HUMAN RESOURCES FOR HEALTH

GOOD PRACTICES
FOR 'COUNTRY COORDINATION AND FACILITATION' (CCF)

AFTER HANOI VERSION 003 FOR CONSULTATION
2 December 2009
### ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AAAH</td>
<td>Asia Pacific Action Alliance on Human Resources for Health</td>
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<tr>
<td>CCF</td>
<td>Good practices for 'Country Coordination and Facilitation'</td>
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<td>EAC</td>
<td>East African Community</td>
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<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunization</td>
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<td>GFATM</td>
<td>The Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>GHI</td>
<td>Global Health Initiatives</td>
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<td>GHWA</td>
<td>Global Health Workforce Alliance</td>
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<td>HHA</td>
<td>Harmonization for Health in Africa</td>
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<td>HRH</td>
<td>Human resources for health</td>
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<td>IHP+</td>
<td>International Health Partnership and related initiatives</td>
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<td>NEPAD</td>
<td>New Partnership for Africa's Development</td>
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<td>MTEF</td>
<td>Medium Term Expenditure Framework</td>
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<td>OCEAC</td>
<td>Coordination Organization for the Fight Against Endemic Diseases in Central Africa</td>
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<td>PEPFAR</td>
<td>US President's Emergency Plan for AIDS Relief</td>
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<td>PHRHA</td>
<td>Pacific Human Resources for Health Alliance</td>
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<td>RECs</td>
<td>Regional Economic Bodies</td>
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<td>SADC</td>
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<td>WAHO</td>
<td>West African Health Organization</td>
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1. INTRODUCTION

The World Health Report 2006\(^1\) identified the threshold in workforce density 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 a critical shortage of human resources for health (HRH), equivalent to 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 also very large in South-East Asia because of its population size.

The Global Health Workforce Alliance (The Alliance) was created in 2006 as a common platform for action to address the 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.

A milestone in the response to the HRH crisis was the first Global Forum on Human Resources for Health, convened by the Alliance in Kampala, Uganda in March 2008. This event brought together over 1500 participants from countries, stakeholders, agencies, organizations and partners. The Forum endorsed the Kampala Declaration and Agenda for Global Action\(^2\), which specifies areas for action over the next decade by all stakeholders involved in addressing the health workforce crisis.

Moving on from Kampala and having made significant achievements in building global awareness about the HRH crisis and the need for action, the time has come to focus at the country level. For this to take place at country level there is the need to have a coordination mechanism that brings together all stakeholders working in HRH. Some countries do have these mechanisms with good results to improve the HRH crisis. Nevertheless, for one reason or the other, such mechanisms do have some constraints of not including all relevant stakeholders and sometimes these mechanisms don’t function well due to poor attendance at meetings by stakeholders, inadequate consultation among stakeholders and infrequent meetings to name a few. It is for these reasons, and based on country experiences, that a set of good practices are being put forward in this document.

- The document is referred hitherto as the HRH: good practices for country coordination and facilitation (CCF)
- The CCF is not a new mechanism; rather it promotes the centrality of the HRH working group or committee as a basis to bring together all stakeholders working in HRH at country level.
- The membership of the CCF should reflect the following: representatives from Ministries of Health, Finance, Education, Labour, Local Government, Public Service Commission/Agency, professional associations, training institutions, civil society (NGOs and Faith based organizations), private sector, development partners (multi lateral and bilateral agencies working in budgetary support or project mode) and regulatory bodies. (See figure 1).

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• The CCF is to function within existing systems such as Swaps, IHP+ and HHA that facilitates collaboration for health systems strengthening

• The CCF is not meant to burden any system with new requirements or criteria for functionality or funding, but to better identify the comparative advantages of the various HRH stakeholders within the country, to see how best their roles and responsibilities can be maximized to improve the HRH crisis.

• The CCF should engage and develop linkages with other country coordination mechanisms of programmes with HRH implications for health systems strengthening such as the CCM for the global Fund, ICCs (which among other activities, develop proposals for GAVI funding) and PEPFAR (for HIV/AIDS)

In countries where there are no HRH working groups or committees, the CCF should be used to galvanize support to use existing entry points to bring together the wide range of stakeholders working to improve the HRH crisis.

