structures for intersectoral coordination and collaboration to plan, implement and monitor health workforce development and retention at

the country level, while working through one national HRH plan. It also entails processes assisting priority countries to ensure that sustainable, motivated and skilled health workers are available to meet health care needs and working with partners to ensure that funding and technical expertise is available for programmes.

This product is intended for everyone who has a part to play in dealing with the health workforce crisis at the country, regional and global level. The CCF approach will continue to evolve and be updated with new evidence-based suggestions; best practices and lessons learnt from country experiences. This, therefore, must be seen as a living document, which will be revised at regular intervals to reflect the new evidence.

The Alliance is actively promoting this innovative approach, so that Governments and other stakeholders can come together under one umbrella to address the health workforce crisis. Without addressing crucial bottlenecks in human resources, the backbone - yet often the weakest link, of health systems, it will not be possible to achieve health-related MDGs.

Dr. Mubashar Sheikh
Executive Director
Global Health Workforce Alliance

ACRONYMS

AAAH	Asia-Pacific Action Alliance on Human Resources for Health
AGA	Agenda for Global Action
AusAID	Australian Agency for International Development
APHRH	Africa Platform on Human Resources for Health
BMZ	Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (German Federal Ministry for Economic Cooperation and Development)
CCF	Country Coordination and Facilitation
CCM	Country Coordination Mechanism for the Global Fund to Fight AIDS, Tuberculosis, and Malaria
CIDA	Canadian International Development Agency
DFID	Department for International Development (United Kingdom)
ECSA	East Central and Southern Africa
EHRP	Emergency Human Resource Programme
FBO	Faith-based organization
GAVI	Global Alliance for Vaccines and Immunization
HAF	HRH Action Framework
HHA	Harmonization for Health in Africa
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMIS	Health and Management Information System
HRH	Human Resources for Health
HRIS	Human Resources Information System
HWAI	Health Workforce Advocacy Initiative
ICC	Interagency Coordinating Committee for Expanded Programme on Immunization
ICM	International Confederation of Midwives
ICN	International Council of Nurses
IHF	International Hospital Federation
IHP+	International Health Partnership and related initiatives
JICA	Japan International Cooperation Agency
MDGs	Millennium Development Goals
MoH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NEPAD	New Partnership for Africa's Development
NGO	Non-governmental organization
OCEAC	Organization of Coordination for the Fight against Endemic Diseases in Central Africa
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHRHA	Pacific Human Resources for Health Alliance
PMI	U.S. President's Malaria Initiative
RRT	Resource Requirement Tool
SADC	Southern African Development Community
SIDA	Swedish International Development Cooperation Agency
SWAp	Sector-Wide Approach
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WAHO	West African Health Organization
WHO	World Health Organization
WMA	World Medical Association

INTRODUCTION

The World Health Report 2006¹ identified the threshold in required workforce density as 23 doctors, nurses and midwives per 10,000 population, below which it was very unlikely to achieve high coverage of essential interventions, including those necessary to meet the health-related Millennium Development Goals (MDGs). Based on these estimates, 57 countries currently have critical shortages of human resources for health (HRH), with a global deficit of 2.4 million doctors, nurses and midwives. The proportional shortfall is greatest in sub-Saharan Africa, although the numerical deficit is immense in densely-populated South-East Asia as well.

The Global Health Workforce Alliance² (The Alliance) was launched in 2006 as a common platform for action to address this crisis. The Alliance is a partnership of national governments, civil society, international agencies, finance institutions, researchers, educators and professional associations dedicated to identifying, implementing and advocating for solutions to address these challenges.

The first Global Forum on Human Resources for Health convened by the Alliance in Kampala, Uganda in March 2008 was a milestone in the response to the HRH crisis. This event brought together 1,500 participants representing countries, agencies, organizations and other stakeholders. The Forum endorsed the Kampala Declaration and Agenda for Global Action³ which specifies efforts needed in the next decade to collectively address health workforce challenges.

Moving forward from Kampala, efforts to raise awareness of the HRH crisis and to catalyze global action have largely succeeded, and focus has now shifted to the country level. Progress in countries will require a coordination process to bring together all HRH stakeholders. Some countries maintain HRH committees⁴ with positive results, while others still face a myriad challenges. To address these issues and build upon country experiences, this document has been compiled to strengthen and establish processes for successful Country Coordination and Facilitation (CCF) and to ultimately assuage the HRH crisis at country level.

The CCF is a strategy that promotes the centrality of the existing HRH committee as a process to bring together all stakeholders, to more effectively harness their contributions and to build coherence, coordination and national relevance of all their actions. The CCF is not a new structure nor is it intended to burden any system with new requirements. Instead, the process aims to identify the comparative advantages of the various HRH stakeholders and facilitate collaboration for health systems strengthening around one national health plan. Through engagement with relevant mechanisms and donor programmes, the CCF will help provide the environment for engagement and the development of linkages among programmes with HRH implications.

In an international effort to cultivate and expand the CCF strategies, four regional consensus-building meetings were held on HRH in Accra, Ouagadougou, Hanoi and San Salvador in 2009 and 2010, bringing together a diverse group of stakeholders from numerous countries. The lessons shared and best practices discussed at these meetings were compiled and circulated to country-level experts and partners for review before printing and circulation of this document.