The document is presented as follows:

Section 1 addresses the areas for country action. This section recalls the Kampala Declaration and Agenda for Global Action. It highlights the strategies of the Agenda for Global action and the activities to improve the HRH crisis in countries.

Section 2 describes the rationale for the CCF and proposes a set of principles can for coordination facilitation among stakeholders working to improve the HRH situation. It spells out the challenges that countries with health workforce shortages face because of lack of coordination of stakeholders in HRH. As a way forward, the section lists the prerequisites for successful outcomes of the CCF around one country HRH plan.

Section 3 describes the different players that can facilitate the efforts of the CCF to improve the HRH situation. It underlines that when roles and responsibilities of the different actors are examined, this will most often reveal bottlenecks and obstacles which can in most cases be quickly resolved with local resources and funding or with regional and global support.

This document is addressed to the following audiences:

Country:

• Political and opinion leaders, Ministers and senior government officials in Health Finance, Education, Labour, Local government, Public service commission/agency

• Constituency stakeholders: All health professional associations, Training institutions, Civil society (NGOs, faith based-organizations, Academia, research institutions, bilateral and multi lateral partners, Trade unions and the private sector
Regional:

- Regional and economic bodies in the different geographic areas such as Economic community of west African States (ECOWAS), South Asian Association for Regional cooperation(SAARC)
- Regional technical agencies such as WAHO( West African Health Organization), ECSA and BIMSTEC(bay of Bengal Initiative Multi Sectoral Technical and Economic cooperation)
- Networks Such as the Africa Platform, the Asia-Pacific Action Alliance on HRH (AAAH), the Pacific Human Resources Alliance (PHRHA), the Pan American Network of HRH observatories, professional associations, regulatory bodies, labour movements, faith-based organizations, the Health Workforce Advocacy Initiative (HWAI), the Advisory Council on Migration, and the New Partnership for Africa’s Development (NEPAD).

Global:

- Multilateral and bilateral partners
- Global health initiatives
- International global forum of world leaders
SECTION I

2. AREAS FOR COUNTRY ACTION

2.1 Guiding principles

Areas for country action are based on the Kampala Declaration and Global Agenda for Action which has the following six interconnected strategies:

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

A selection of priority actions for each of the above strategies is presented below. These actions are to be based on country-specific circumstances and implemented by stakeholders of national alliances for HRH with regional and global support.

A tracking survey with indicators is on course to establish a baseline to measure progress over the next 12 months in the implementation of country actions. The results of the survey will be reported to the second HRH Forum to be held in January 2011 in Bangkok, Thailand. Special studies on particular workforce crisis problems and constraints as well as information from other sources such as country HRH profiles, will also be part of the report. Identified gaps in the report will form the basis for support to country capacity building and institutional strengthening in line with country self-assessments processes for HRH plans.

2.2 Building coherent national and global leadership for health workforce solutions

The health workforce crisis calls for extraordinary leadership at all levels, focused on solutions and driving results, to give visibility to all issues that hinder access to health workers across the globe. Far better coherence is required across sectors of government, such as between health, education, trade, finance, labor and local governments. Agreeing on a comprehensive and costed country 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 and migration of the workforce. The plan must reflect the needs of the Ministry of Health, in addition to other public sectors such as the health services of the Ministry of Defense, the private sector and civil society including non-governmental organizations (NGOs). It should also take into consideration special instances where stakeholders of national Alliances for HRH may have different policies such as an incentive policy for rural health workers in hard-to-reach areas. In such cases it is important that the policies are harmonized to ensure consistency and transparency.
Countries may be at different stages in the development and implementation of national HRH plans. Some countries may be in the process of reviewing their second generation plans; others may be starting from scratch.

No matter what stage a country is at, country actions should include the following:

- Public commitment by government leaders, Ministers of Health and other national leaders to addressing the health workforce crisis as a critical component to achieving health and development goals, through proactive advocacy;
- Mapping of all HRH partners in a database indicating their functions, e.g. education and training, service delivery, medicines/drugs management and supplies, research, policy development, recruitment or administration and management;
- Convening of 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;
- Assessment of all policies and strategies on HRH with the objective of harmonizing and aligning them around one country HRH plan; and
- Building capacity and institutional strengthening of national government existing structures for coordination to include HRH. The HRH department or unit in the Ministry of Health should be well equipped to act as the focal point for HRH and to carry out the required functions of coordination.

2.3 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 costed, comprehensive HRH plan. However, such data are invariably not available. In most cases there is no human resources information system, nor any linkages to the health and management information system. Capturing HRH trends, particularly on migration and equitable distribution of health workers, is therefore very difficult and means that often, this kind of vital information is unavailable for planning purposes and policy-making.

Country actions should include the following:

- Development of a human resources information system (HRIS) that is linked to the national Health Management Information System (HMIS) and that enables the collection of HRH data from the district to the national level. 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 Global Agenda for Action. Together, results from these data sources will contribute to the biennial report on the progress made related to the Kampala Declaration and Global Agenda for Action. Gaps will be identified for strengthening of country HRH databases.
- Establishment of national observatories that take into consideration information from all stakeholders working in HRH.
- Provision of information to regional databases and observatories that act as repositories to enable them to develop and validate country HRIS and provide trends information on all aspects of HRH.
Undertaking of operational research that will provide information on time and motion studies on effective and efficient deployment of available workforce and its productivity.

2.4 Scaling up health worker education and training

Existing HRH capacity in countries is insufficient at most levels, be it in-service, in education and training or in management. This has been complicated by the need to expand services to meet the MDGs. The responsibility on countries to meet the Kampala Declaration and Global Agenda for Action is great; yet without capacity building and institutional strengthening, countries will not be able to fulfill these expectations. This critical situation and associated challenges have been presented in the report of the Alliance Task Force on Scaling up of Education and Training for Health Workers.

In order to rapidly scale up and expand education and training to meet service needs, a number of countries and partners have embarked on expanded health worker training. However, in most cases, capacity is unavailable to teach or monitor the institutions to establish the required quality of training and standards become hard to maintain in the absence of regulation and accreditation systems.

Task shifting exercises have also been undertaken, but in an ad hoc manner without proper assessment of the country needs or the required resources to facilitate such delegation of functions. Above all, there are no service guidelines determining the type of services that can be provided according to a skills mix. The expansion of training facilities, the production of new health workers and the transfer of skills need new resources. Steps should be taken to integrate in-service training into pre-service training. Countries within regions experiencing similar HRH problems need to share information about good practices and innovative actions taken to solve their HRH problems in training and education.

Country actions should include the following:

- Adaptation and modification of tools and guidelines on HRH to fit country needs;
- Establishment of agreements between the public and private sectors in the training, utilization and deployment of staff;
- Development of scaling-up plans to roll out different health worker training, particularly for community health workers and specialized staff, as recommended by the Task Force on Scaling up Education and Training for Health Workers;
- Development of in-service training plans and a roadmap for integration into pre-service training;
- Development of a training information system for health workers that will track all trainings undertaken as part of career development;
- Establishment of regulations to standardize training requirements and the duration of training for all categories of the health workforce;
- Formalizing requirements for accreditation of training institutions and facilities;
- Establishment of a system for the standardization and categorization of the various of cadres of the health workforce; and
Undertaking of strategic assessments to develop the kinds of task shifting and country specific, multipurpose health workers that are required.

2.5 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 systems. While financial incentives have proved to be important for retention, other aspects such as a conducive environment with the required equipment and commodities can be a motivating factor to retain staff as they find pride in providing quality services. Another factor is patient security and workplace safety. Relevant workplace policies addressing the prevention of cross-infection, such as HIV, or even physical injury can make a significant difference.