Highlights of this vital resource include:

- the rationale, principles and expected outcomes of the CCF, along with the Zambia experience of coordination of HRH and Malawi's example of linking HRH coordination and health systems strengthening;
- the roles for various stakeholders in utilizing the CCF to improve the HRH situation, mechanisms for monitoring the CCF, and strategies for resolving bottlenecks and mobilizing resources; and
- country strategies and activities needed to actualize the Kampala Declaration and Agenda for Global Action. (Annex 1)

The Human Resources for Health: Country Coordination and Facilitation Principles and Process document is a resource aimed at all partners involved in curbing this global crisis. (Annex 2)

1 World Health Report 2006: Working Together for Health, WHO Geneva, 2006, accessible at: <http://www.who.int/whr/2006/en/>

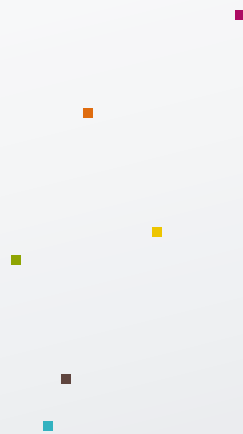
2 <http://ghwa.org/>

3 http://www.who.int/workforcealliance/knowledge/resources/kampala_declaration/en/index.html

4 "HRH committee" will serve as a generic term in this document, referring to all relevant HRH committees, working groups or task forces. Terminology for this entity varies tremendously among countries, yet their function remains the same for the purpose of Country Coordination and Facilitation.



RATIONALE, PRINCIPLES AND PROCESS



SECTION I

1. RATIONALE, PRINCIPLES AND PROCESS

1.1 Rationale for Country Coordination and Facilitation (CCF)

HRH is a key element for a strengthened health system, which is vital for achieving national health goals and the MDGs. Facilitating country actions to address the HRH crisis means building the capacity of priority countries to assess, formulate, manage and implement the appropriate policies and interventions in their own communities. It also entails assisting them to ensure that a sustainable, motivated and skilled cohort of health workers is available to meet health care needs and working with partners to ensure that funding and technical expertise is available for programmes.

Given the diverse nature of country-level stakeholders involved in HRH, coordination is essential for addressing the crisis locally. Structures for such coordination exist in many countries and are referred to as HRH committees. Meanwhile, challenges persist in these and other developing nations, including:

- the need for better defined roles among large numbers of diverse stakeholders;
- lack of strong government leadership and stewardship in processes for coordination;
- lack of coherence in HRH policies and priorities from different stakeholders, which in a number of cases portray conflicting messages;
- fragmented efforts and inadequate consultation among stakeholders to find solutions to specific HRH issues; and
- inadequate technical, convening or organizational capacity of stakeholders in HRH.

The CCF process will help address these and other issues with solutions based on country experiences, while offering strategies for strengthening HRH committees and ensuring its functionality within the health system. The CCF helps clarify roles and responsibilities, while helping to prevent duplication and promoting synergy for the HRH. In countries where there are no HRH committees, existing agencies or organizations can use the CCF to bring together the wide range of stakeholders working to alleviate the HRH crisis, such as a national HRH observatory.

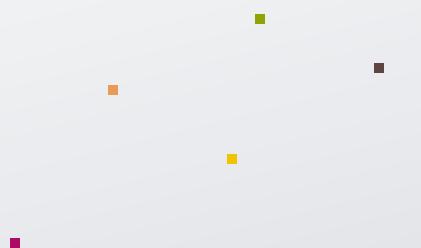
1.2 Principles and Process for the CCF

1.2.1 Coordination

Coordination of stakeholders through the HRH committee should be the core of the CCF. The HRH unit in the Ministry of Health (MoH) instituted preferably at the level of a directorate should be the focal point for coordination and convening. The CCF should be linked to broader health sector coordination mechanisms for health systems strengthening such as sector-wide approaches (SWAps), Harmonizing Health in Africa (HHA) and the International Health Partnership (IHP+). These mechanisms help strengthen coordination around one country's HRH plan and budget.

Furthermore, the HRH unit may require additional capacity building of human and material resources to fully execute its coordination role. A capacity assessment can be undertaken to identify gaps and develop a plan for supporting the unit. Government or development partners should be mobilized for support if gaps or resource needs are identified. In countries which have a federal administration system, the HRH committee will function at a national level. However, in countries where there is decentralization to the provincial or state levels, the CCF process can be replicated to these levels by using the available decentralized structures.

The Zambian experience of country-level coordination for HRH described in Box 1 provides an illustration of best practice of engagement of multiple stakeholders that resulted in tangible achievements in addressing the HRH challenges.



BOX 1

Country Coordination Mechanisms for HRH in ZAMBIA

An example of effective HRH coordination within the health sector programme is the HRH Technical Working Group in Zambia and the development partners' policy committee of the health SWAp coordination mechanism. In 2005, Zambia developed its first National HRH Strategic Plan, following a directive from the President of the Republic.

The planning process was collaborative, involving stakeholders that included the MoH Human Resources Department, Cabinet Office, bilateral and multilateral cooperating partners, the Churches Health Association of Zambia, NGOs, the Zambia National AIDS Network, regulatory institutions and professional associations such as the Zambia Medical Association and Zambia Union of Nurses Organization.

The HRH strategic plan is comprehensive, harmonized, evidence-based and budgeted for five years and is monitored and evaluated against annual targets. The plan is also the framework within which the HRH Technical Working Group operates as it seeks to increase the number of trained and equitably distributed health staff across the country through the implementation of local, regional and international policies.

The HRH Technical Working Group meets monthly and seven task groups report to the group on recruitment, retention, performance management, HRH information systems, national training and operational plans, the community health worker strategy, and financial tracking. Achievements include harmonization of the implementation of the HRH programme, creation of a dedicated HRH funding basket, and scale-up of interventions.

In the past five years, the HRH Technical Working Group has also helped contribute to:

- an increase in medical officers from 84 to 161;
- growth in the number of health care workers increased to reach 882;
- 26 training institutions received additional funding and two training institutions were re-opened that were previously closed;
- a direct entry training programme was launched for midwives parallel to the traditional midwifery training programme and now accounts for 40% of all midwives nationally; and
- growth in the production and absorption of healthcare workers.

1.2.2 Membership of the HRH Committee

HRH committees in countries should include professional associations; training institutions; non-governmental organizations (NGOs) and faith-based organizations (FBOs); private sector partners; representatives from Ministries of Finance, Education, Labour, local government and other relevant entities; public service commissions or agencies; multilateral and bilateral development partners and regulatory bodies.

A stakeholder analysis should be employed to ensure that all constituencies are represented adequately on the HRH committee. Steps should be taken to rectify cases of non-representation. In addition, representatives from constituency stakeholders should establish coordination mechanisms and processes to share information and obtain feedback from members to the HRH committee.

1.2.3 Linkages between the CCF and other coordination mechanisms

A number of initiatives for coordination exist in relation to specific global health mechanisms, bringing additional funding to the health sector and, as such, have HRH implications. These mechanisms and initiatives include the Country Coordinating Mechanism (CCM) of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), the Interagency Coordinating Committee (ICC) for Expanded Programme on Immunization, and implementing partners for the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the U.S. President's Malaria Initiative (PMI).

By utilizing the CCF strategies, the HRH committee can link into possible additional funding to address HRH issues. Formal links for systematic collaboration should be established with these mechanisms and programmes to ensure that HRH requirements of these initiatives are reflected in the country HRH plan.

Examples of practical steps to facilitate this collaboration include:

- representation by the HRH committee on the CCM or ICC and participation when grant proposals are being developed;

- ensuring that guidelines for including HRH needs in proposals are clear with a common understanding by all concerned stakeholders; and
- monitoring of the grant process and implementation by the HRH committee to ensure that the additional human resources required are provided.

Box 2 provides a best practice example from Malawi on linking HRH coordination with other such mechanisms.

BOX 2

Malawi: Linking HRH Coordination with Health Systems Strengthening Mechanisms

The Government of Malawi has implemented a number of health sector reforms to improve the delivery of health services and boost the health status of the population. The health SWAp was employed as an overarching strategy to increase efficiency and utilization of available internal and external resources in order to achieve shared health sector goals. Through the SWAp mechanism, Malawi instituted a Health Sector Review Group and Technical Working Group on HRH to ensure a participatory approach in decision-making for all stakeholders in the health sector.

In February 2004, Malawi faced a number of serious challenges in the health sector, including the rapid decline in indicators and high vacancies in nurses, physicians and other priority cadres. Only 20 doctors were graduating a year, and less than half were working in the public sector. The HIV/AIDS epidemic was rapidly growing, increasing demand for services and reducing capacity to respond. Available personnel often moved into more lucrative jobs offered by the private sector, donors, NGOs and research institutions. Low wages, high workloads, weak supervision, inadequate housing, shortages of drugs and supplies and weak management further compounded health sector problems.

The government declared a crisis of human resources and launched the Emergency Human Resources Programme (EHRP), a nationally-owned and fully integrated programme formulated with international donor support. The six-year programme committed to improving incentives for the recruitment and retention of staff, expanding domestic training capacity, using international volunteers as a stop gap measure, providing technical assistance and building monitoring and evaluation capacity.

As a result, the public health system in Malawi emerged from the critical emergency situation with significant achievements:

- Salaries increased for health sector workers.
- EHRP was integrated into the health sector programme and was part of wider health sector reforms.
- Global Fund Health Systems Strengthening grant and other funding partners began supporting the health system.
- Training and enrolment targets were generally met, utilizing more and better tutors, increased outputs and better infrastructure.
- Government hired and retained staff with innovative locum schemes.

- Increased district level funding enabled local solutions such as improvements in working and living conditions.
- All graduates of Kamuzu College of Nursing were recruited for public sector work, when previously none had been.
- The number of doctors increased from 43 in 2004 to 265 in 2009.
- Nurses increased from 3,456 in 2004 to 4,812 in 2009.
- Anti-retroviral therapy scaled up, increasing from 13,000 in 2004 to 276,000 in 2009.
- Outpatient services increased 49 percent.

"The health service has turned around. There is now hope. We are all working to common aims."