Effective and equitable deployment of a scarce health workforce is also critical. The concentration of the health workforce in urban areas or capital cities at the expense of the rural and hard-to-reach areas does not help countries to achieve the health-related MDGs. Special attention has to be paid to attract and retain the health workforce in these areas. Effective deployment of the health workforce can also be addressed by reviewing the way health infrastructures are planned and sited. Productivity and time and motion 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. Dialogue and consultations with the private sector, as well as non-governmental and faith-based organizations 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 Environment Campaign[^3] that has been 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 should include the following:

- Establishment of special incentive packages for the workforce in rural and hard-to-reach areas;
- Planning for a smooth transition and recruitment process for new graduates from training institutions to service delivery;
- Establishment of a career development structure that is transparent and provides opportunities for training based on merit and performance;
- Establishment of an annual award system that recognizes performance and outstanding contribution to improving health service delivery;
- Establishment of policies for prophylaxis and treatment of accidental cases of infection such as needle-stick injury;

Establishment of a definition of service categories according to skills, competencies and training;
Setting up agreements between the public and private sectors in the training, utilization and deployment of staff; and
Establishment of a system of long-distance learning and a comprehensive supervision system that fosters joint learning, skills building and mentoring.

2.6 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 far beyond their shores 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 stability of the health workforce.

Organized and systemic policies for career development, campaigns such as the Positive Practice 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 taken root in some countries. This is in addition to the negotiations being spearheaded by WHO for a code of practice on the international recruitment of health personnel. Recipient countries can contribute to strengthening training institutions in source countries to increase the number of trainees.

Country actions should include the following:

Organization of bilateral agreements with countries within the same region and with recipient countries in other regions to manage staff recruitment and movement in an orderly manner;
Improvement and expansion of training facilities and infrastructure with support from recipient countries to increase the number of trainees;
Institutional strengthening of professional councils and associations to provide information and advice to members about recruitment arrangements;
Engagement of professional councils and health workers association to undertake periodic reviews of salaries and allowances of the health workforce;
Engagement of professional councils and health worker associations to explore innovative ways to acknowledge good health worker performance; and
Establishment of systems to introduce and monitor the WHO Code of Practice for international recruitment (currently under development and consultation). 4

2.7 Securing additional and more productive investment in the health Workforce

Information on financial flows for HRH is hard to come by. Where such information exists, it is scanty and spread over the records of different stakeholders. Furthermore, in most cases it is difficult to disaggregate financing for HRH within resources for health. Health budgets are invariably inadequate to address comprehensive HRH plans. Although personnel costs account for the largest portion of health budgets, such provisions traditionally account for salary costs only. Currently, there are opportunities through the Global Health Initiatives (GAVI, the US President’s Emergency Plan for AIDS Relief and the Global Fund to fight AIDS, Tuberculosis and Malaria) and the IHP+ and HHA to access resources (technical and financial) for HRH through the national health sector plan. However, guidelines for such support are not clear as to how HRH issues can be addressed and financed. In addition, resources for health systems strengthening are often allocated to commodities such as medicines, which are more tangible than the health workforce.

Furthermore, the overarching challenge of fiscal space whereby countries are unable to absorb and utilize additional resources need to be addressed. It is expected that the products and recommendations of the Alliance Task Force on Financing Human Resources for Health 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.

Country actions should include the following:

- Financing of HRH plans as an integral component of national health plans and compacts consistent with the Medium Term Expenditure Framework (MTEF) and Sector-Wide Approaches (Swaps);
- Mapping of financial flows for HRH and establishment of a tracking system to capture such HRH resources. This should be done in conjunction with systems for national health accounts;
- Seeking technical assistance as necessary to develop viable and sustainable HRH financing proposals as part of the national proposal submitted for funding to any particular global health initiative; and
- Identification of HRH champions among opinion leaders, e.g. parliamentarians, the media and professional associations to advocate for HRH so that governments can meet international commitments, such as the pledge in the 2001 Abuja Declaration to allocate at least 15% of the national budgets to health and development.
SECTION II

RATIONALE FOR COUNTRY COORDINATION AND FACILITATION

One of the essential factors for the successful implementation of the actions described in section one is an efficient and functional HRH coordination mechanisms between stakeholders. However, evidence has shown that in most countries with critical health worker shortages, coordination of the various stakeholders faces numerous challenges, including:

- the large numbers and diversity of players and the need for better defined roles, e.g. ministries of health, finance, labour, education, local government, training institutions, ministry or public service commission/agency responsible for recruitment of public sector workers (including health care workers), the private sector, civil society including NGOs and Faith based-organizations and professional associations;
- lack of strong government leadership and stewardship in mechanisms for coordination and;
- varied HRH policies and priorities from different stakeholders which in a number of cases, portray conflicting messages
- fragmented efforts and inadequate consultations among stakeholders to find solutions to specific HRH issues.
- Inadequate technical, convening or leadership capacity of stakeholders in HRH