- District Health Officer in Malawi

1.2.4 Functions of the HRH Committee

The core functions of the HRH Committee include:

- ensuring that HRH priorities are identified and established as an essential component of the health system;
- promoting frequent dialogue and information sharing on developments in HRH with all concerned partners in resolving the HRH crisis;
- providing robust and transparent information on HRH that can be used for planning and management of the health workforce;
- advocating for adequate resources for health and for governments to adhere to commitments made to national and international goals and pledges on HRH;
- ensuring that HRH is prioritized during planning for health and proposal development and implementation, as well as in national strategies and budgets, such as the Medium Term Expenditure Framework (MTEF) and the poverty reduction strategy;
- equipping champions to promote the importance of HRH and its contribution to health systems development;
- establishing linkages with all public sector departments, private and civil society institutions that are involved with HRH;
- supporting negotiations and arbitration with different partners on matters relating to HRH;
- documenting best practices on HRH development and management;
- organizing annual reviews of the status of HRH in the country and facilitating the publication of a report to share these results; and
- monitoring and evaluating the progress of HRH implementation, including the HRH strategic plan.



EXPECTED OUTCOMES OF THE CCF

2. EXPECTED OUTCOMES OF THE CCF

Following implementation of the above-mentioned principles and processes for the CCF, countries will have likely achieved significant outcomes, enabling them to move towards realization of a comprehensive, costed, evidence-based HRH plan.

2.1 One comprehensive, costed, evidence-based HRH plan

Through the CCF process, the HRH committee has the primary responsibility for developing a comprehensive, costed, evidence-based HRH plan for the country. All stakeholders should collaborate and facilitate its development and help ensure that it reflects the national needs and supply of health workers for the MoH, other public sector services, the private sector and NGOs. Components such as training, recruitment, retention, performance, remuneration, equitable distribution, responsiveness and migration of the workforce should all be included as well. The plan should aim to achieve health goals and targets (e.g. the MDGs) and be consistent with priorities in the overall national health strategy as well as the strategies recommended in the Kampala Declaration and Agenda for Global Action. The plan should reflect and incorporate human rights principles, including gender sensitivity. Finally, the plan must be based on a thorough national HRH situation analysis, reflecting HRH priorities as agreed upon by all stakeholders.

2.2 Financing of the HRH plan

Funding a comprehensive, costed, evidence-based HRH plan is a challenge for many countries whose health budgets are invariably inadequate to address HRH issues. To mitigate this constraint, stakeholders should collaborate and facilitate the financing of one HRH country plan, and those who make financial contributions to the plan should do so transparently. Additional resources from multilateral donors such as the Global Fund and bilateral programmes such as PEPFAR provide other opportunities for funding HRH efforts and curbing the HRH crisis.

In this respect, all stakeholders should be engaged in the proposal development. Proposals in health system strengthening must place more emphasis on HRH.

2.3 Capacity building of stakeholders

Capacity among HRH stakeholders varies immensely, as does their level of engagement in collaborative dialogue. To better identify gaps in capacity, partners in HRH should undertake a situation analysis of all stakeholders to determine the various capacity building needs that will impact the comprehensive, costed, evidence-based HRH plan. In many countries, strategic planning and advocacy are two recurring capacity gaps that could be considered as starting points for future work. All stakeholders should be encouraged to contribute, facilitate and participate in the process of capacity building. Numerous technical tools are available from the Alliance, such as the Resources Requirement Tool (RRT)⁵ and the HRH Action Framework,⁶ and can be used as the basis for activities.

2.4 Consistency in implementation of the HRH plan

All stakeholders should collaborate and facilitate the implementation of the HRH plan and should adhere consistently to the policies and strategies that have been developed and linked to the national health plan. Established processes should be respected, and HRH partners should avoid developing specific policies and strategies that could compromise the plan and lead to imbalances in the workforce. In special situations where stakeholders may have different policies, such as an incentive policy for rural health workers, or inconsistent policies by donors for financing in-service training, it is important that such requirements are harmonized to ensure consistency and transparency.

2.5 A unified monitoring and evaluation framework

Country stakeholders should collaborate to monitor and evaluate the implementation of the comprehensive, costed, evidence-based HRH plan by employing a unified framework of indicators. Provision of accurate and transparent information by stakeholders to support the process is crucial. It is also imperative that monitoring of HRH programmes of partners complies with the national HRH plan, strengthens human resources information systems and involves the national health workforce observatories.

5 <http://www.who.int/workforcealliance/knowledge/publications/taskforces/rrtdescription.pdf>

6 http://www.who.int/workforcealliance/about/taskforces/tools_guidelines/en/index.html



SUPPORTING THE CCF

3. SUPPORTING THE CCF

It is essential that national governments and all stakeholders at local, regional and global levels work together for the successful implementation of the CCF. (Annex 3)

3.1 Government authorities

The highest level of the various government ministries involved in HRH should provide the political leadership and commitment to the CCF process. Given the gravity of the HRH crisis and varying roles of stakeholders in resolving the crisis, leadership and close monitoring will be required by ministers, permanent secretaries and general directors of all concerned government entities. This will ensure that their specific contributions, commitment and participation are provided in a timely manner to strengthen the HRH committee.