These challenges can be addressed by establishing or strengthening existing coordination mechanisms around the HRH working group/committee. This mechanism hitherto is referred as the country collaboration and facilitation (CCF). The CCF among others will ensure that roles and responsibilities are clearly defined and means for establishing consultation and functionality are agreed. The CCF should prevent duplication and ensure synergy of efforts for HRH. Where such mechanisms do not exist, an entry point of a stakeholder organization can form the nucleus of the CCF to bring together the wide range of stakeholders to work to improve the HRH crisis. One such stakeholder organization can be the health workforce observatory.

4. PRINCIPLES FOR COUNTRY COORDINATION AND FACILITATION

The CCF should work along the following principles:

4.1 Coordination

*The HRH working group or committee should be the core of the CCF. The HRH unit in the MOH should be the focal point for coordination and convener. The CCF should be linked to broader health sector coordination mechanisms for health systems strengthening such as Swaps, Harmonization for Health in Africa (HHA) and the IHP+. These mechanisms help to strengthen the process of planning around one country plan and budget.***
• In the MOH of some countries the functions of HRH are divided between HRH management and HRH development divisions. In such situations oversight for the CCF should be at the level of the minister or permanent secretary to guarantee the stewardship role of the MOH in its coordination functions.

Furthermore, to enable the HRH unit to execute the coordination functions there may be the need to strengthen its capacity with the necessary human and material resources. A capacity requirement assessment should be undertaken to identify gaps and a plan for supporting the unit developed. Government or development partners may be able to support the plan.

In country situations where there is decentralization to the provincial and district level, the CCF should be replicated where feasible using the decentralized MOH structure or the best available entry point of stakeholders particularly the Ministry of local Government which may be responsible for government business.

4.2 Membership of the CCF should include: professional associations, training institutions, civil society NGOs and Faith based organizations), private sector, representatives from Ministries of Finance, Education, Labour, Local Government, Public Service Commission/Agency, development partners (multi lateral and bilateral agencies working in budgetary support or project mode) and regulatory bodies.

It is essential to examine the composition of the HRH working group to determine if all the constituency stakeholders are represented. Steps should be taken to rectify cases of non representation quickly. In addition representatives from constituency stakeholders should ensure that mechanism of coordination with adequate processes are in place to share information and obtain feedback from constituency members to the HRH working group

4.3 Linkages between the CCF and other mechanisms involved in health systems strengthening

There are a number of mechanisms which have been established to address specific health problems and do make decisions and plans that have HRH implications. These should include the following examples:

• CCM for the Global Fund which provides oversight to proposals development with HRH implications for health systems strengthening
• Interagency Coordinating Committee for EPI (ICC) (with oversight for the development of proposals for GAVI)
• Programmes such as PEPFAR and PMI which have demonstrated keen interest and made commitments to contribute to improve the HRH crisis.

Formal steps should be taken to establish mechanisms for systemic collaboration to ensure that HRH matters reflected in their programmes do respect the country HRH plan and contribute to the outcomes of the CCF. Practical steps which can be taken include

• Representation by the CCF in the CCM and other mechanisms when GHI grant proposals are being developed.
• Clarifying guidelines for submitting proposals on HRH
4.4 Functions of the CCF:
- ensure that HRH priorities are identified and established as an essential component of the health system;
- ensure frequent dialogue and information sharing on developments in HRH with all concerned partners in resolving the HRH crisis;
- ensure the availability of robust and transparent information on HRH that can be used for planning and management of the health workforce;
- advocate for adequate resources for health and for governments to adhere to commitments made to national and international goals and pledges on HRH;
- advocate for and ensure that HRH is prioritized during planning for health and in particular for the Global Health Initiatives, IHP+ and HHA;
- act as champions and promote the importance of HRH and its contribution to health systems development;
- ensure linkages are established with all public sector departments, private and civil society institutions that are involved with HRH;
- support negotiations and arbitration with different partners on matters relating to HRH;
- ensure that best practices on HRH development and management are documented;
- ensure that annual reviews of the status of HRH in the country are organized and to facilitate the publication of an annual report on the results of the review;
- ensure the monitoring and evaluation of the progress of HRH implementation.