Government support should include adequate allocation of financial resources to HRH, regular attendance and active participation by representatives at HRH committee meetings, as well as the examination of all HRH policies to ensure consistency. Above all, governments should continue to raise the visibility of the HRH crisis at all forums where health is on the agenda.

3.2 National constituency stakeholders

National constituency stakeholders (such as health professional associations, training institutions, NGOs, FBOs, academia, research institutions, bilateral and multilateral partners, trade unions and the private sector) should similarly support the functionality of the HRH committee through active participation and regular attendance at meetings. They may also be required to provide technical or financial support. Local capacity and the relative strengths of each stakeholder should be fully exploited in finding solutions to bottleneck and obstacles to improve the HRH crisis. Constituency stakeholders should examine their roles, policies and strategies to assess the impact of their programmes and how they can better contribute to resolving HRH issues in their country.

3.3 Global and regional partners

If local solutions are not possible or adequate, an assessment should be made by the HRH committee to identify areas needing technical and/or financial support from global and regional partners. Based on the results of the assessment, the following sources may be considered for support:

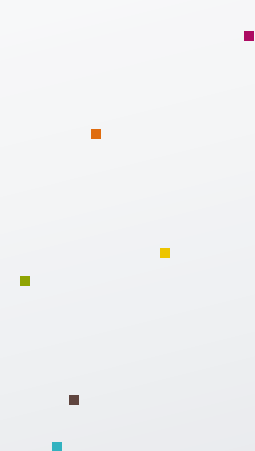
- Development partners or multilateral agencies such as WHO and other entities engaged in health can offer a range of expertise and support functions.
- Technical agencies of regional economic and political bodies and other health related organizations, which are important for continued advocacy to raise the visibility of the HRH crisis and for increased funding and to provide a platform for collective support for the rapid scaling up or harmonization of policies and strategies at the regional level.
- Networks from technical, advocacy, academic and research areas, including universities, research institutions, the private sector, NGOs and FBOs that are locally or regionally located can be a good resource for technical support.

3.4 Global health initiatives

Global health initiatives such as the Global Fund, Global Alliance for Vaccines and Immunization (GAVI) and PEPFAR are major funders to the health sector and have demonstrated the willingness to fund HRH within health systems strengthening proposals. These developments have become even more important as the recent announcement by the High Level Task Force on Innovative International Financing for Health Systems financing that GAVI, Global Fund and the World Bank should design a common platform for health system financing in a process facilitated by WHO. HRH committees in countries should engage with these mechanisms to strategize how best to use resources for health systems and to better address HRH challenges.



MONITORING THE CCF PROCESS



4. MONITORING THE CCF PROCESS

Measuring the performance of the CCF process is crucial to ensure that activities impact HRH. The direct influence of the CCF on HRH implementation may take time to be realized, because activities such as training, and increases in health workers will produce gradual results. However, relevant benchmarks should be developed to measure progress and anticipated outcomes of the CCF and to help inform the activities of the HRH committee. Relevant indicators for measuring impact could include the following:

- composition and capacity of membership of the HRH committee and frequency of its meeting;
- level of representation by stakeholders in the HRH committee;
- timely availability of information from stakeholders for planning purposes and the methods and channels used for dissemination;
- number and types of HRH issues that are prioritized by the HRH committee;
- number of contradicting policies by stakeholders;
- credible financial tracking mechanisms for HRH;
- availability of HRH annual review report;
- linkages between HRH committee and other national mechanisms for strengthening health systems; and
- availability of in-country or regional sources of technical support.





CONCLUSION

Since the formation of the Alliance, significant achievements have been made in galvanizing global awareness and the need for action around the HRH crisis. Despite the growing awareness of actions that can improve HRH, countries still face challenges in the implementation of these strategies. However, much can be achieved if there is a process to coordinate stakeholders working to improve the HRH crisis. The CCF offers a viable mechanism to ensure functionality and HRH linkages within the national health system and among stakeholders. The principles and process detailed above offer partners an opportunity to work together in a collaborative way that will counter fragmentation and build synergy, a vital ingredient towards ensuring effective and lasting change in countries.



ANNEX

Annex 1. Strategies for the CCF

The Kampala Declaration and Agenda for Global Action (AGA) provides guidance on specific strategies and actions that the countries and stakeholders may take. Areas for country action are based on the following six interconnected strategies:

- AGA1: building coherent national and global leadership for health workforce solutions;
- AGA2: ensuring capacity for an informed response based on evidence and joint learning;
- AGA3: scaling up health worker education and training;
- AGA4: retaining an effective, responsive and equitably distributed health workforce;
- AGA5: managing the pressures of the international health workforce market and its impact on migration; and
- AGA6: securing additional and more productive investment in the health workforce.

The CCF process will assist the countries to determine how to address the HRH challenges and improve the situation. A selection of priority actions for each of the above strategies is presented below.

AGA 1: Building coherent national and global leadership for health workforce solutions

The health workforce crisis calls for extraordinary leadership at all levels which is focused on solutions and driving results. These efforts will give visibility to the issues that hinder access to health workers worldwide. Coherence and collaboration are required across sectors of government, such as between health, education, trade, finance, labour and local governments to ensure progress.

Agreeing on a comprehensive HRH plan within the context of primary health care renewal is essential. This plan must reflect all components such as training, retention, performance, remuneration, equitable distribution, responsiveness and migration of the workforce. It should aim to achieve the health goals and targets such as the

MDGs and be consistent with goals and strategies in the overall national health strategy. The plan should include the needs of the MoH and other public sectors such as the health services of the government, the private sector and civil society, including NGOs. Human rights considerations such as gender should be incorporated. Policies of implementing stakeholders that differ from those in the national plan should be harmonized to ensure consistency and transparency.

Countries will be at different stages in the development and implementation of national HRH plans, but regardless of the progression, the following efforts are essential for all countries working in HRH:

- establish public commitment by government leaders, particularly from the MoH, to address the health workforce crisis as a critical component to achieving health and development goals;
- map all HRH partners in a database indicating their functions, e.g. education and training, service delivery, drug management and supplies, research, policy development, recruitment or administration and management;
- convene all partners, including the private sector and civil society, to ensure partnership coordination on all HRH matters with one focal point, supported by the highest level of government;
- assess all policies and strategies on HRH with the objective of harmonizing and aligning them around one country HRH plan; and
- build capacity and strengthen existing government structures for coordination to include HRH. The HRH department or unit in the MoH should be well equipped to act as the focal point for HRH and to carry out the required functions of coordination.

AGA 2: Ensuring capacity for an informed response based on evidence and joint learning

Assessments of the HRH situation in a country are critical for the development of a national HRH plan. However, data for such assessments are invariably inadequate or unavailable in the majority of countries. In most cases a human resources information system

(HRIS) is lacking, or if it is available, it may not link with the health and management information system (HMIS). As a result, capturing HRH trends, particularly those on migration and equitable distribution of health workers, is extremely difficult, and vital information for policy-making and planning is missing. WHO and partners produced a handbook on monitoring and evaluation of HRH that will guide countries to select indicators which needed to strengthen the HRH information system.⁷

Country actions to mitigate these challenges should include the following:

- develop an HRIS based upon the HRH data collected from the health facilities and districts and linked to the national HMIS. The HRIS should also be linked to the progress indicators and monitoring framework of the HRH national plan and to the progress indicators for monitoring achievements to the Kampala Declaration and the Agenda for Global Action. Together, the results from these data sources will contribute to the biennial report on the progress made related to the Kampala Declaration and Agenda for Global Action. Gaps will be identified for strengthening of country HRH database;
- establish national observatories that take into consideration information from all stakeholders working on HRH;
- provide information on HRH to regional databases and observatories that act as repositories to enable them to develop and validate country HRIS and provide information on all aspects of HRH; and
- undertake operational research in areas such as that will provide information on time and motion studies, on effective and efficient deployment of available work force and its productivity.

AGA 3: Scaling up health worker education and training

Many countries are unable to provide the number and quality of health workers necessary to respond to

current demands. Education, training, and management capacities are often lacking, while infrastructure and logistics are also in grave need of improvement. These problems have been complicated by the need to expand services to meet the MDGs. Without capacity building and institutional strengthening, countries will not be able to meet the aims of the Kampala Declaration and Agenda for Global Action. Additionally, this critical situation and associated challenges have been presented in the report of the Alliance Task Force for Scaling up Education and Training for Health Workers.⁸

In order to rapidly scale-up and expand education and training to meet service needs, countries and partners have embarked on expanding health worker training. However, local capacity is frequently inadequate for teaching and monitoring quality, and standards are difficult to maintain in the absence of regulation and accreditation systems. Temporary solutions such as task-shifting need to be properly planned to respond to country needs, and in-service training should be organized in tandem with pre-service training to avoid keeping health workers away from delivering services. Established guidelines are also needed to determine the type of services that can be provided according to the skills of the health care worker.

The expansion of training facilities, the production of new health workers and the transfer of skills also require additional resources. Countries with similar HRH challenges are encouraged to share information about good practices and innovative actions to address training and education issues.

Country actions by stakeholders should include the following:

- adapt and modify the tools and guidelines on HRH to fit country needs;
- establish agreements between the public and private sectors in the training, utilization and deployment of staff;
- develop scaling-up plans to roll out different health worker training, particularly for community health

⁷ The handbook can be accessed at: <http://www.who.int/hrh/resources/handbook/en/index.html>

⁸ http://www.who.int/workforcealliance/documents/Global_Health%20FINAL%20REPORT.pdf

workers and specialized staff, as recommended by the Task Force for on Scaling up Education and Training for Health Workers;

- devise in-service training plans and a road map for integration into pre-service training;
- create a training information system for health workers that will track all trainings undertaken as part of career development;
- establish regulations to standardize training requirements and the duration of training for all categories of the health workforce;
- formalize requirements for accreditation of training institutions and facilities;
- establish a system for the standardization and categorization of various cadres of health workforce;
- undertake strategic assessments to develop the kinds of task shifting and country specific, multipurpose health workers that are required; and
- develop training and education programmes that increase the likelihood of health workers serving in rural and hard to reach areas, including through targeted recruitment from rural areas and disadvantaged populations, targeted scholarship and fellowship programmes, locating training institutions in these areas, prompting community-based medical education and internship and mentoring programmes.