5. EXPECTED OUTCOMES OF THE CCF

5.1 One national costed comprehensive HRH plan

The CCF has the primary responsibility for developing the national costed comprehensive plan. All stakeholders should collaborate and facilitate the development of the one national costed and comprehensive HRH plan. This plan must also reflect the national needs and supply of health workers for the Ministry of Health, in addition to other public sectors such as the health services of the Ministry of Defense, the private sector and NGOs. Components such as training, recruitment, retention, performance, remuneration, equitable distribution and migration of the workforce should all be included in the plan. Finally, the plan must be based on a thorough national HRH situation analysis with the HRH priorities as agreed upon by all stakeholders.

5.2 Financing one national costed comprehensive HRH country plan

Funding the HRH costed plan is a challenge for countries, whose health budgets are invariably inadequate to address comprehensive HRH plans. All stakeholders should collaborate and facilitate the financing of the one national costed comprehensive HRH country plan. All stakeholders who make financial contributions to the plan should do so in a transparent manner and declare all such resources for reflection in the country HRH plan. Furthermore, all stakeholders should be given opportunities to access financial resources to improve the HRH crisis from the global health initiatives such as the Global fund and GAVI. To ensure this, where required, all stakeholders should be engaged in the proposal selection and writing processes. Proposals in health system strengthening must be strong on HRH.
5.3 **Consistency in implementation of one national costed comprehensive HRH plan**

All stakeholders should **collaborate and facilitate** the implementation of the one national costed comprehensive HRH plan and should adhere to the policies and strategies that have been developed and linked to the national health plan in a consistent manner. All stakeholders of should respect this process and should avoid developing specific policies and strategies that will derail 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 in hard-to-reach areas, it is important that they are harmonized to ensure consistency and transparency.

5.4 **A unified monitoring and evaluation framework**

All stakeholders should **collaborate and facilitate** the monitoring and evaluation of the national costed comprehensive HRH plan through a unified monitoring and evaluation framework of indicators. Stakeholders should be willing to provide accurate and transparent information that will support the process. Such monitoring and evaluation can only be possible if the HRH programmes of all partners comply with the national HRH country plan. In this respect it will be important to strengthen human resources information systems and the national health workforce observatories to ensure that accurate, reliable and transparent information is provided by all stakeholders.

5.5 **Capacity building for stakeholders**

In as much as HRH stakeholders of the HRH coordination mechanism are very diverse, so are their capacities. Given this imbalance, not all stakeholders are actively engaged as equals in the dialogue process. National professional associations for example are unable to build their capacity and agenda due often to lack of resources. Building capacity of stakeholders particularly in the areas of information to provide evidence for good planning and advocacy can be a good start. However, to better identify gaps in capacity it will be useful to undertake a situation analysis of stakeholders to assess what capacity gaps exist. The results should form the basis for response. All stakeholders should **contribute and facilitate** in the process of capacity building.
SECTION III

5. SUPPORTING AND MONITORING COUNTRY COORDINATION AND FACILITATION

National governments and all stakeholders local, regional and global have to work together for a successful implementation of the CCF (Annex 1).

6.1 Government authorities
The highest level of Governments through the MOH and supported by other relevant ministries should provide the political leadership and commitment to make the CCF work. Given the gravity of the HRH crisis and different roles of so many stakeholders in resolving the crisis, leadership, direction and close monitoring will be required at the level of the Ministers, Permanent secretaries and Directors General of all concerned government ministries under the stewardship of the minister of health. Unless this commitment is assured most of the obstacles of the HRH crisis that the CCF wants to address will not be achieved. In providing such support governments should ensure that adequate financial resources are allocated to HRH. All concerned ministries should examine their policies to ensure that they are not in contradiction to improve the HRH crisis. Governments should continue to raise the visibility of the HRH crisis at all forum where health is an agenda.