AGA 4: Retaining an effective, responsive and equitably distributed health workforce

Retaining skilled health workers, particularly newly trained staff, is critical for the effective delivery of quality health services. While financial incentives have proved to be important for retention, other aspects such as maintaining a positive working and living environment with the required equipment and commodities can be a motivating factor to retain staff. Patient security, workplace safety and relevant workplace policies which address prevention of cross-infection or physical injury can also aid in boosting health worker satisfaction.

Effective and equitable deployment of the health workforce is also critical. Concentration of the health workforce in urban areas or capital cities at the expense of rural and hard-to-reach areas undermines the countries efforts to achieve the health-related MDGs.

Special attention must be paid to attract and retain the health workforce in these areas. Effective deployment of the health workforce can also be addressed by reviewing infrastructure planning and site selection.

Productivity studies have revealed a failure to maximize the schedules of health workers, either because health facilities are not well located vis-à-vis population density or because facilities are concentrated in a particular area. Consultations with the private sector, NGOs and FBOs will facilitate the proper localization of facilities to ensure more effective use of staff time.

An important mechanism that may be referred to and employed is the Positive Practice Environments Campaign⁹ launched by the Alliance in partnership with health professional associations. This presents a global platform for discussion and strategic planning on the diverse issues that affect health workers in their professional environment. The five-year, facility-centred campaign aims to improve the recruitment and retention of health workers as well as their well-being, health and safety in the work environment.

Country actions related to this objective should include the following:

- establish special incentive packages for the workforce in rural and hard-to-reach areas;
- plan for a transition and recruitment process for new graduates from training institutions to service delivery;
- create a career development structure that is transparent and provides opportunities for training based on merit and performance;
- develop an annual award system that recognizes performance and outstanding contribution to improving health service delivery;
- establish policies for prophylaxis and treatment of accidental cases of infection such as needle-stick injury and ensuring confidential health services are available for health workers;
- define service categories according to skills, competencies and training;
- set up agreements between the public and private sectors in the training, utilization and deployment of staff;

⁹ <http://www.ppecampaign.org/>

- create a system of long-distance learning and a comprehensive supervision system that fosters joint learning, skills building and mentoring; and
- develop and implement a comprehensive approach to reduce stigma and discrimination by health workers and to enhance health workers respect for the rights of all patients.

AGA 5: Managing the pressure of the international health workforce market and its impact on migration

The migration of the health workforce can be attributed to several causes. Inadequate and non-competitive remuneration and allowances as well as delays in the recruitment of newly qualified staff have led health workers to look beyond their own country for better conditions of employment. Poor working environments and a lack of consideration for safety, particularly for female staff, have also contributed to the lack of stability of the health workforce.

Organized and systemic policies for career development, campaigns such as the Positive Practices Environment, and mentoring by professional associations can provide a supportive environment particularly for staff working in remote areas. Codes of practice to organize and manage regional recruitment on a bilateral basis have also been implemented in some countries, in addition to the negotiations being spearheaded by WHO for a code of practice on the international recruitment of health personnel. Recipient countries can also contribute to strengthening training institutions in source countries to increase the number of trainees.

Country actions by stakeholders should include the following:

- organize bilateral agreements between countries within the same region and with recipient countries in other regions to manage staff recruitment and movement in an orderly manner;
- improve and expand training facilities and infrastructure with support from recipient countries to increase the number of trainees;
- strengthen professional councils and associations to provide information and advice to members about recruitment arrangements;

- engage professional councils and health workers association to undertake periodic reviews of salaries and allowances of the health workforce;
- engage professional councils and health worker associations to explore innovative ways to acknowledge good health worker performance; and
- establish systems to introduce and monitor the WHO Code of Practice for international recruitment of health personnel (adopted in May 2010).¹⁰

AGA 6: Securing additional and more productive investment in the health workforce

Accurate financial data for HRH is difficult to attain and when such information exists it is often dispersed among different stakeholders. Furthermore, it is challenging to disaggregate financing for HRH within total resources for health. Health budgets are invariably inadequate to address comprehensive HRH plans, although personnel costs and salaries often account for the largest portion of health budgets. Currently, there are opportunities through international funding mechanisms and programmes, such as the Global Fund and PEPFAR, to access technical and financial resources for HRH through the national health sector plans. However, guidelines are not straightforward, and resources for health systems strengthening are often allocated to commodities instead of human resources.

Furthermore, the overarching challenge of fiscal space whereby countries are unable to absorb and utilize additional resources needs to be addressed. It is expected that the products and recommendations of the Alliance's Task Force on Financing Human Resources for Health¹¹ will strengthen country capacities to plan and manage financial resources required for HRH. Similarly, the ongoing work of the High Level Taskforce on Innovative International Financing for Health Systems is also expected to propose new mechanisms to increase the availability of resources for HRH financing.

¹⁰ Information on WHO Code of Practice for international recruitment of health personnel can be accessed at: <http://www.who.int/workforcealliance/media/news/2010/codestatementwha/en/>

¹¹ Information on Task Force on Financing Human Resources for Health can be accessed at: <http://www.who.int/workforcealliance/about/taskforces/financing/en/>

Country actions should include the following:

- finance HRH plans as an integral component of national health plans and compacts and incorporated into the Medium Term Expenditure Framework (MTEF) and SWAPs;
- map financial flows for HRH and establish a tracking system to capture such HRH resources, conducted in conjunction with systems for national health accounts;
- develop a comprehensive strategy for securing necessary financing for the HRH plan, including through domestic and international channels;
- build capacity within and strengthen dialogue between health and finance ministries to enable HRH financing needs to be better incorporated into national budgets;
- explore new ways to increase fiscal space available for HRH and other health needs, including ways to increase government revenue and reviewing current macroeconomic policies and possible alternatives;
- seek technical assistance as necessary to develop viable and sustainable HRH financing proposals as part of the national proposal submitted for funding; and
- identify HRH champions among opinion leaders, such as parliamentarians, members of the media, civil society and professional associations, to advocate for HRH so that governments can meet international commitments, such as the pledge in the 2001 Abuja Declaration¹² to allocate at least 15% of the national budgets to health and development.

Annex 2. Potential audiences for this document

Country level:

- Government authorities: political leaders, ministers and senior government officials in health, finance, education, labour/employment, local government and public service commission/agency;

¹² Abuja Declaration 2001 can be accessed at: http://www.un.org/ga/aids/pdf/abuja_declaration.pdf

- Constituency stakeholders: health professional associations, training institutions, NGOs, FBOs, academia, research institutions, bilateral and multilateral development partners, trade unions and the private sector.

Regional level:

- Regional technical agencies and economic bodies such as West African Health Organisation (WAHO), East Central and Southern Africa (ECSA) Health Community, the Organization for the Coordination to Fight Endemic Diseases in Central Africa (OCEAC), and others;
- Networks such as the AAAH, Africa Platform for Human Resources for Health (APHRH), the Pacific Human Resources for Health Alliance (PHRHA), the Pan American Network of HRH observatories, professional associations, regulatory bodies, labour movements, the Health Workforce Advocacy Initiative (HWAI), the Health Worker Migration Global Policy Advisory Council, and the New Partnership for Africa's Development (NEPAD).

Global level:

- Political leaders of G20 and G8 forums;
- Bilateral and multilateral partners such as WHO, United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), United Nations Development Programme (UNDP), Joint United Nations Programme on HIV/AIDS (UNAIDS), The World Bank, African Development Bank, Asian Development Bank, Islamic Development Bank, United States Agency for International Development (USAID), Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (BMZ), Japan International Cooperation Agency (JICA), and others;
- International organizations and foundations and private companies engaged in global health;
- International Council of Nurses (ICN), International Hospital Federation (IHF), World Medical Association (WMA), International Confederation of Midwives (ICM) and other international professional associations.

Annex 3. Examples of stakeholders and functions for HRH partnership in countries

Sector	Institutions	Functions
Government	Ministry of Health	Stewardship of policies and strategies for HRH
	Public service commission	Recruitment and career development
	Ministry of Finance	Funding of the health budget
	Ministry of Labour	Ensuring health workers' rights
	Ministry of Defence	Organization and management of health services for the armed forces
	Ministry for the Interior	Organization of health services for the police and security forces
	Ministry of Education	Training of some categories of health workers
	Ministry of Local Government	Health services administrations decentralized to district and regional levels in some countries
	Other line ministries or departments	Engaged in different functions related to HRH
Multilateral agencies	WHO	UN Specialized technical agency for health
	UNICEF	UN agency for the health and social welfare of women and children
	UNFPA	UN agency that promotes the rights of all populations
	UNDP	UN programme for development activities
	UNAIDS	Multiagency programme for HIV/AIDS
	World Bank; regional development banks such as African Development Bank, Islamic Development Bank, Asian Development Bank, Inter-American Development Bank, European Bank for Reconstruction and Development	Provide loans for HRH within country programmes
Private Sector	Private hospitals and concessions, national hospital association, international health worker recruiters	Major employer of health workers and may organize and manage health services for employers
Bilateral agencies	USAID, JICA, Department for International Development of the United Kingdom (DFID), Canadian International Development Agency (CIDA), Swedish International Development Cooperation Agency (SIDA), Australian Agency for International Development (AusAID), etc.	Provide direct funding and technical support when working at country level
Civil society	NGOs, FBOs, advocacy coalitions, etc.	Offer valuable experiences and lessons on implementation and on community health personnel; sometimes are the largest provider of services in a country, particularly in rural areas; strong advocates for HRH and for accountability of HRH plans and commitments; can ensure perspectives of marginalized communities accounted for in HRH plans and in the monitoring and evaluation process
Academia	Universities and research institutions	Technical support and research; monitoring and evaluation of programmes
Professional associations	Doctors, nurses, pharmacists and others	Involved in welfare of members in areas of salary negotiations, incentives and working conditions, including working environment and professional development
Regulatory bodies	Doctors, nurses, pharmacists and others	Regulates the registration of practitioners, accreditation of training institutions
Labour movements	Some allied health workers and support staff	Involved in welfare of members in areas of salary negotiations, incentives, and work conditions
Networks	Asia-Pacific Action Alliance on Human Resources for Health (AAAH) and others partnerships and networks	Provide technical assistance and linking with other countries and initiatives
Foundations	Bill & Melinda Gates Foundation, Rockefeller Foundation, Clinton Foundation, etc.	Offer avenues for funding at the national, regional and global levels

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

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