6.2 National constituency stakeholders
Constituency stakeholders (health professional associations, Training institutions, Civil society organizations, faith based-organizations, academia, research institutions, bilateral and multilateral partners, trade unions and the private sector) should examine their roles, policies and strategies to assess the impact of their programmes and how they can better contribute to the access for all people to health workers. Local capacity and the relative strengths of each stakeholder should first be fully exploited in finding solutions to bottleneck and obstacles to improve the HRH crisis.

6.3 Regional and global partners
Where local solutions are not possible or adequate, an assessment should be made by the CCF to identify areas that need technical and or financial support from the regional and global partnerships. Based on the results of the assessment the CCF can agree and approach the following sources for support:

- Constitution stakeholders can approach regional or global constituency partners. The global Alliance can help to create an enabling environment where an intervention is needed that is beyond the capacity of the country stakeholders.
- Development partners or multilateral agencies such as WHO and other partners engaged in health.
- Regional economic and political bodies and other health related organizations. There are a number of these bodies and their composition and functions vary according to the geographic regions. They are heads of state or technical organizations. These bodies are important for continued advocacy to raise the visibility of the HRH crisis, for increased funding, to act as champions or special representative to raise the visibility of...
the HRH crisis. They also provide a platform for collective support for the rapid scaling up or for harmonizing policies and strategies for the regional level. Regional bodies should also demand for periodic reports as to what progress countries are making to improve the HRH crisis and the situation of HRH in the region.

- **Networks** (E.g Technical, advocacy, academic and research) These are universities, research institutions, the private sector and civil society that may be based in-country or within regions and can be a good resource for technical support for country actions. These networks should be the first port of call in providing technical support to help countries monitor the benchmarks for the functioning of the CCF.

### 6.4 Global health initiatives

Global health initiatives such as the Global Fund, GAVI and PEPFAR are major funders to the health sector. In recent times the GHIs have demonstrated the willingness to fund HRH within health systems strengthening. These developments have become even more important as the recent announcement by the high level task force on health systems financing that: GAVI, Global Fund and the WB facilitated by WHO should design a common platform for health system financing. These opportunities should not be missed. The CCF should engage and enter into dialogue with mechanisms of the GHI to see how best these resources for the health system can better address HRH.

### 6.5 Monitoring the CCF

Measuring the performance of the CCF is crucial to ensure that the processes and expected outcomes contribute to improve the HRH crisis; relevant benchmarks should be developed to measure the processes (functioning) and expected outcomes of the CCF. Results of the exercise can help us to examine whether progress is being made to improve the HRH crisis. It is important to understand that just having the structures in place may not produce the outcomes. Above all a monitoring exercise will help us to have evidence to improve on performance of the CCF.

Relevant indicators that can be considered to assess the following should be developed:

- Composition and types of membership of the HRH working group and frequency of its meeting
- Availability of information for planning purposes
- Prioritization of HRH issues by the HRH working group
- Methods and channels of communications of the HRH working group
- No. of contradicting policies by stakeholders
- Various channels of financial flows for HRH
- Availability of HRH annual review report
7. CONCLUSION

Since the formation of the global health workforce Alliance, significant achievements have been made in galvanizing global awareness and the need for action about the HRH crisis as is evident in the Kampala Declaration and Agenda for Global Action. In spite of known country actions that can improve the HRH crisis, countries still face many challenges in the implementation of these strategies. However, much can be achieved if there is a mechanism to coordinate stakeholders working to improve the HRH crisis. This document; principles for country coordination and facilitation (CCF) is an attempt to strengthen or establish mechanisms to improve the HRH crisis. The MOH should assume the coordination role of the CCF. However, government political commitment and collaboration by all stakeholders is required for the CCF to succeed. Establishing linkages with other mechanisms and working with regional and global partners can also help the facilitation of the CCF.
## ANNEX 1. *EXAMPLES OF CATEGORIES OF STAKEHOLDERS AND FUNCTIONS FOR A PARTNERSHIP ON HRH AT COUNTRY LEVEL*

<table>
<thead>
<tr>
<th>Sector</th>
<th>Institutions</th>
<th>Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>Ministry of Health</td>
<td>Stewardship of policies and strategies for HRH</td>
</tr>
<tr>
<td></td>
<td>Public service commission</td>
<td>Recruitment and career development</td>
</tr>
<tr>
<td></td>
<td>Ministry of Finance</td>
<td>Funding of the health budget.</td>
</tr>
<tr>
<td></td>
<td>Ministry of Labour</td>
<td>Ensuring health workers rights.</td>
</tr>
<tr>
<td></td>
<td>Ministry of Defence</td>
<td>Organization and management of health services for the armed forces.</td>
</tr>
<tr>
<td></td>
<td>Ministry for the Interior</td>
<td>Organization of health services for the police and security forces.</td>
</tr>
<tr>
<td></td>
<td>Ministry of Education</td>
<td>Training of some categories of health workers.</td>
</tr>
<tr>
<td></td>
<td>Ministry of Local Government</td>
<td>In some countries health services administration is decentralized to the district and regional levels</td>
</tr>
<tr>
<td>Multilateral agencies</td>
<td>WHO</td>
<td>Specialized technical agency for health.</td>
</tr>
<tr>
<td></td>
<td>UNICEF</td>
<td>UN agency for the health and social welfare of women and children</td>
</tr>
<tr>
<td></td>
<td>UNFPA</td>
<td>UN agency that promotes the rights of all populations</td>
</tr>
<tr>
<td></td>
<td>UNDP</td>
<td>UN programme for development activities</td>
</tr>
<tr>
<td></td>
<td>UNAIDS</td>
<td>Multiagency programme for HIV/AIDS</td>
</tr>
<tr>
<td></td>
<td>World Bank, African Development Bank,</td>
<td>Provide loans for HRH within country programmes</td>
</tr>
<tr>
<td></td>
<td>Islamic Development Bank</td>
<td></td>
</tr>
<tr>
<td>Private Sector</td>
<td>ADB</td>
<td>Provide loans for HRH within country programmes</td>
</tr>
<tr>
<td></td>
<td>Private hospitals, Private</td>
<td>Depending on size, can be a major employer of health workers. May organize and manage health services for employers.</td>
</tr>
<tr>
<td></td>
<td>concessions</td>
<td></td>
</tr>
<tr>
<td>Bilateral partners</td>
<td>Canada, European Union, Italy, Japan,</td>
<td>These are some of the bilateral partners that may be present at country level. They can provide direct funding and in some cases technical support to countries.</td>
</tr>
<tr>
<td></td>
<td>USAID and others</td>
<td></td>
</tr>
<tr>
<td>Civil society</td>
<td>NGOs, (several categories, specializing in various aspects of HRH)</td>
<td>Being very close to the communities, NGOs can provide valuable experiences and lessons on implementation and on community health personnel. Can be the largest provider of services in a country, particularly in rural areas.</td>
</tr>
<tr>
<td>---------------</td>
<td>---------------------------------------------------------------</td>
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</tr>
<tr>
<td></td>
<td>Faith-based organizations (several categories, specializing in various aspects of HRH)</td>
<td>Being very close to the communities, NGOs can provide valuable experiences and lessons on implementation and on community health personnel. A group of organization based on religious background. Can be the largest provider of services in a country, particularly in rural areas.</td>
</tr>
<tr>
<td>Academia</td>
<td>Universities and research institutions</td>
<td>Can provide technical support and undertake research to provide evidence as requested in special cases. Also useful for supporting the monitoring and evaluation of programmes.</td>
</tr>
<tr>
<td>Professional associations</td>
<td>Doctors, nurses, pharmacists and others</td>
<td>Involved in well fare of members in areas of salary negotiations, incentives and working conditions including working environment and professional development.</td>
</tr>
<tr>
<td>Regulatory bodies</td>
<td>Doctors, nurses, pharmacists and others</td>
<td>Involved in regulations for the registration of practitioners, accreditation of training institutions</td>
</tr>
<tr>
<td>Labour movements</td>
<td>Some allied health workers and support staff</td>
<td>Involved in well fare of members in areas of salary negotiations, incentives and working conditions and working environment.</td>
</tr>
</tbody>
</table>

* Depending on the countries, the categories can include Parliamentarians, representation from the Planning Ministry or National planning board/commission and the media.